C E S - POINT FOCAL OEDT
GRAND-DUCHE DE LUXEMBOURG

European Monitoring Centre
for Drugs and Drug Addiction

2008 NATIONAL REPORT (2007 data) TO THE EMCDDA
by the Reitox National Focal Point

"GRAND DUCHY OF LUXEMBOURG"

New Developments, Trends and in-depth Information on selected issues

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REITOX

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ABBREVIATIONS

AST	Service d'Action Socio-Thérapeutique
CATF	Chemical Action Task Force
CePT	Centre de Prévention des Toxicomanies
CAS	Commission d'admission et de surveillance (CHDP)
CES	Centre d'Etudes en Santé
CFSP	Common Foreign and Security Policy
CHDP	Controlled Heroin Distribution Program
CHNP	Centre Hospitalier Neuro-Psychiatrique
CICAD	Inter-American Drug Abuse Control Commission
CMO	Comprehensive Multidisciplinary Outline (UN)
CND	Commission on Narcotic Drug
CNDS	Comité National de Défense Sociale
CNER	Comité National d'Ethique de Recherche
CNPD	Commission Nationale de Protection des Données
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
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
DEA	Drug Enforcement Administration (United States)
EWS	Early Warning System on New Synthetic Drugs
GID	Groupe Interservices Drogue (de la Commission européenne)
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMEA	European Medicines Agency
EUROPOL	European Police Office
FBI	Federal Bureau of Investigation (United States)
FED	Fond Européen de Développement
FATF	Financial Action Task Force on Money Laundering
FEDER	Fond Européen de Développement Régional
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
HDG	Horizontal Working Party on Drugs

Honlea	Heads of National Drug Law Enforcement Agencies
ICD	Interministerial Commission on Drugs
ICPO/Interpol	International Criminal Police Organization
ILO	International Labour Organization
INCB	International Narcotic Control Board
JDH	Fondation Jugend- an Drogenhëllef
LNS	Laboratoire National de Santé
MSF	Médecins Sans Frontières
NDLEA	National Drug Law Enforcement Administration (Nigeria)
NFP	National Focal Point of the EMCDDA
NIDA	National Institute on Drug Abuse (United States)
OAS	Organization of American States
OCDE	Organisation de Coopération et de Développement Economiques
OGD	Observatoire Géopolitique des Drogues
OLAF	Europen Anti-Fraud Office
ONDCP	Office of National Drug Control Policy of the White House (United States)
PECO	Pays d'Europe Centrale et Orientale
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
REITOX	European Information Network on Drugs and Drug Addiction
SADC	Southern African Development Community
SEPT	Semaine Européenne de Prévention des Toxicomanies
SID	Système d'Information Douanier
SIS	Système d'Information Schengen
SNJ	Service National de la Jeunesse
SPG	Système de Préférences Généralisées
SPJ	Service des Stupéfiants de la Police Judiciaire
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organization
WHO	World Health Organization
ZePF	Zentrum für Empirische Pädagogische Forschung – Universität Landau

Foreword

The 2008 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 EMCDDA focal point of the Grand Duchy of Luxembourg.

The report has been edited by Alain Origer, head of the EMCDDA national focal point in collaboration with Sofia Lopes Da Costa, Céline Diederich (NFP/CES/CRP-Santé) and Simone Schram (Directorate of Health).

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Luxembourg, October 2008

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Summary
Annual National Report on the Drug Situation
(Edition 2008)

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 decentralised agency of the European Union. It 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 organisational 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. This led to the creation of the national drug coordinator's office in 2000.

The 2004 governmental programme has introduced no changes concerning competences and attributions in the drugs field and constituted 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 collaboration 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 drug 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 drug coordinator, jointly with the Interministerial Committee on Drugs (ICD), follows up the implementation process of the national drug action plan. In 2006 the national drugs coordinator has been appointed chair of the ICD.

The **global budget of the Ministry of Health** granted to drug-related services and programs went up from 1,270,169 EUR in 1999 to 5,770,643 - EUR in 2004, indicating a progression rate of 354% since 1999. The 2007 budget figures 6,689,000.- EUR. In regard to the 2008 budget, 7,288,000 - EUR have been allocated to concerned services representing an increase of 9% compared to 2007. Human resources dedicated to specialised state financed drug agencies have known a significant increase from 30.75 full time posts in 2000 to 78.5 in 2008.

The total number of drug users in the world is estimated at some 200 million people, equivalent to about 5 percent of the global population aged 15-64. Cannabis remains by far the most widely used drug (some 159 million people), followed by amphetamine-type stimulants (± 33.5 million people), which include amphetamines (± 25 million people) and ecstasy (almost 8.5 million people). The number of opiate abusers is estimated at 16 million people, of which 11 million are heroin abusers. Around 14 million people are cocaine users.

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 in prevalence.

National drug prevalence in the general population

Drug prevalence in school population and in general population

Comparable data from national school surveys conducted between 1992 and 2000 has shown increasing lifetime prevalence in young people (16-20 years) for all common illicit substances. Use of opiates in school populations are is consistently very low.

According to still incomplete data from most recent school surveys (HBSC, 2006) a higher proportion of 15 years old students report repeated lifetime drunkenness if compared to the data from 2002 HBSC, 2002). In reference to the same serial surveys lifetime prevalence of cannabis use in 15 years old youngsters (23%) has increased 1.2% whereas last 12 months prevalence (18%) witnessed a decline of 3.8 %. A large scale and representative survey in general population is foreseen for 2009-2010.

National prevalence of problem drug use (PDU)

Data on institutional contacts and drug treatment demands

The **number of problem PDUs** indexed by national institutions in 2007 figures 4,758 (2002: 4,701) (in this figure double counting is included meaning that a given person could have been indexed twice and more by different institutions. It is thus not representing the actual prevalence, which has to be assessed by other methods). For comparison, 2,383 users have been indexed by national specialised drug demand reduction agencies and 2,318 drug law offenders by supply reduction agencies in 2002.

In 2007 the same agencies have indexed 2,859 and 1,687 persons respectively. Overall the number of persons showing drug related contacts with DR or SR agencies in 2007 is showing an increase after 4 years of slow decrease. This situation is mainly due to a sensible increase in drug treatment demands whereas contacts with law enforcement agencies do remain stable. The number of substitution treatment demands has also been fairly stable over the last 5 years. Outpatient counselling demand increased sensibly and so did the number of contacts in low threshold services, having reached 60,000 in 2007. 14% (10%) of respondents are first treatment demanders.

If institutional contacts, including treatment demands and drug law offences, are applied as an indicator in conjunction with contextual data further developed in the present report, it is reasonable to presume that the national PDU prevalence has not significantly increased over the last 5 years and currently situates between 2,500 and 2,800 persons.

Socio-demographic profile of PDUs

The male/female ratio of the PDU population is 3:1. The last ten years the proportion of indexed non-native PDUs has be showing strong variations but a clearly increasing tendency since 2003, which showed signs of stabilisation in 2007. The population of non-natives drug users largely consists of Portuguese nationals, a proportion constantly increasing until 2004. Although the referred proportion stabilised since then, it is still consistently higher than the one observed in general population. Notably, one observes a remarkable increase of PDUs of French origin (23%). This trend is confirmed by data on drug law offenders over the last 7years.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 30 years and 9 months in 2007. The gap between youngest and oldest PDUs continues to grow, notably due to the increase of PDUs aged 40 and more. One observes an average aging of the population of long-term drug injectors and a sensible decrease in age referred to "new" PDUs. Worth mentioning is also a significant increase of the mean age of overdose victims and an important but currently decreasing proportion of minors among drug law offenders until 2006, with a weak increase in 2007. For the second time in succession since reliable data are available, **rates of first cannabis use**, in **11-13 years** old youngsters went beyond 35%. Respectively 89% and 44% of current PDUs have tried cannabis and heroin (i.v.) while being minor of age. In 1995 the same proportions figured 71% and 23%. Most interestingly, evolution of drug use patterns tend to accelerate in terms of shorter time spans separating first non-iv use from first iv-use. This acceleration is also observed as far as first treatment demands are concerned. PDUs tend to contact drug treatment facilities at an earlier stage, which may be due to a more diversified offer currently available.

The **residential status** of indexed respondents has improved over the last years. In 1995, 31% of the users reported stable accommodation; in 2007 the same proportion figures 73%. This improvement is partly due to various accommodation and housing offers for addicted people set up in the framework of the drug action plan. In 2006 and 2007 an increasing number of PDU report to live alone (47%). This evolution should be paid particular attention to since it increases overdose and other health-related risks.

All indicators included, **employment status** of PDUs suggest a weak amelioration in 2007, as the rate of PDUs with a stable job shows an increase of 10% compared to 2006 data. After a high level stabilisation (46-50%) during the past 5 years and even a new increase in 2006 (67%), the **unemployment rate** has decreased in 2007 (23%), as only PDUs benefiting from unemployment allocations have been considered considered.

Problem drug use prevalence and consume trends

The first national multi-methods PDUs prevalence study, 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 indirect follow-up indicators (Origer, 2005), **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. As already reported, the switch to intravenous drug use occurs earlier. The ratio of intravenous opiates consume to the inhalation mode has stabilised at 5:3. The prevalence of the use of cocaine as primary drug increased until 2005 and from there on tends to stabilise.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use had known a sensitive increase at the beginning of the 21st century but decreased again to stabilise between 2005 and 2007. **Amphetamine** type 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** (89% in 2007) stabilised at high level after a record level of 92% 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 with a tendency to stabilise. In 2007, age of first use of cocaine (iv/non-v) and heroin (iv) shows a weak decrease. For non-intravenous heroin, the mean age at first consume shows a clear decrease of 3–4 years in 2007. The average age at first cannabis use (almost 1/3 of respondents were not older than 13 at the moment of first cannabis use) after having decreased for several years, tends to stabilise.In general, the proportion of PDUs older than 39 years and of users less than 19 years is increasing continuously as well as the gap between these two groups.

Drug-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. Data from the Laboratory of Retrovirology of the CRP-Santé suggest a long term and discontinuous decreasing tendency of average proportion of IDUs in newly diagnosed HIV cases until 2004. HIV infection rates in IDUs situate around 4 percent and are witnessing a currently stable trend. A recent study (Origer and Removille, 2007) based on serological testing, confirmed a significant increase in HCV prevalence in PDUs and IDUs during recent years, especially in prison settings.

The implementation of the 2000-2004 and 2005-2009 action plans has been accompanied by a significant decrease of **overdose cases** in the Grand-Duchy of Luxembourg (2005: 8 cases). This decrease was mainly observed in male victims, the number of female overdose victims has remained fairly stable for the last 6 years.

In terms of number of overdose cases in the general population of the Grand-Duchy of Luxembourg, this proportion figured 1.76 overdose deaths per 100,000 inhabitants in 2005 (2000: 5.9 cases per 100,000 inhabitants). In 2007, however, 5.67 (2006: 4.13) acute od cases per 100,000 inhabitants were registered, which represents a two year increasing tendency likely to be confirmed by 2008 figures. An expert working group analysed possible reasons for this evolution and stressed the impact of high purity variation of street drugs currently on the market and generalized polydrug use including a series of prescription drugs with potentially dangerous interactions patterns with illegal drugs. **Forensic data** from 1992 to 2007 show that the most frequently involved substance in drug-related death is heroin, followed by methadone and cocaine. Since 2000, methadone traces in blood samples of overdose victims have been increasingly detected.

The vast majority of overdose victims are male (74%) and their mean age at the moment of death has been showing an important increase over the past 10 years (in 1992: 28.4 years and in 2006: 32.3 years). The number of victims aged less than 20 years remained relatively unchanged and the proportion of those older than 35 has been increasing during the retained observation period. A confirmed majority of acute drug death victims are known by law enforcement agencies for their drug user "career", with average

durations of 10 years. Worth mentioning also that more than 80% of the known victims followed at least one treatment before their death and half of the latter had an accommodation that could be qualified as stable. A confirmed majority of drug-related victims are natives. During the entire observation period Portuguese citizens stand in second place, followed by Italian and French natives. Recently, one could observe an increasing number of victims from border countries (BE, DE, F) and a decreasing number of victims of Portuguese origin.

In 2007, 11 **indirect drug death cases** have been indexed. Main causes of indirect deaths between 1996 and 2007 are, in order of importance: suicide, traffic accidents, undefined intoxication, associated cardio-vascular or pulmonary complications, drug (pharmaceutics) addiction, 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 between 1996 and 2005 figuring roughly 26 to 33 cases per year. In 2007, 38 drug-related deaths have been reported (27direct and 11 indirect drug related death cases).

Law enforcement indicators[1]

Seizures of illicit substances at the national level

Great variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analysis 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.

In terms of quantity **seizures** of heroin have been fairly stable since 2000 and even decreasing as far as cocaine and cannabis are concerned. The number of seizures did not show significant variations during the same period, with the exception of cannabis going up. Also, the number of offenders involved in seizures has been showing an overall decreasing trend. This may suggest that greater quantities of drugs are trafficked by smaller groups of traffickers. A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

The important increase quantity of ATS seized could not be confirmed by 2007 data. 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 over the last decade.

Drug law offenders and prison sentences

The **number of police records** for presumed offences against the modified drug law of 1973 went from 764 in 1995 to 1,372 in 2007. A similar evolution has been observed with regard to the number of drug law offenders. In 2007, 226 (225 in 2006) arrests for presumed offences against the modified 1973 drug law have been reported. However, in recent years, the number of police records, the number of drug law offenders and the number of persons arrested for the same charge have stabilised or even decreased.

[1] If not specified, data refer to 2007. Figures between brackets refer to 2006 if not otherwise specified.
[2] Non–transit drugs destined to the national market

88% 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** went from 52% to 68% in 2007. 32% (30%) of the registered cases were **first drug law offenders;** the percentage of **minors** in drug law offenders has increased from 5.4% in 1993 to 13.8% in 2003 and decreased again to 6.8% in 2007. National prison data of 2007 refer to 1,030 (1,043) new admissions of which 212 (20.6%) were related to drug law offences; a proportion having represented 42.6% in 1996.

Profile of the national drug market

According to observational data provided the Judicial Police and all decentralised national police units, 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 originates 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, expansion of **more structured distribution networks** by organized criminal associations has been reported. The national market increasingly attracts “drug professionals” aiming to set up a purely commercial distribution network. The proportion of non-natives involved in drug trafficking has been increasing over the last four years and may be stabilising according to 2006 and 2007 (72%) data. Asylum demanders implicated in illicit cocaine trafficking mainly originate from West African countries, particularly the Ivory Cost.

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. Numerous traffickers have changed from heroin to cocaine traffic and currently are also involved in cannabis traffic. Given the geographical position of Luxembourg, the national police forces closely cooperate with border countries and the Netherlands and do participate in large scale joint operations in the framework of international policy cooperation agreements aiming at the setup of a surveillance and intervention mechanism to fight illicit drug traffic originating from the Netherlands and drug trafficking and consumption at the regional level.

Overall, the national **drug market has become of a more aggressive nature** in terms of selling techniques. Dealers increasingly tend to actively approach confirmed or potential clients. More recently ethnic groups join to improve their drug distribution strategies whereas previously none of these criminal groups actively searched contact with other groups. Moreover it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible for police as for instance private flats or bars.

Compared to the situation in 2003, **purity** of heroin and cocaine has remained fairly stable. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (over 30%) in herbal cannabis samples seized in Luxembourg in 2007. **Prices** show broad ranges for heroin and cocaine, and a still ongoing decrease for ecstasy like products. Cannabis and derivates however have known certain stability during the last 5 years as far as street prices are concerned.

Since 2003, no new clandestine drug laboratory has been dismantled thus far. In 2006 and 2007 significant quantities of magic mushrooms and khat (60kg) have been seized in Luxembourg. The perceived illicit drug availability in general population is high and follows a weakly increasing trend according to recent surveys.

Harm reduction activities

The number of **sterilised syringes** (2007: 288,247/ 1996: 76,259) distributed in the framework of the national needle exchange program has been constantly rising from the start of the latter until 2005. The same trend has been observed with regard to the number of used syringes collected [2007: 260,252 (90%)/ 1996: 28,646 (38%)]. An increasing majority of injectors (34%) procure their syringes in specialised agencies followed by pharmacies and automatic dispensers. The **number of contacts** registered by low threshold structures has increased dramatically over the last 10 years and literally exploded from 2004 onwards (2007: 60,405 / 2005: 47,730/ 1996: 6,456). The number of syringes distributed by the same agencies has been following a similar evolution although stabilising for the first time in 2005 and decreasing in 2006 and 2007.

The number of clients of the national **methadone substitution programme** went from 30 in 1993 to 113 in 2007 (decreasing since 1998). In addition to the methadone substitution programme financed by the Ministry of Health, PDUs also address substitution treatment demands to **licensed GPs**. Data delivered by the Union of Health Insurance Founds refer to 979 different patients who did receive substitution treatment in 2007 (2002: 889 patients) by means of the prescription of methadone or buprenorphine containing medicaments by 122 prescribing GPs (1999: 125).

Most Relevant Trends

All indicators included an overall stabilization of PDU prevalence has been observed over the last 5 years. An increasing number of PDUs enter treatment or use low threshold offers and less come in contact with law enforcement agencies.

Intravenous opiate use remains the predominant PDU pattern. However, quality of street drugs went down, which had as a consequence an overall spread of polydrug use. The number of drug-related deaths reached 27 cases in 2007 signing as in many EU countries a last 2-years increase, which as far as Luxembourg is concerned seems not to be associated to an increasing overall PDU prevalence, but to an overall aging of heroin users, high variations in the purity of street drugs, and to generalised polydrug use including non therapeutic use of prescription drugs, presenting dangerous interaction effects with illicit substances' use.

There is great concern about infectious diseases in drug users and in particularly IDUs. HIV is low and stable; however, hepatitis C in PDUs has been increasing continuously. Latest research results based on serological testing (Origer & Removille, 2007) suggest HCV infection rates over 70% and even higher prevalence rates in prison populations.

The national drug market in led by more aggressive selling techniques and distribution strategies due to improved collaboration between criminal groups of different ethnic origins previously operating independently A tendency to move selling points to locations or settings less visible for police as for instance private flats or bars is also observed in this context. Attention has finally to be paid to the striking differences in maximum and minimum purities of street drugs as well as to a historically high maximum concentration of THC (over 30%) in herbal cannabis samples seized over the last 2 years.

The most relevant developments at the response side result from the implementation of the national drug strategy and its associated action plans. Over the last years counselling and specialized care networks have been developed, which had as a positive and proven consequence that PDUs start treatment at an early stage of their drug career. Coordination mechanisms have been reinforced between NGOs and national authorities and evaluations mechanisms are put in place. Drug action plans have allowed disposing of financial means that have known a disproportional increase compared to the time preceding drug action plans. If primary prevention is considered most important, there have been visible improvements in early intervention measures. Major efforts have also been made in the diversification of care offers and finally harm reduction measures have been significantly developed. Housing offers and reintegration programmes have obviously contributed to improve socio-professional situations as document by latest RELIS data. Substitution treatment, special care and low threshold offers have been decentralised and continue to be so.

Consistency between Indicators

Demand reduction indicators are highly consistent with supply reduction data (see fig. 4.2). Both indicators are suggesting a mid term stabilisation of problematic drug use at the national level. Interestingly harm reduction activity indicators continue to witnessing and different evolution if compared to DR and SR data. Thus, the number of contacts registered in low threshold agencies has been going up consistently and continuously over the last 10 years although the number of distributed syringes has been decreasing for the last 2 years. Also, the number of overdose cases has been increasing during the same time period. Possible explanations for these evolution, further developed present report, are important increase and diversification of national low threshold offers the decrease and high variations of in street drugs' quality, aging opiate users population, generalised polydrug use in combination with prescription drugs' use and, as far as the declining number of distributed syringes, the opening of the drug injection room in 2005. If analysed more in detail, these trends appear to be influenced by external factors not directly linked to a presumed increase of PDU prevalence and thus not in contradiction with a general stabilisation of the latter.

Part A: New Developments and Trends

1. National Policies and Context

Overview

Drug use is defined as behavioural pattern potentially associated to health and social damage. Consequently national drug policies are based on shared political competencies and responsibilities. Furthermore, in terms of intervention strategies, the more holistic concept of addictive behaviour is gaining in importance and influences increasingly policy debates. This tendency is reflected by the recent enlargement of ICD (Interministerial Committee on Drugs) competences and its increased external visibility.

National parliamentary elections of June 2004 have resulted in a new coalition government of social democrats (CSV) and labour 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, an adapted approach towards law enforcement by means of legislative amendments and the promotion of harm reduction measures, were appropriate.

In June 2005, the Minister of Health presented the new drug strategy and action plan 2005 – 2009, elaborated by the National Drug Coordinator who was also appointed chair of the ICD by the Minister of Health in 2006. The referred action plan is based on the evaluation outcome of the previous action plan and the assessment of current and future needs. A mid-term evaluation of the state of implementation of the 2005-2009 drugs action has been published in April 2008. A final external output and progress evaluation of the national drug strategy and action plan 2005-2009 is foreseen for 2009.

- LEGAL FRAMEWORK
    - Basic Drug Law and recent drug related laws

The basic national drug law, namely: 'Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie[4]' 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[5] 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.

[3] Governmental Declaration of 2004, http://www.gouvernement.lu/salle_presse/actualite/2004/08/04declaration/index.html

[4] Official gazette A 1973, p.319

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

- **law of 11 August 2006**[6] on the fight against tobacco regulates advertising of tobacco and related products, the prohibition of smoking in certain areas and the prohibition of sale of oral tobacco. Main legal amendments concern an increase of the number of smoke free public areas, a prohibition of smoking in catering establishments, a general prohibition of advertising, the prohibition of tobacco sale to minors under 16 and the prohibition of import and sale of tobacco in forms of candy or toys. The prohibition of smoking in spaces where food is served can be compassed by the implementation of separate smoking rooms, not exceeding 25 % of the total area, with specifically installed smoke extraction systems. Access is denied to youngsters aged less than 16 years. Pubs and bars are only concerned during core hours as far as they serve meals. Hospitals are allowed to install one smoking room exclusively reserved to patients.

Fines in relation to offences in regard to publicity, sale and import of oral tobacco and tobacco-like toys and candies range from 25 to 50,000 euros. Fines related to smoking in prohibited areas vary from 25 to 250 Euros for clients and up to 1,000 euros for the operator or manager of the venue. Sanctions for selling tobacco to minors lie between 251 to 1,000 euros. Legal amendments also concern the modified law of 17 June 1994 on security and health at workplace, the modified law of 16 April 1979 on general status of state civil servants and the modified law of 24 December 1985 on general status of communal civil servants. These amendments concern the protection of non-smokers at the workplace which underlies the responsibility of the employer. Due to the extend of modifications, the modified law of 24 March 1989 has been abrogated.

- law of 13 July 2007[7] referring to the markets of financial instruments and including the implementation of the : - directive 2004/39/CE of the European Parliament and of the Council from the 21 April 2004 concerning markets of financial instruments, modifying the directives 85/611/CEE and 93/6/CEE of the Council and the directive 2000/12/CE of the European Parliament and of the Council and abrogating the directive 93/22/CEE, - article 52 of the directive 2006/73/CE of the Commission of the 10 August 2006 executes the directive 2004/39/CE of the European Parliament and of the Council with regard to the organisational requirements and operational conditions applicable to investment companies and the definition of some terms of the aforesaid directive .

- **law of 18 September 2007**[8] lowers the alcohol concentration tolerance level from 0.8‰ to 0.5‰ and the introduction of a level below 0.2‰ for specific categories of drivers (young drivers and professional drivers). Fines are applied and driving licence “points” are subtracted if alcohol level is equal or superior to 0.5‰, respectively 0.2 ‰. An immediate driving license withdrawal will be applied for 8 working days:

- in case of an alcohol level equal or superior to 1,2‰
- in case of refusal to submit oneself to an alcohol or drug test,
- in case of exceeding the speed limit of 50% of the authorised maximum speed, the excess being of at least 40km/h.

It also provides a legal framework to roadside (illegal) drug testing by means of rapid tests (Drugwipe II). Tolerance levels according to types of drugs are as following:

THC: 2ng/ml ATS: 50ng/ml Cocaine: 50ng/ml Opiates: 20ng/ml.

[6] Official gazette A 2006, p.2265, (Adoption: 13/07/2006, Entry in force: 05/09/2006)
[7] Official gazette A 2007, p.2076 (Adoption: 13/07/2007, Entry in force: 01/11/2007)
[8] Official gazette A 2007, p.33475, (Adoption: 18/09/2007, Entry in force: 01/10/2007)

Law of 18 December 2007[9] having the approbation of the United Nations Convention against the organised transnational criminality**,** adopted by the annual general meeting of the United Nations in New York, on the 15th of November 2000. The object of the Convention consists in the development of the cooperation in order to prevent and to fight the organised transnational criminality in a more efficient manner.

- Grand Ducal Decrees (2004/2008)

- The **grand ducal decree of 16 March 2006**[10] defines maximum prescription periods for methylphenidate, oral morphine, transdermic fentanyl, buprenorphine, hydromorphone and methadone.
- The **grand ducal decree of 18 January 2005**[11] establishes the model of prescription forms of narcotic based pharmaceutics. The referred prescription form contains 2 separate annexes. The first to be used in case of substitution treatment and the second to be completed in case of other types of medical treatments.

- The **grand ducal decree of 7 October 2004**[12] 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**[13] 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.
- Grand ducal decree of **30 January 2004** modifying the grand ducal decree of 2 February 1995[14]
- Grand ducal decree of **13 February 2007** on the surveillance and commerce of drug precursors[15]

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[9] Official gazette A 2007, p. 4410 (Adoption: 18/12/2007, Entry in force: 28/12/2007)
[10] Official gazette A 2006, p.1156, (Adoption: 16/03/2006, Entry in force: 31/03/2006)
[11] 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
[12] 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
[13] 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

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.europa.eu.

- Projects and propositions of law

No projects or propositions of law in relation with drugs or drug addiction were introduced in 2007.

- Laws implementation

Legally speaking, police has no discretional power: every offence, once disclosed, must be reported. However, depending on the case, (e.g. first offence 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.

Narcotic offences are covered by the law (concerning the sale of medicinal substances and the fight against drug addiction) of 19 February 1973 (hereinafter referred to as ‘the 1973 law’) that was modified by the law of 27 April 2001.

The modified 1973 law essentially remains a repressive law, towards drug consumers as well as dealers. Even though the 1973 law does not specifically provide for alternative measures to prison for drug-addicted delinquents, the following options, constituting a medical alternative, are available during the investigation, the pre-trial stage and at trial.

In accordance with Article 23 of the 1973 law, cases involving personal use of drugs (individually or in a group) and/or cases involving offences against Article 8 of the 1973 law are dropped if the offender, before the illegal use was discovered, undertook treatment for drug addiction. Moreover, the public prosecutor can offer the offender the option of voluntary treatment for the addiction. If the offender successfully completes the treatment proposed by the prosecutor, the charges have to be dropped.
According to the terms of Article 24 of the 1973 law, when preliminary charges are brought for personal use of drugs and when it is established that the offender is the subject of medical treatment, the investigative judge may order treatment for drug addiction at the request of the prosecutor or the accused person.

Article 25 of the 1973 law makes provision for the juvenile court to refer an addicted minor treatment.

Article 26 of the 1973 law provides for the courts to order a drug addict to undergo treatment, in which case the verdict can be postponed. If the accused person meets all conditions imposed by the courts, the charges for illegal use may be dropped.

The above measures are only available to drug users and no other categories of offenders.

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[14] Official gazette A 2004, (Adoption: 13/02/2007, Entry in force: 22/02/2007)
Règlement grand-ducal du 13 février 2007 relatif à la surveillance du commerce des précurseurs de drogues [...].
[15] Official gazette A 2007, (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.

In addition to the special measures set forth in the 1973 law, the courts can still avail of the reformed sentencing measures or of any of the extenuating circumstances which are an option for all offences, as outlined in the Code of Criminal Law and the Code of Criminal Investigation. The extenuating circumstances outlined in Articles 73 to 79 of the Code of Criminal Law allow the judge the option of ordering community service or a fine, or even to forgo sentencing in favour of a police fine (between EUR 25 and 248).

Articles 619 to 634(1) of the Code of Criminal Investigation allow the judge the option of either postponing the verdict, with/without a trial period, or suspending the sentence, with/without probation and with a trial period.

The last measures are the most used (mainly the extenuating circumstances and suspended sentencing). The legal option for a medical alternative, provided by the 1973 law, are only rarely used, for cases where the judge is convinced that the drug addict is sincere in his desire to be treated.

The law of 27 April 2001[16] modifying the basic drug law of 19 February 1973 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[17] on substitution treatment, have largely contributed to increase the congruity between drug legislations and prosecution routines. Also, current drug legislation and prosecution policies put higher priority on drug dealing and trafficking than on drug consumption and promote harm and risk reduction measures. The creation of a national supervised drug consumption room has been welcomed by law enforcement since street and public drug use as well as related public nuisances have decreased significantly. Also police officers have the possibility to refer exclusive (injecting) drug users to the injection room as an alternative to street drug use thus contributing to the harm and nuisance reduction strategy.

The reaction to an offence committed by a drug user must be proportional to the harm it aims to prevent. All the legal experts of Luxembourg are in agreement with this statement, and the principle is applied in practice. In fact, as long as the drug addict remains a simple user, any damage caused is to himself/herself and the legal response remains minimal as long as public order is not greatly disturbed. However, if the drug addict causes harm to others, the response will become firmer according to the seriousness of the offence.
The highest priority is given to trafficking of 'very dangerous' drugs. Such traffickers may be considered to be trafficking in death. Since the first objective of Luxembourg's drug policy is to prevent addiction and related risks, it is fundamentally important to pursue the dealers. As long as there are widely available 'dangerous' drugs on offer, the price will be relatively low. This situation will increase the temptation for consumers of other drugs (even the legal ones, such as alcohol and tobacco) and access to 'very dangerous' drugs will remain easy. Consequently, all efforts must be concentrated on fighting dealers in 'very dangerous' drugs, in order to limit the availability of such drugs. The penalties handed down to traffickers should have a deterrent effect. All the legal experts, the police and the social workers agree on this. It is not possible to tolerate any trafficking of hard drugs if an efficient fight is to be conducted against drug addiction.

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

Another priority is the fight against serious offences (other than drug offences) committed by drug addicts. The majority of crimes and property offences are committed by drug addicts to finance their drug consumption, which is an enormous infringement of public order. A significant reduction of such offences would inevitably reduce public order disturbances, which would encourage the public to regard drug addicts as sick people in need of help. It is possible to foster this view of drug addicts by continuing to be vigilant against drug use and sale of drugs in public.

For drug offences committed in private, other procedures, such as criminal mediation, decriminalization, postponement or suspension of a sentence, or enforced treatment for drug addiction, are an option – particularly in cases of minimal public nuisance or a first-time offence.

The courts in Luxembourg impose a prison sentence, sometimes suspended, and then offer the accused the option to submit to treatment programme in order to avoid imprisonment. However, many social workers believe that such a response is inappropriate, since such treatment is thought effective only when an addict chooses to follow it according to his own free will and not when he/she is 'forced' to do so, which has in fact been supported by outcomes of such treatments over recent years.

In Luxembourg, it is generally agreed that drug users are sick people in need of treatment in the first place and that simple drug use should not be subject to criminal proceedings. Measures such as warnings, fines and forfeiture of drugs are more appropriate, and are already applied in practice by various competent authorities in Luxembourg in cases involving minor disturbance to public order. There is, however, consensus among the legal experts that these measures should not be the only ones available, since there are cases where even simple drug use seriously disturbs public order (particularly when it occurs in schools, for example), for which specific penalties should be developed.

There is also consensus among the experts that the police, who are in direct contact with the users, should not have the power to apply any further action. Such decisions should be reserved for the magistrates, who can objectively assess a case based on the facts. There are differing viewpoints as to whether use/possession of drugs for personal use should warrant imprisonment. Social workers generally believe that, if an addict is to be considered as a sick person, consumption of drugs should never be penalized, or, at most, a fine should be imposed. The legal experts, on the other hand, consider that the option of imprisonment for drug use should remain, even if it is only for users of 'very dangerous' drugs, since situations sometimes arise where imprisonment is the only solution to ongoing public nuisance.

- INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES

  - Coordination arrangements

Following the 1999 parliamentary elections, the coordination of drug demand reduction, risk reduction and research has been granted to the Ministry of Health. In November 2000 a National Drug Coordinator was appointed by the Minister of Health and mandated with the overall co-ordination (including interministerial coordination) 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)*. In 2006, the national drugs coordinator has been appointed chair of the ICD by the Minister of Health. The ICD is composed of senior delegates from the main governmental departments and delegates from selected NGOs 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 4 to 6 times yearly. 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. Outcomes of the ICD meeting are transmitted to all competent ministers and national media in order to ensure complete public visibility. Since 2006, the ICD has been granted an enlarged mandate and addresses currently issues ranging from illicit drug use to alcohol use and prescription drugs under the general heading of addictive behaviour and its consequences. In May 2008 the ICD issued its first press communication on alcohol misuse in youngsters, first to raise awareness and secondly in order to give increased visibility to the work and priorities of the IGD.

At the governmental level, there exists a Special Parliamentary Commission on Drugs as an advisory body to the government.

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 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 periodically with conventioned NGOs (collaboration platforms) in order to share information and elaborated responses to emerging trends. A new forum called 'COCSIT' has been created by specialised drug agencies with the objective to follow up drug trends and to advice national authorities. The national drug coordinator is regularly invited by COCSIT and sporadically participates in its work. Recently common recommendations on reducing drug-related mortality have been edited as an example of good practice in the field of collaboration between national Health authorities and NGOs specialised in drug care.

- National plan and strategies (NNIA)

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.

- Implementation of policies and strategies (NNIA)

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: ‘1. Description/objective of action – 2. Responsibilities – 3. Budget – 4.Outcome – 5. 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. 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.

- Evaluation of policies and strategies

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 consecutive drugs action plans 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 drug action plans 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.

A mid-term evaluation of the state of implementation of the 2005-2009 drugs action plan has been published by the ICD. in April 2008. In summary, 82% of planned measures are progressing timely or have been implemented in due time, while the action plan is only halfway from the end its foreseen duration. 13% of the actions are in progress but will be finished after the deadline or have been accomplished with delay. 7% of the measures had to be suspended for budgetary or other reasons. It should be noted that the observed delays are not of conceptual order or attributable to respective project managers. They are partly due to delays in administrative procedures and to the necessity to include the lessons of some innovative projects in the planning of other projects (e.g. program of controlled heroin distribution).

Beside the efforts made by the totality of involved actors and networks, the positive outcome has also to be related to the considerable increase of the budgetary means allocated to the fight against drug addiction. An increase of 224% of the budget invested by the Ministry of Health in drug demand reduction occurred between 2000 and 2007.

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 to the population of PDUs, to reduce considerably the number of drug overdoses and finally to promote research activities in the field.

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

Meanwhile a working group chaired by the national drug coordinator and composed of experts from the Ministry of Health and specialised drug and psychiatric departments has been mandated by the minister of Health to undertake a needs assessment in the field of specialised drug care and rehabilitation services. The recommendations of this group complemented in addition to the output of the final evaluation will serve the national drug coordinator and the Interministerial Commission on Drugs to elaborate the national drugs action plan 2010-2015.

- BUDGET AND PUBLIC EXPENDITURE[18]
    - Law enforcement, social and health care, research, international actions, coordination and national strategies

The fight against drugs is multidisciplinary. Thus, in Luxembourg: 11 ministries and 13 departments are involved to a different extent in the enforcement of national drug policies. As in most EU Member states, the structure of the national state budget does not allow for a drug budget allocation analysis exclusively based on labelled expenditures. Following are some of the preliminary problems one typically is confronted with in a public expenditure study:

- Budget lines may be generic (legal & illegal drugs), aggregated (addiction prevention), over inclusive (social solidarity) or unidentifiable (others),

- Apportionment of budgets may not be provided,

[18] See related chapter in Part B

- Difference between provisional budget, voted budget and final expenditure (provisional budget often more detailed than voted budget),

- Expenditures may be annual, multiannual, unique, ordinary, extraordinary, etc. If they occur during the study reference year, they should be included even though they might give a biased picture of average or routine expenditures, especially when they are important (e.g. investments in real estate)[19],

- In terms of follow-up: budget lines may be restructured, integrated or divided over time,

- In the field of public health, expenditures may result from direct state financing or social security reimbursement,

- Lack of clarity due to National mixed (Multi-ministries) financing (e.g. Public research Centres – multi projects' financing) or National & EU & International shared financing,

- Eligibility of cooperation projects vs. variability of yearly contributions,

- Assessment of impact of general education and educational interventions (e.g.) on DDR impossible.

This list is not exhaustive. Nevertheless drug related public expenditure studies are feasible although they demand a considerable amount of analytical work for labelled or dedicated budget lines as they require a certain degree of creativity as far as non-labelled expenditures are concerned. Researchers may be forced to take decisions whether to include or not a series of expenditures. It is important that those decisions are taken according to reproducible standards and, even better so, according to harmonized and ultimately widely recognized methodological benchmarks.

As these standards are only about to be developed, the answer to a general question should guide the researcher in each single decision he or she has to take, namely: *Would the service, offer, measures, action, institution, etc. also exist or be the same if there were no drug addicts or illegal drugs to be dealt with?*

In order to tailor and fine tune a methodology that fits the national context and in line with the work plan of the EMCDDA, 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).* The original research report can be accessed under: http://www.relis.lu. In the framework of 2006 EMCDDA contractual requirements an update of the Origer 2002 study has been performed and main results are produced in the selected issues section. A detailed description of the methodology applied in 2002 can be consulted in the original study. The same methodology has been applied for the present and other yearly updates.

Given the geographical size of Luxembourg and its political organisation, listed expenses are of centralized and national nature. There are no significant regional or local drug related budgets to be considered in the present analysis.

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[19] In order to highlight the different status/nature of budget lines, the following abbreviations have been used in the expenditure tables: S. : Standard budget (annual expenditure / budget line) I: Investments (unique year dependant expenditure)

• **Methodology**

The objective of the present analysis is to assess direct public expenditures for the fight against drugs and drug addiction. The constituent concepts are defined as follows:

DIRECT: Excluding 'costs of indirect consequences' (e.g. loss of income, taxes) and 'non quantifiable costs' (e.g. loss of welfare) as well as expenditures related to the acquisition of illicit drugs by the consumer him- or herself.

ECONOMIC: Monetary impact and not social impact (costs) or loss of life quality e.g.

COSTS: Expenditures and not revenues created by illegal drug market.

NATIONAL DRUG POLICIES: Public finances and not private expenditures or investments

The applied methodology refers to the concepts of the '**Cost of Illness**' (C.O.I.) theory in opposition to "Cost-Benefit" approach. **COFOG and REUTERS** classifications were applied as recommended by the EMCDDA. The following techniques have been applied and combined according to existing contexts:

- Analysis of state budget and provisional state budget
- Clarification meeting with involved financial authorities
- Qualitative interviews
- Analysis of activity reports of ministerial departments and NGOs
- Analysis of state conventions and financial statements of specialized NGOs
- Detailed financial breakdown and budget apportionment provided on demand by a series of institutions (NGOs, Social Security, Hospitals)

Main reference documents:

- Laws and projects of law regarding the budget of revenues and expenditures of state
- Annual ministerial activity reports
- Activity reports of specialised agencies
- State conventions with NGOs
- Annual financial statements of specialised NGOs
- Statistical registers of UCM

The main data sources referred to in the framework of this chapter are as follows:

Ministère des Finances (2006). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.
Ministère des Finances (2007). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.
Ministère des Finances (2008). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.
Ministère de la Santé (2008). Rapport d'activités 2007, Ministère de la Santé, Luxembourg.
Ministère de la Santé (2005). Stratégie et plan d'action national en matière de lutte contre les drogues et les toxicomanies 2005 – 2009. Ministère de la Santé. Luxembourg.
Origer, A. (2002b). Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies. Séries de recherche n°4, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

Tab. 1.1 National estimates of labelled drug related expenditures

Ministry / Department	Budget /Title	Budget / Expense (EUR)		COFOG	REUTERS
01 Ministry of Foreign Affairs and Immigration	**S** 01.7 / 35.031 35.40 /01.53 Cooperation and Development: Voluntary contributions to international organisations Contribution to UNODC	100,000.-		01.2.2.	/
04 Ministry of Finances	**S**. 04.3 /12.310 03.20 Staff and operational costs of the Special Drugs Division of Customs Costs related to drugs dogs brigade	3,773,260.- 40,000.-		01.1.2. *(03.6.0)*	3
05 Ministry of Finances Treasure and Budget	**S.** Operational costs and 2007 national investments of the National Fund against Drug Trafficking **I** 34.3 74.300 01.22 Acquisition of drug detection equipment for Customs Administration	845,241.- 65.000.-		01.1.2. *(03.6.0)* 03.6.0	1,2,3,4 3
07 Ministry of Justice	**S**.07.0 35.060 03.10 International Relations: Contribution to EUROPOL DRUG UNIT **S** 12.370 / 12.30 / 03.03 Care programme for drug addicts in prison	6,000.- 700.000.-		01.2.2. 07.2.0.	3
10 / 11 Ministry of Education of Professional Training	**S**.10.0 12.223 04.01 Drug prevention in primary and post primary schools S11.4 12.301 08.30 Drug prevention and Sport	0.- 2,000.-		07.4.0 07.4.0	1 1

12 Ministry of Family, Social Solidarity and Youth	**S** 12.8 / 12.252 06.32 Drug Prevention in retention centres for minors	12.530.-		03.4.0	1
14 Ministry of Health	**S**14.0 12.000.05.00 Fees for National Drug Substitution treatment commission	1,500.-		07.4.0.	2
	S14.1 12.343 05.00 Control of national enforcement of UN drug conventions	10,000.-		01.2.2.	3
	S14.1 33.002 05.00 Co-financing of staff and operational coast of the national EMCDDA focal point	124,345.-		07.5.0.	/
	S 14.1 / 33.013 05.23 - 33.014 05.23 Staff and operational cost of specialized drug agencies conventionned by state	5,676,983.-		07.2.0	1,2,3,4
	S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	510,000.-		07.1.2.	4
	S14.2 12.301 05.20 / 12.801 05.20 Toxicological surveillance of drug addicts	152.000.-		07.4.0	/
	I 44.7 52.000 05.22 05.23 / 52.002 05.22 Construction works and acquisition of equipment for conventionned specialized drug agencies	500,000.- 55,000.-		07.2.0	2
22 Ministry of Public Buildings	**I**.52.4 72.022 05.20 05.22 / 74.092 74.22 Construction works and acquisition of equipment for conventionned specialized drug agencies	30,000.-		07.2.0	2
TOTAL A	**Labelled Public drug-related expenditures**	**12,603,859.-**			

2. Non labelled drug-related expenditures and definitions of attributable proportions

Table 1.2 provides an exhaustive overview of non labelled drug-related public expenditures as well as information on proportion calculations. In case the attributable proportion keys are complex, a more detailed description is provided below.

Tab. 1.2 National estimates of non labelled drug related expenditures (attributable proportions)

Ministry / Department	Budget /Title	Budget / Expense (EUR)	Attributable proportion	COFOG	REUTERS
01 Ministry of Foreign Affairs and Immigration	**S.** 01.7 Staff ,operational and mission cost related to drug related issues	19,790.-	Estimation by MFA based on analysis of work and mission reports and career of involved agents	01.2.2.	/
05 Ministry of Finances Treasure and Budget	**S.** 05 Renting of real estate for specialized drug agencies	273,560.-	Standard rent prices according to location and surface	0.1.1.2	2
07 Ministry of Justice	**S.** 07.0 Staff ,operational and mission cost of MJ related to drug related issues	6,500.-	Estimation by MJ based on analysis of work / mission / career	03.6.0	3
	S. 07.1. 0 Staff ,operational and mission cost of judiciary services (courts, etc) related to drug related issues	1,120,000.-	Total cost of judicial services x proportion of drug offences affairs (based on ad hoc register)	03.3.0	3
	S. 07.2 Prison drug related expenditures	9,119,630.-	Total prison budget x proportion of drug law offenders in total prison population	03.4.0	3

	S.07.4 Police drug related expenditures	1,162,360,- 3,691,600.-	Dedicated staff, operational and mission costs (Special drug units 100%) + Assessment by Police Directorate based on analysis of job descriptions and related operational costs	03.1.0 03.1.0	3 3
12/13 Ministry of Family, Social Solidarity and Youth	**S**. 13.1 / 12,140 06. 32 Information campaigns on drugs	14,960.-	Internal budget breakdown	07.4.0	1
	S. 13.1 **/** 11.000 11.00 Staff ,operational and mission costs of MF related to drug related issues	22,092.-	Estimation by MF based on analysis of work / mission / career	07.4.0	1
14 Ministry of Health	**S** 14.0 Staff ,operational and mission cost of MH related to drug related issues	22,092.-	Estimation by MH based on analysis of work / mission / career	07.6.0	1,2,4
14.1 Directorate of Health	**S** 14.1 / 33.014 05.23 Staff and operational cost of National Aids counselling Centre	188,217.-	25% of total budget : average proportion of PLWHIV/AIDS infected via IDU in clients	07.2	1
	S 14.1 / 11.000 05.00 / 12.010 05.00 Staff and mission costs of Directorate of Health allocated to drug related issues	244.000.-	Dedicated staff to drug issues + Estimation by MH based on analysis of work / mission / career	07.6.0 .	1,2,4
14.2 Public Health Laboratory	**S** 14.2 / 11.000 05.20 Staff ,operational and mission costs of Laboratory related to drug related issues	22,092.-.-	Estimation by Laboratory based on analysis of work / mission / career	07.4.0	2

17 Ministry of Social Security *Health / Social insurance*	**S** 17.2 Staff ,operational and mission costs for agents in charge of drug treatment referral abroad	77,694.-	Estimation by MSS based on analysis of work / mission / career	07.4.0	2
	<u>*A. Substitution treatment*</u>				
	- Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (Net, patient's contribution excluded)	265,025.-	Detailed breakdown by Union of Sickness Funds (UCM)	07.2.2	2
	- Reimbursement of medical counselling costs related to substitution prescriptions	41.975-	Detailed breakdown by Union of Sickness Funds (UCM)	07.2.2	2
	<u>B. Inpatient hospital drug treatment</u>				
	- Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification)	2,320,805.-	ICD-10: F11, F12, F14, F15,F16, F18 and F19 hospital episodes x cost per ep. (provided by UCM)	07.3.2	2
	- Medical counselling costs associated to hospital treatment episodes	153,645.-	Number of medical consultations x reimbursed fees according to duration of stay	07.3.2	2
	<u>C. Drug treatment abroad</u>				
	- Reimbursement of drug treatment costs abroad (e.g. residential therapy or specialized therapeutic offers not available in Luxembourg)	1,220,000.-	Adjusted breakdown provided by UCM in 2005	07.3.2	2
	<u>D. Cost of HIV/AIDS treatment provided to patients infected via IDU</u>	1,830,000.-	Number of HIV/AIDS patients infected via IDU in treatment x yearly average cost of HIV/AIDS treatment (+/- 20,000.- EUR) x reimbursable proportion	07.2.2 07.3.2	2

TOTAL A	Non-Labelled Public drug-related expenditures	21,816,037			
TOTAL A+B	Labelled + Non-Labelled Public drug-related expenditures	34,344,916			

Tab. 1.3 Overall expenditure in fiscal year 2007 by 1st level COFOG functions

COFOG 1st level function	Labelled expenditures	Non-labelled expenditures	TOTAL
3 (Public Order and Safety)	4,736,031.-	15,100,090.-	19,836,121.- (58%)
7 (Health)	7,751,828.-	6,422,597.-	14,174,425.- (42%)
		TOTAL	34,010,546.-

Tab. 1.4 Overall expenditure in fiscal year 2007 by 2nd level COFOG functions

COFOG 2nd level function	Labelled expenditures	Non-labelled expenditures	TOTAL
3.1 (Police services)	3,838,260.-	4,853,960.-	8,692,220.-
3.3 (Law courts)	/	1,120,000.-	1,120,000.-
3.4 (Prisons)	12,530	9,119,630.-	13,898,711.-
7.1 (Medical Products, appliances and equipment)	510,000.-	/	318,151.-
7.2 (Outpatient services)	6,961,983.-	495,217.-	7,457,200.-
7.3 (Hospital services)	/	5,524,450.-	5,524,450.-
7.4 (Public Health services)	155,500.-	136,838.-	292,338.-
		TOTAL	32,728,368.-

• **Additional explanatory notes on attributable proportion calculation keys (not addressed in tables)**

05 Ministry of Finances Treasure and Budget
05 FLTS: (Eligibility? / revenue - expenditure). Confiscated assets re-invested in the fight against drugs. Only financial means invested in national projects as these would have to be financed by public money if the FLTS did not exist.

07 Ministry of Justice
07.2 State prisons.

Distinction between new entries and stock of prisoners/year.
Prison administration provided proportion of "drug offenders" in prison (prevalence: 25%) (Incidence: 21% new entries):

A) Calculation of total costs
B) 25% of total costs

But: Estimation bias: Prevalence based estimation does not take into account duration of prison stays. Better method if data available:

$$\text{Estimation key} = \frac{\text{Sum drug prisoners days}}{\text{Total prison/person days per year}} = \text{e.g. } \frac{140{,}160 \text{ days}}{28{,}800 \text{ days}} = 20.5\%$$

17 Ministry of Social Security (Health expenditures)
II.1 HIV/AIDS treatment (IDU related infections and health costs)

For HIV/AIDS treatment rates the following calculation formula has been applied:

- **A :** Total number of registered PLW HIV/AIDS infected via IDU (diagnosis reporting) (status: alive)
(If not available: Total number of PLWHIV/AIDS infected via IDU x mortality rate of target population)
(Higher precision (if available): Total number of PLW HIV/AIDS IDU in treatment during year X that might be provided directly by central social security department)

- **B:** Average cost of HIV/AIDS treatment / year X provided by UCM

- TOTAL COST OF PLW HIV/AIDS IDU TREATMENT = A x B

01 Ministry of Foreign Affairs and Immigration
II.1 National Contribution to the EU 'drugs budget'

The first national study on public drug-related expenditures (Origer, 2002) also included the national Contribution to the EU "drugs budget" as public money is at stake. The following method has been applied:

a) Assessment of the EU "drugs budget" (x EUR) = difficult since EU drug budget lines are scattered, affected to internal and external programmes and there are multiannual budget lines. At the time of study only an inventory of drugs related EU budget did exist (COM (2001) 301 final).

Methodology: Sum of annual EU drugs budget lines + proportional share of multiannual EU drugs budget lines for year of study.

b) Determination of the national contribution share to the total EU budget (y%)
c) Estimation of national contribution: X x Y.

Remark: Other international contributions are accounted for in the budget lines of the Ministry of Foreign Affairs and Cooperation. The referred expenditures have not been included in the present analysis since EMCDDA guidelines do not refer to.

- **Relevant or pertinent expenditure breakdowns:**

The following minimum breakdowns on total expenditures should be performed if required data are available:

- Expenditure per inhabitant (EUR)
- Expenditure per est. PDU or IDU (EUR)
- Demand reduction / Supply reduction / Risk/damage reduction / Research (COFOG level 3 and 7 is insufficient)
- % of GDP
- % of total national public expenditures / state budget
- % of total national social expenditures / social budget

The NFP follows up the annual budgetary evolutions by means of the most representative indicator, which is the annual budget of the Ministry of Health allocated to drug-related activities. Figure 1.1 shows the budgetary progression since the implementation of the first drugs action plan in 2000 and figure 1.2 summarises the annual progression of budget of the Ministry of Health and human resources allocated to drug-related activities to the mid-term evaluation period.

Fig. 1.1 Annual budget of the Ministry of Health allocated to drug-related activities 2000 - 2007

Year	2000	2001	2002	2003	2004	2005	2006	2007
Budget (EUR)	2,066,000	3.210,000	4,294,000	4.862,000	5,771,000	6,196,000	6,584,000	6,689,000
Progression rate	Reference year	55%	108%	135%	180%	200%	217%	224%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2008. Volume 1. (Ministère des Finances 1999-2007)

Fig. 1.2 Annual progression of budget of the Ministry of Health and human resources allocated to drug-related activities 2004 - 2008

Budget Year	2004	2005	2006	2007	2008
Budget (EUR)	**5,771,000.-**	**6,196,000.-**	**6,584,000.-**	**6.689.000.-**	**7,288,000.-**
Annual progression rate	Reference year	7.36%	6.27%	1.59%	8.97%
Annual cumulative progression rate	Reference year	7.36%	14.09%	15.91%	26.29%
Dedicated human resources Full Time Equivalent (FTE)	**59.5**	**63.5**	**69.25**	**73.5**	**78.5**
Annual progression rate	Reference year	6.72%	9.06%	6.14%	6.80%
Annual cumulative progression rate	Reference year	6.72%	16.39%	23.53%	31.93%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2006/2008. Volume 1. (Ministère des Finances 1999-2007)

- 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 NGO 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

In May 2008, the Directorate-General Justice, Liberty and Security of the European Commission published the public opinion poll "Young people and drugs among 15-24 years olds"(N°233) within the scope of Eurobarometer surveys. In 2002 and 2004, two previous surveys had been conducted among youngsters coming from EU15 member states (Special Eurobarometer N°172 and Flash Eurobarometer N°158).

For the new Flash Eurobarometer N°233 (2008) the questionnaire had been redesigned and telephone interviews had been used instead of face to face interviews.In Luxembourg the Gallup Europe institute conducted telephone interviews between 14 and 18 May 2008. A total of 250 youngsters aged 15 to 24 years have been interviewed.

1. How should society's drugs problems be tackled

The following table presents the results of the question: "What do you think is the most effective way for public authorities to deal with drug problems in society? What would be the second most effective way?":

	Tough measures against drug dealers and traffickers		
	the most effective way	the second most effective way	Total %
Luxembourg	33	22	55
EU27	39	24	63
	Information and prevention campaigns		
LU	24	23	47
EU27	24	22	47
	Treatment and rehabilitation of drug users		
LU	21	18	39
EU27	14	19	33
	Tough measures against drug users		
LU	6	15	21
EU27	7	16	23
	Reduction of poverty/unemployment		
LU	6	13	19
EU27	6	9	15
	Legalisation of drugs		
LU	8	4	12
EU27	8	5	13

Generally and in line with the EU average, youngsters from Luxembourg consider tough measures against drug dealers and traffickers as the most effective way for public authorities to deal with drug problems, followed by information and prevention campaigns, treatment and rehabilitation of drug users, tough measures against drug users, reduction of poverty and unemployment and least the legalization of drugs.

However, concerning severe measures against drug dealers and traffickers, youngsters from Luxembourg (55%) considered repressive state answers as less effective as the EU average (63%). Also a slight difference regarding the effectiveness of treatment and rehabilitation of drug users is observed. Luxembourgish youngsters (39%) considered treatment and rehabilitation slightly more effective than the EU average (33%). Native youngsters (19%) also seem to be more in favour of the reduction of poverty and unemployment as an effective measure than the 'average European' (15%) shows.

2. Information channels used in the past year

The following table presents the results of the question: "Through which of the following channels – if any – have you been informed about the effects and risks of illicit drug use over the past year?" (Please choose up to three):

	LU	EU27
through media campaigns	34	46
trough a school prevention programme	50	39
found it on the internet	35	35
from friends	33	26
from parents/relatives	19	18
from the police	22	10
prevention materials of specialized counselling centres	11	7
from a drug and/or alcohol telephone helpline	5	2
I have not been informed about the effects and risks of illicit drug use	5	8

Contrary to the EU average which shows that media campaigns (46%) are the most popular source of information on effects and risks of illicit drug use, youngsters of Luxembourg considered school prevention programmes (50%) as the most important source of information followed on second place by the internet (35%) and only third place by media campaigns (34%). An important difference is also observed with regard to the percentage of youngsters considering the police as information channel of effects and risks of illicit drugs. In contrast with the EU average (10%), 22% of Luxembourgish youngsters declared having been informed by the police which lies on second place on the top of the European ranking.

- Attitudes to drugs and drug users (NNIA)

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[20]" 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.

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[20] EORG (2002). Public opinion regarding attitudes and opinions of young people in the European Union on drugs

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 (nationally representative).

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**
LU	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	
LU	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	
LU	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 if 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 abusers, youngsters on the run or clandestine people.

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.

- Initiatives in Parliament and civil society

In May 2006 the Parliament organized a so called “actuality session” on drugs that put special attention to the state of implementation of the EU and the national drugs strategy and action plans and activities of the NFP, which witnesses the increasing implication of MPs in the follow up of drug policies.

In March 2007 a parliamentary question on the state of progress of the national drugs action plan and the work of the Interministerial Group on Drugs was addressed to the Minister of Health.

In September 2007 an interpellation on the state of the implementation of the EU drugs action plan 2005-2008 was introduced by a MP.

The construction project of a permanent building in Luxembourg City hosting the TOXIN centre, which includes the national injection room, was subject to major discussions between the Ministry of Health, the City of Luxembourg, civil society and local citizens. Although the necessity of such a centre is widely recognized, the location this permanent centre should have been constructed on was largely controversial. Therefore, the Parliament adopted in October 2007 a motion that invites the government to implement the new centre on a suitable site and to develop complementary projects in order to decentralise low threshold offers of this type at the national level.

- 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 provide objective information although a few more socially oriented radio stations and newspapers put further emphasis on controversial, yet constructive, analysis of the current situation.

The NFP performed routine analysis of main daily and weekly Luxembourg newspapers published between August 2007 and July 2008. The screening revealed that nearly 30% of the articles covered themes of supply reduction. They mainly addressed drug traffic,

drug seizures, arrests and court decisions and addressed the evolution of the drug scene in the area of the main railway station of Luxembourg City. In 2007, special interest was put on the impact of the drug consumption room, as already in 2006. The future construction of a permanent building (replacing the temporary structure near the central railway station) was frequently mentioned in press. Articles covering themes like driving under influence (of alcohol, cannabis or other substances) have been largely discussed, because of a new law on the lowering of the legal blood alcohol limit and on the detection of illegal drugs. As a result of the "Tour de France" and different competitions before the Olympic games, many articles concerning doping have been published. Articles concerning NGOs mainly referred to annual reports and their local activity. Some major weekly newspapers focussed on national drug policies and the national drugs action plan. Several articles have mentioned the topic of heroin prescription by the state. Finally almost all national newspapers informed about the launch of the EMCDDA annual report 2007 as also the launch of the national focal point RELIS 2007 report, including main information about the European and national drug situations.

Concerning international topics, most interest was shown for important drug traffic cases and seizures. Citations of international organisations involved in drug issues, 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 General Population and specific sub-groups

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, when ingested, affects mental processes. Psychoactive substances may be of licit or illicit production, sale, or use and associated risks may be 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. It should be stressed that a new HBSC study referring to 2005/2006 data has been presented in 2008 (Ministry of Health, in press). The section on drug use in youngsters thus allows to updating a series of current data.

HBSC 2002 and HBSC 2005/ 2006

	HBSC 2002						**HBSC 2005/2006**					
	age 11		age 13		age 15		age 11		age 13		age 15	
	boy	girl	boy	girl	Boy	girl	boy	girl	boy	girl	boy	girl
Tobacco												
ever smoked tobacco	-	-	39.4%	38.8%	59.6%	57.9%	13%	8%	34%	29%	57%	60%
at least once a week	0.5%	0%	9.2%	8%	24.7%	26.1%	2%	1%	6%	6%	17%*	21%*
daily smoking	0.5%	0%	5%	5.5%	20%	21%	1%	0%	4%	5%	13%	16%
Alcohol												
Drunkenness (proportions that reported having been drunk at least twice)	2.3% (11 and 12 years)	1.4% (11 and 12 years)	6% (HBSC 2006: 5.5%)		21,9% (HBSC 2006: 23.5%)		2%	1%	6%	5%	27%*	20%*
weekly drinking (proportions that reported drinking any alcohol at least every week)	-	-	17.1%	13.4%	37.7%	22.9%	4%*	2%*	9%	6%	30%*	19%*
Cannabis												
Lifetime use (at least once)	3.9%	0.2%	3.5%		21.8% (HBSC 2006: 23%)						25%	21%
Recent use – last 30 days – at least once											13%*	7%*
Cannabis use in the last 12 months	3.8% (11 and 12 years)	0.6% (11 and 12 years)	3.5%		21.8% (HBSC 2006: 18%)						21%	16%

* indicates a significant gender difference ($p < 0.05$)

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

Source: Fischer 1999

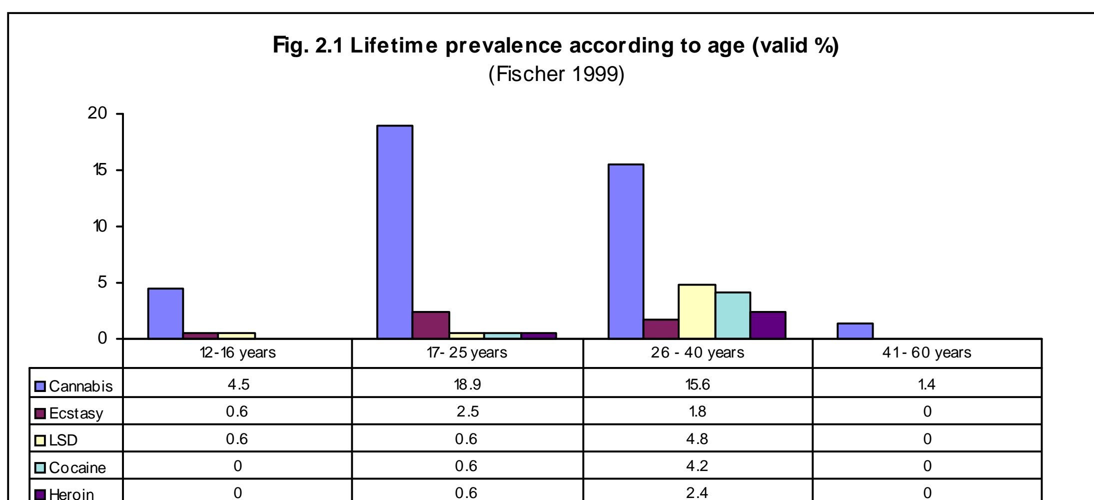


Fig. 2.1 Lifetime prevalence according to age (valid %)
(Fischer 1999)

	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*

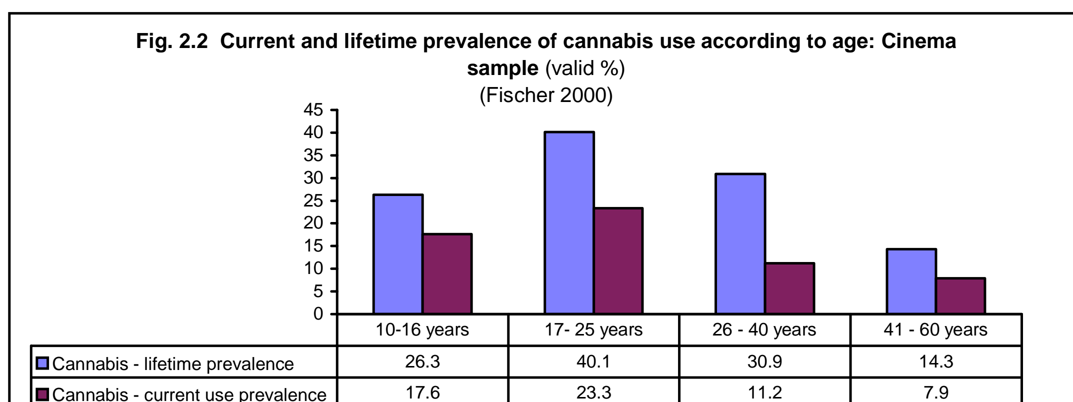


Fig. 2.2 Current and lifetime prevalence of cannabis use according to age: Cinema sample (valid %)
(Fischer 2000)

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%

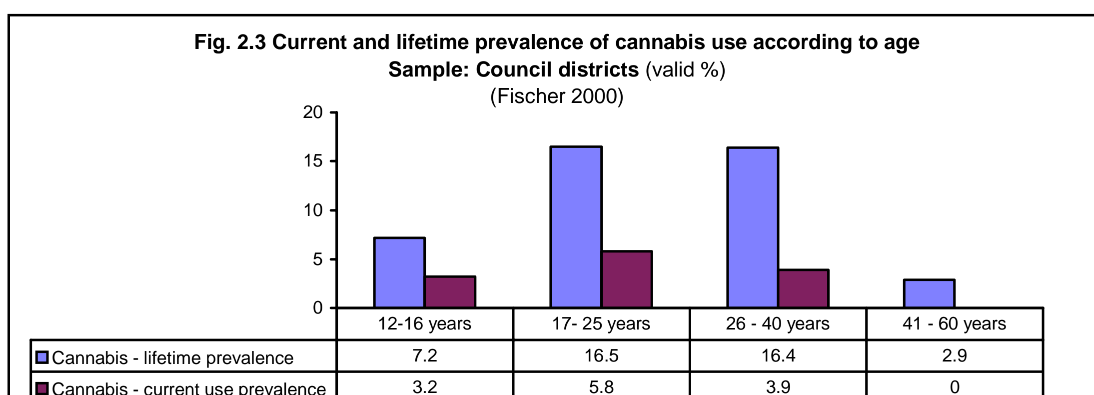


Fig. 2.3 Current and lifetime prevalence of cannabis use according to age Sample: Council districts (valid %)
(Fischer 2000)

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).

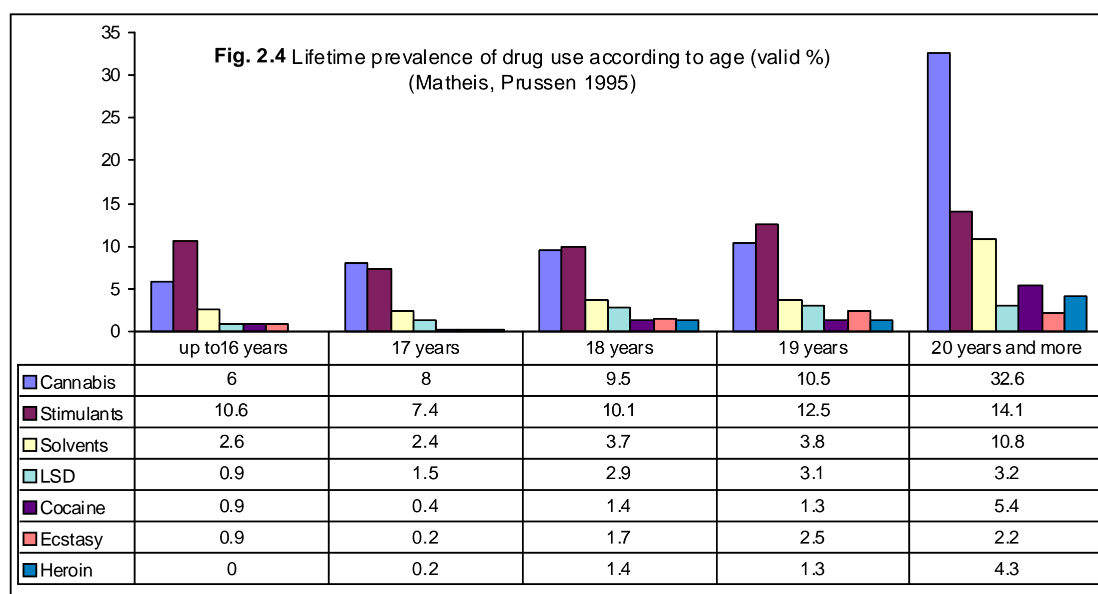
Discussions are currently held with the CRP-Santé to collaborate in a general study on health behaviour in general population in order to include items on drug use. This study may be conduced in 2008.

- 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 conducted 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.



	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%

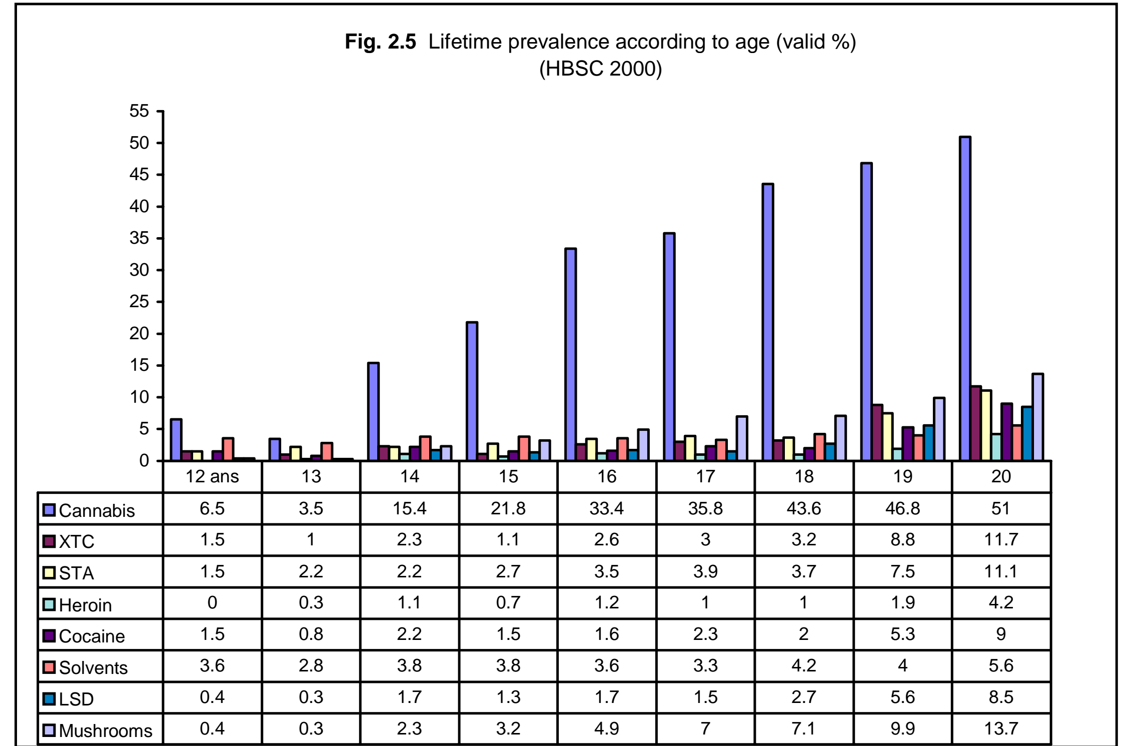


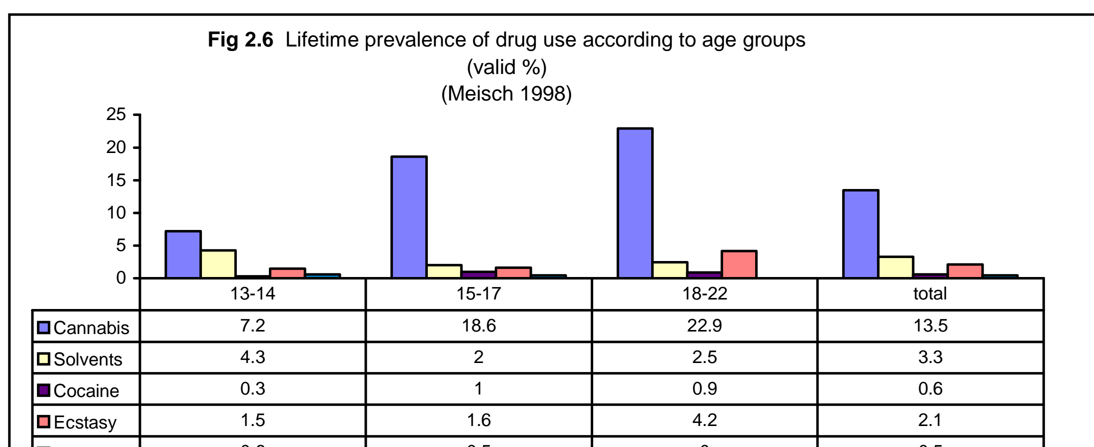
Fig. 2.5 Lifetime prevalence according to age (valid %) (HBSC 2000)

	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

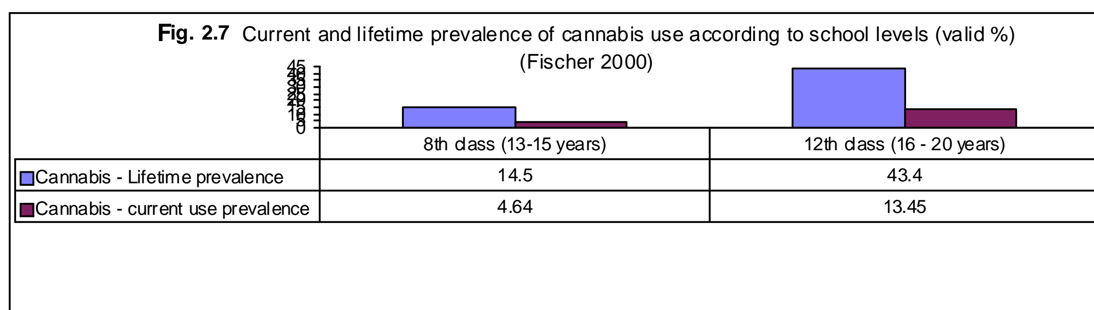
The consumption of illegal drugs has clearly increased the last years. A comparison of the Matheis 1992 study and the most recent HBSC 2000 study reveal that in 1992, 18.1% of secondary school students of 5th class in secondary school (16-20 years) declared having had contact with illegal drugs. In 2000, 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%



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%



SYNOPSIS OF MAIN COMPARABLE RESULTS AND OBSERVED TRENDS

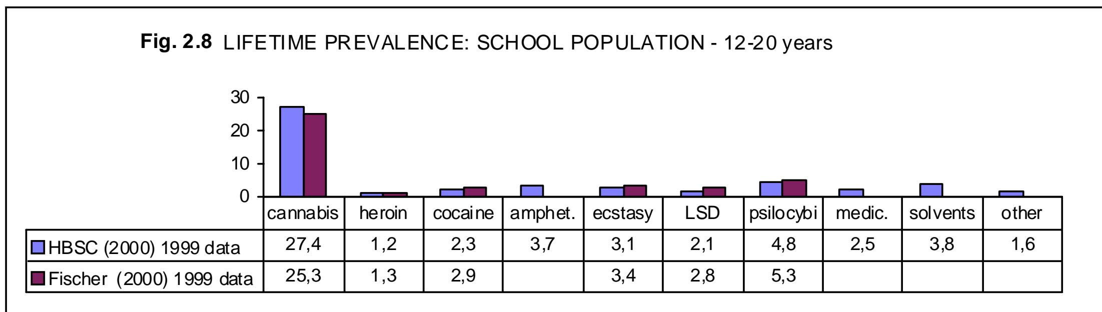
LIFETIME PREVALENCE: SCHOOL POPULATION:

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 show stable figures since 1992.

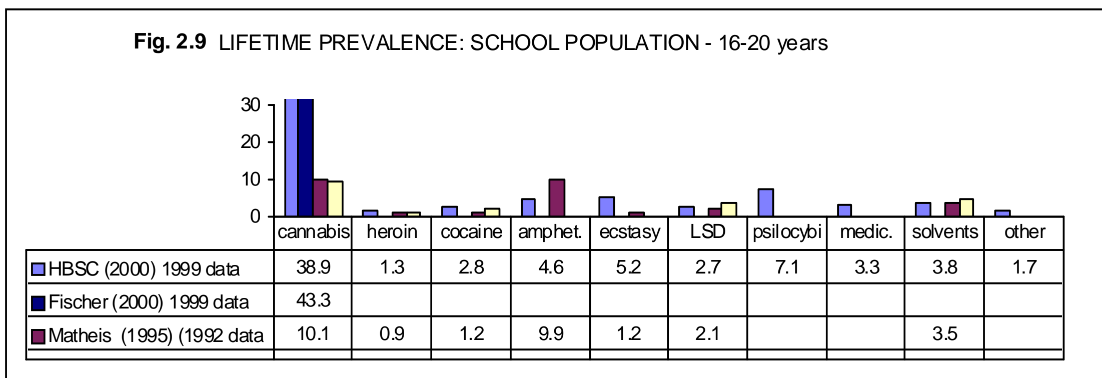
Regarding age group **13-14**, one should emphasise the increase of cannabis (9.7 - 10.5%) and cocaine (1.6 - 2%) lifetime prevalence over the last two years. In age group **15-16** years, all prevalence rates show increasing figures since 1992 (cannabis: 27.7%, psilocybin: 4.1%). Compared with the latter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



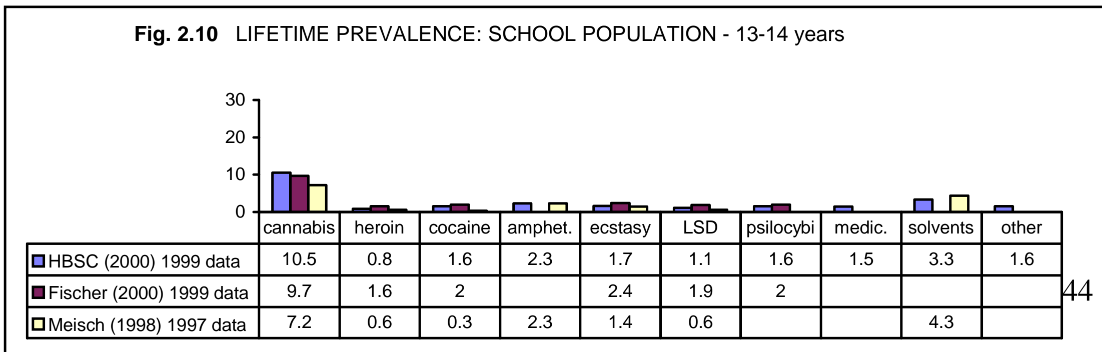
	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybi	medic.	solvents	other
HBSC (2000) 1999 data	27,4	1,2	2,3	3,7	3,1	2,1	4,8	2,5	3,8	1,6
Fischer (2000) 1999 data	25,3	1,3	2,9		3,4	2,8	5,3			

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



	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybi	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	

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



	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybi	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	

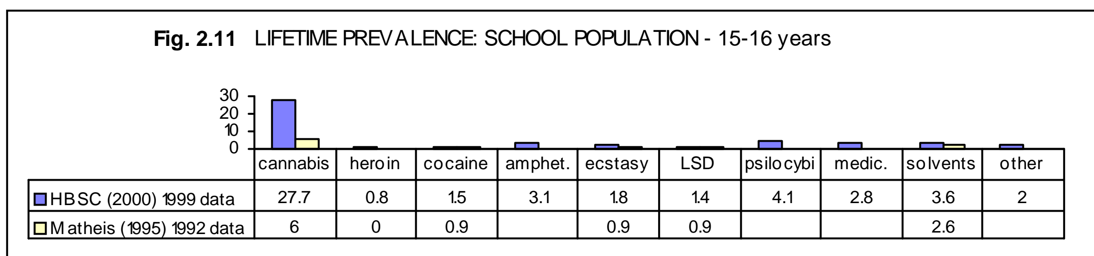


Fig. 2.11 LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years

	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybi	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.

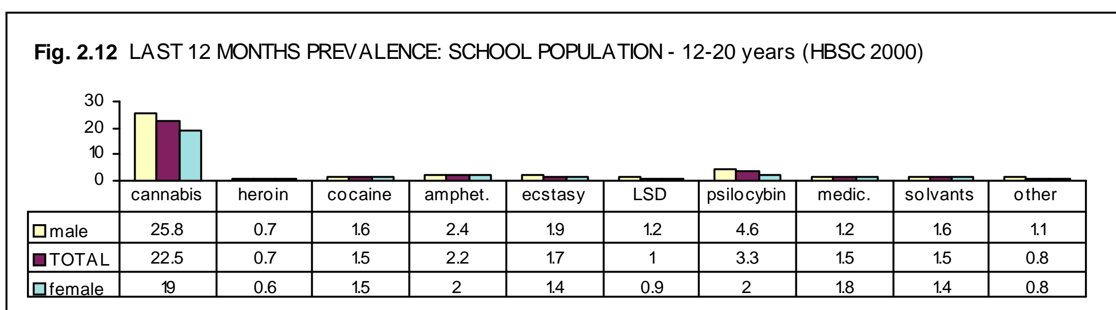


Fig. 2.12 LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION - 12-20 years (HBSC 2000)

	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.

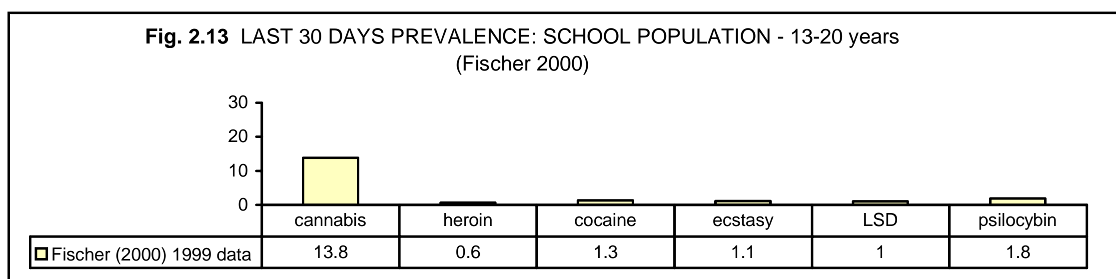


Fig. 2.13 LAST 30 DAYS PREVALENCE: SCHOOL POPULATION - 13-20 years (Fischer 2000)

	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 2007, the National EMCDDA focal point published the results of action research on HIV and hepatitis infections in drug users (Origer and Removille, 2007).

REFERENCE c.1	**Origer A., Removille N., (2007) Prévalence et propagation des hépatites virales A,B,C et du HIV au sein de la population problématique de drogues d'acquisition illicite, Point Focal OEDT / CES / CRP-Santé. Luxembourg.** **EN:** Prevalence study on HIV, HCV, HBV and HAV in PDUs In Luxembourg
Year	2007
Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence national PDU population
Area covered	In- and outpatient drug agencies and national prisons
Type sample	Random sampling during 8 months in 2005
Age range	> 17
Data coll. Procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES AND SEROLOGICAL TESTING
Sample size	366
Sampling frame	Random sampling
Response rate (M, F, T)	33.96%

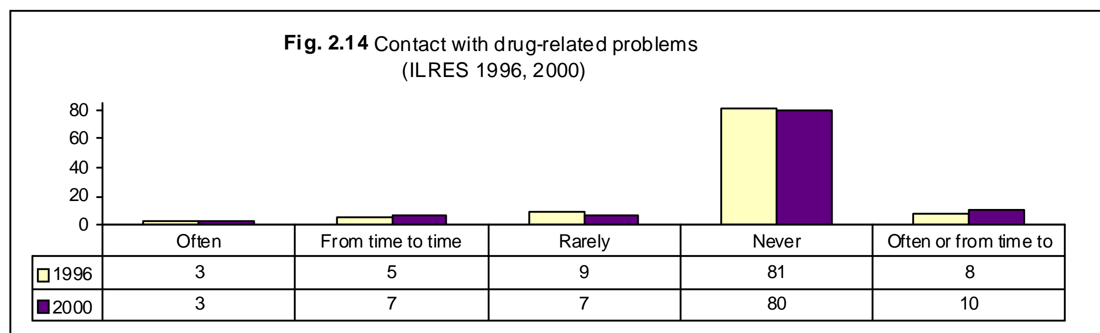
MAIN RESULTS:
- 67.21% of PDUs reported at least 1 prison stay during the last 10 years
- of which 56.1% report drug use in prison
- of which 54.3% report IVDU in prison

- ATTITUDES TO DRUGS AND DRUG USERS

Worth mentioning here are 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	Nationally representative
Age range	12-60 years
Data coll. Procedure	Phone interviews
Sample size	609 valid cases

Figure 2.14 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, using drugs, finding used syringes, etc.).



	Often	From time to time	Rarely	Never	Often or from time to
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

Capacity building, awareness raising and mobilization of individual resources and promoting protective factors are the main benchmarks as far as national prevention strategies are concerned. Measures may target the general public or selective, specific or risk populations or communities.

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** addresses primary prevention as a main intervention area.
The priorities of the drug prevention action plan as approved in 2005 are as follows:

- Interventions in school and youth environments, peer education and multipliers;
- 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 900,000.- EUR in 2007. These figures include staff and operating costs of agencies and ministerial department specialised[21] 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.

[21] The exact estimation of prevention related costs is speculative 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.

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.

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. In the framework of its 10th anniversary, the CepT published a manual on the training of multipliers in primary drug prevention available at www.cept.lu.

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 does intervene. Furthermore, the Grand-Ducal Police organises school courses for the 6th classes of primary school and 7th classes of secondary schools provided by specialized police teams out of regional police units and from the drug department of the Judicial Police.

In recent years particular attention has been paid to:

- School prevention and other related prevention projects
- Elaboration and follow-up of prevention measures
- Advice for prevention in school environments
- Mediator between school establishments and police units
- Prevention in secondary classic education and technical education settings

In 2007, these specialised employees have provided about 900 hours of information sessions in more than 140 schools and different organisations.

In 2000, the CePT in collaboration with the 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.

Meanwhile, three basic training sessions were offered to the project partners by the CePT and the 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.

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. Currently the CePT in putting in place so called “prevention groups “ in secondary schools n order to find solutions that fit each particular context. In this framework training sessions for educational staff, information evenings for parents and presentations of pedagogical material are organised.

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 schools participated in this project.

In the framework of the partnership ‘**European Healthy School and Drugs**‘(EHSD), coordinated by the Trimbos Institut (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 multipliers, evaluation or monitoring systems. A 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[22]) and the MSF Solidarity Youth (on site-interventions planned).

The CePT is continuously 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.
In October 2004, the European Congress "Motivation and Qualification of Volunteers" (MoQuaVo) was organised by the CePT in Luxembourg. The objective of the congress was 'new competences and capabilities' building for volunteers. More detailed information can be found under http://www.ecbap.net/.

[22] 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 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.

- SELECTIVE PREVENTION
    - <u>Recreational Settings</u>

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.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** [23]" 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. 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 been set up in order to elaborate a concept for future activities. A programme called '**Sport and drug prevention**' started in 2002.

Currently there exists no **legal framework** regulating prevention and harm reduction interventions 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 planned events. However, there is no legal obligation to do so. Moreover, nightlife

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[23] See EDDRA

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)[24] 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[25] 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 implemented in 2006 included 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 special working group continues its work for an undefined duration.

- At-risk groups

In 2006, MDs without frontiers - Youth Solidarity in collaboration with the Public Prosecutor's Department of Youth Protection and the Judicial Police- Drugs Unit launched a new project called **CHOICE**, which is based upon a pilot project of "early intervention of first drug offenders" (FreD) initiated by the Federal ministry of health and social security of Germany. The target group consists of youngsters aged 12 to 17 who entered in conflict with drug law. The overall aim of CHOICE is to offer youngsters an early and short-term intervention in order to prevent further development of drug abuse and drug addiction. An "in-take" interview allows assessing whether a participation in the CHOICE project or an individual psychological follow up is indicated. A CHOICE group consists of four interactive sessions (6 to 8 participants) which provide information on drugs, legislation and treatment services, promote auto-reflexion, reinforcement of personnel skills and motivation to change attitudes towards drugs. In a first phase, the project is regionally limited to the judicial district of Luxembourg City. Police officers hand out CHOICE flyers to youngsters in breach with drug law including all information on the intervention and inform the Public Prosecutor's department of Youth Protection. The youngsters and eventually their parents contact COICE team within two weeks and the latter inform the Public Prosecutor on the participation level. A certificate testifies the participation of the youngster. In 2007, 48 CHOICE sessions have been organized. An external evaluation is foreseen for 2008.

The 2004-2009 governmental programme also underlines the necessity to further develop prevention programmes for youngsters with regard to polydrug use and in particular the increasing use of alcoholic mix-drinks. 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 2007 to implement specific prevention and treatment options for **recent immigrants**. More precisely a project called" **DIMS**" (Intervention mobile for sexual health) is meant to inform on risk behaviour and provide free infectious disease testing in

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

[25] 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.

difficult to access populations, such as immigrants The DIMS project will start in the beginning of 2009.

In this context and due to an increased prevalence of HIV infection cases, AIDS and drug related problems in the Portuguese speaking community of the Grand-Duchy of Luxembourg, the Committee of AIDS Surveillance in collaboration with the Ministry of Health have commissioned an exploratory study on current knowledge and needs of the target group in relation to HIV prevention (Dellucci, 2006). By means of anonymous questionnaires and semi-structured interviews, 270 persons, thereof 24 persons interviewed, have answered questions addressing their way of living, perceived importance to HIV prevention, HIV screening, drug dependence, sexual behaviour, needs of information.

Particularly attention has been paid to the section "AIDS and Drugs" of the questionnaires. Intravenous drug use (29.1%), sexual intercourses (28.9%) and homosexual intercourses (12.4%) have been referred most frequently as HIV transmission risk factors. Also 93.2% of the respondents identified a high risk of infection associated to the sharing of injection material with an HIV infected person. Accordingly, 82.9% would recommend a HIV test in case injection equipment had previously been used by other persons. Among respondents, 6 persons qualified themselves as injecting drug users. Five of them (83.3%) indicated to undergo an HIV screening in case of using shared injection material, a proportion identical to the one observed in the total sample (82.9%). Concerning the exchange of injection material, 5 persons declared practicing exchange, one of them frequently, the others rarely.

In general, half of respondents believed themselves sufficiently informed on HIV/AIDS. However, 11.1% of respondents asked information concerning the topic "AIDS and Drugs". Most of respondents showed to be sensitized to the dangers of a transmission via intravenous drug use.Content analysis of the semi-structured interviews showed that references to HIV transmission by infected syringes in the context of drug use came in second place followed by sexual intercourses. Concerning HIV protection, syringe exchange has been rarely mentioned. As far as the assessment of risk groups is concerned, drug users have been perceived as a particularly exposed population to HIV infection. Respondents declared drug users as the major source of newly infected HIV cases in Luxembourg notably in relation to intravenous drug use. Generally, AIDS has been perceived as a disease concerning above all specific risk-groups such as homosexuals, prostitutes, non-natives and intravenous drug users.

Results showed respondents not belonging to perceived risk groups underestimated HIV infection risks for themselves and overrated risk associated to more vulnerable groups. The study identified needs of information concerning risks and protective factors, measures of prevention, AIDS and sexuality, AIDS and drug dependence, screening and socio-medical support. However a specific HIV prevention programme for the Portuguese speaking community was not deemed to be appropriated since focusing on a specific community could provoke various resistances. The study recommends, among others, a linguistic diversity as far as prevention messages and the composition of counselling teams are concerned.

Finally the CePT introduced an EU project in the framework of the Grundtvig-Programme called 'Promotion of social and personal competences in socially unprivileged persons' – PROSKILLS. Its objective is to elaborate didactic material for multipliers working in the field of the promotion of social and personal competences. Germany, Finland, Greece, Italy, Slovenia and Hungary collaborate in the project. The material output has been presented in 2008.

- At-risk families

Since 2003 the Youth-and Drughelp foundation (JDH) is running a parental project with the aim to provide psycho-social aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative capacities. This long term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. In 2007, 53 different family situations have been reported, 56.6% of them were mono parental situations involving in all 85 children. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

Moreover CPT, in collaboration with JDH offers training courses for at risk mothers in order to build up their capacities as parent and improve mother-child relationship. (Project: **O Mamm O Kanner**)

- Occupational settings

In cooperation with the human resources department of the City of Luxembourg, the CePT has initiated a pilot project to prevent addiction behaviour and its consequences in City employees based on a preliminary situation and needs assessment.

- INDICATED PREVENTION

  - Children at risk with individually attributable risk factors

No studies specifically addressing youth at risk in deprived environment/neighbourhoods and/or with drug related problems have been performed thus far. However, the Research Centre on the situation of Youngsters in Europe (CESIJE) coordinates and promotes projects on youngsters' living conditions and performs research projects to contribute to national youth policy. Not specifically specialized in drug-related research, a currently ongoing study (in press) 'Youngsters in urban areas' analyses structures, habits and problems of youngsters in the South of the Grand Duchy of Luxembourg and will give insight into problems encountered by youth in also deprived places.

Early school leave may be considered under certain circumstance as potentially undermining future development of children and youngsters. The study of "School leave in Luxembourg"[26] (2006) surveyed a population of 37,347 secondary school students. During a period from 1st November 2004 and 30 April 2006, a total of 2.422 students have been leaving school without a professional certification (temporary stay offs from school have also been taken into consideration). The study refers to a proportion of 6.5% of "school leavers". This proportion figures 3.6% if one is considering the total number of students having been reached but who have not reintegrated a school in Luxembourg. Concerning this category of school leavers, composed of students attending courses abroad, being employed, following professional insertion measures and those without occupation (N=1,357), the situation was as follows: 41.2% of students who dropped school have integrated the job market (work or professional insertion measure), 39.8% didn't work nor went to school and 19% attended school courses abroad. In general boys, youngsters from abroad and aged more than 15 years (age of school obligation) are more vulnerable to the risk of early school leave.

[26] Ministère de l'Education nationale et de la Formation professionnelle (2006). Le décrochage scolaire au Luxembourg. Luxembourg

4. Problem Drug Use and Treatment Demand

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 […]*'. In contrast to the EMCDDA definition, the mode of administration (injection) is not a selective criterion in the national definition although types of substances involved are identical. Regular / long duration use of heroin via inhalation is thus included. According to the national definition, problem drug use is associated to a high probability of intervention or the need of involvement of a third party from the law enforcement or the care sector. This approach is consistent with the fact that PDU surveillance systems in Luxembourg are based on the institutional contact indicator and not exclusively on the treatment demand indicator.

Data on PDUs 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. Overall, most demand and supply reduction indicators are showing a fairly established stabilisation or even a decrease of PDU prevalence at the national level.

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDUs. The recent increase in low quality cocaine use in combination with heroin has not been confirmed by 2006 and 2007 data. Ecstasy-like substances and ATS are still popular even though seizure figures do suggest an inverse and currently stable trend. Methamphetamine use in Luxembourg is very limited. The use of most 'new synthetic substances'[27] recently detected in other EU Member States has not been reported thus far. All indicators on cannabis use (problematic and recreational) have been on the increase for several years but tend to stabilise more recently. Cannabis showing high THC concentrations (max: 31.05%, mean: 9.61%) is increasingly found on the national market. Marijuana shows the highest purity but also the most important variations in terms of quality.

The ratio of intravenous opiates consume to the inhalation mode has decreased from 2:1 in 2006 to 5:3 in 2007. Provision of 'blowing paraphernalia' (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns. The mean age of first use of cannabis, ecstasy and i.v. heroin tends to decrease. Also, the average age, applied to the total PDU population and to overdose victims has markedly increased from 2000 onwards although stabilised in 2007. The proportion of PDUs aged **40 and more and those younger than 20 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 still 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 years 2004 to 2007 a discontinuous downward trend has been observed in treatment and police data.

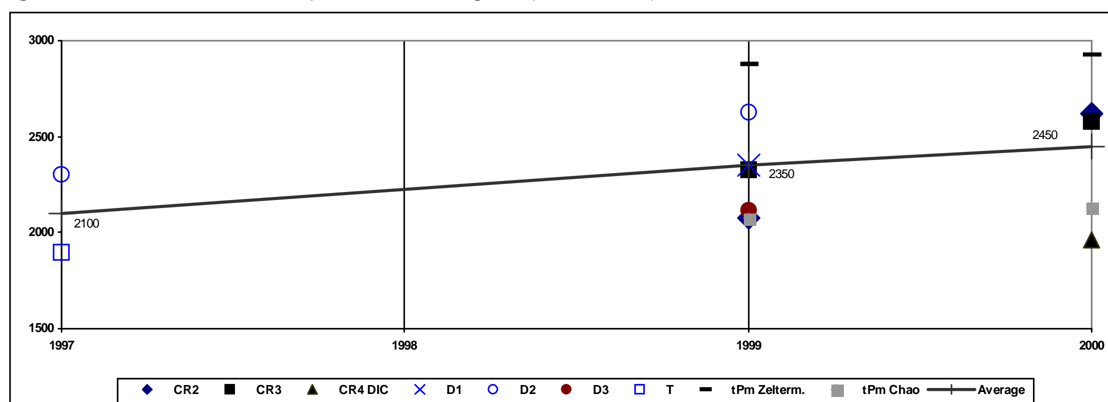
[27] Substances such as MBDB, 4-MTA, Ketamin, PMMA 2C-I, 2C-T-2, 2C-T-7, 2C-D, 2C-E, TMA-2, BZP, TFMPP, 5-MeO-DIPT, 5-MeO-DMT, AMT, ALEPH 7, DXM, DPT.

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 8 years. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2007.

- PREVALENCE AND INCIDENCE ESTIMATES OF PDU (SEE ALSO ST 7-9)

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") conducted by the focal point between 1999 and 2001 (Origer 2001)[28] 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).

Fig 4.1. Prevalence estimation of problem HRC drug use (1997 – 2000)



Source: Origer 2001

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: 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 (IVDU)			
Prevalence IVDU	1.370	1.780	1.715
Total prevalence rate – IVDU	3.25 /^{1000}	4.12 /^{1000}	3.91/^{1000}
Total prevalence rate – IVDU – age: 15-54	5.71 /^{1000}	7.26 /^{1000}	6.90/^{1000}

Source: Origer 2001

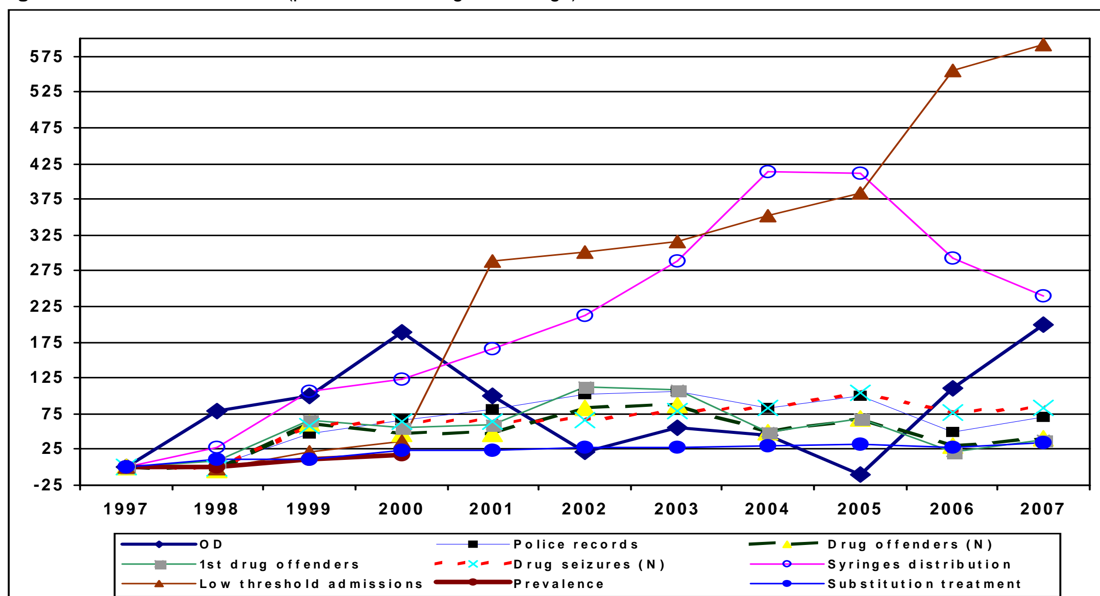
[28] Downloadable at http://www.relis.lu

In order to validate estimated prevalence rates, data from different sources had to be considered. As shown 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 acute drug deaths and low threshold contacts and number of distributed syringes, have stabilised for several years. The fact that the number of ODs has increased in 2006 and 2007 mismatches the evolution of all other indirect indicators. A national expert group studied this phenomenon and came to the conclusion that high variability in substances' purities, increased polyuse and especially the combination of street drugs, substitution drugs and prescription drugs in general in out- and in-patient settings and gaps in the follow-up of patients after institutional release (detoxification, therapy, prison, etc.) are major risk factors at stake if it comes to drug related mortality and morbidity but do not support the assumption of an significant increase of the PDU prevalence in general. Number of low threshold admission have known an increase primarily because low threshold offers have been diversified and opening hours enlarged and thus do not allow to conclude to an increase in the drug population prevalence. The number of distributed sterile syringes has been decreasing since 2004, which is not in line with the observed increase of low threshold services' demand. Knowing that inhalation mode of opiate may have become more popular, different type of syringes are currently distributed, patterns of injecting drug use have changed (e.g. more frequent use of a single syringe) and syringes used in the injection room are not included in the final count, this downward trend has to be interpreted with caution. Moreover, since 2002 drug treatment offers have been highly diversified, which naturally increases the number of treatment demands without necessarily being an indicator of an increase of PDU prevalence.

Taking into account the previous comments, one may state that **PDU prevalence tends to stabilise, or presumably even to decrease** at the national level. A second national drug prevalence study, which is foreseen for year 2009, in the framework of a final evaluation of the drugs action plan will provide more hard data of the current situation.

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



Source: Origer 2008

LOCAL PREVALENCE STUDIES (NNIA)

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

NATIONAL 'DRUG SCENES' (NNIA)

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

- a sub-group of **cannabis consumers**, mainly minors, located in specific areas of the municipal park 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 careers 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 fairly 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.

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 2007 figures 4,758 (2002: 4,701) (in this figure double counting is included meaning that a given person could have been indexed twice and more by different institutions. It is thus not representing the actual prevalence, which has to be assessed by other methods).

For comparison, 2,383 users have been indexed by national specialised drug demand reduction agencies and 2,318 drug law offenders by supply reduction agencies in 2002. In 2007 the same agencies have indexed 2,859 and 1,687 persons respectively.

The male/female ratio of the PDU population is 3:1. The last ten years the proportion of indexed non-native PDUs has shown strong variations but a clearly increasing tendency since 2003, which tends to stabilise in 2007. The population of non-native drug users largely consists of Portuguese nationals, a proportion constantly increasing until 2004.

Although the same proportion stabilised since then, it is still consistently higher than the one observed in general population. Notably, one observes a remarkable increase of PDUs of French origin (23%). This trend is confirmed by last 7-years data on drug law offenders.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 30 years and 9 months in 2007. 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 during the last years and a weak increase of the proportion of minors among drug law offenders STUP in 2007. Respectively 89% and 44% of current PDUs have tried cannabis and heroin (i.v.) while being minor of age. In 1995 the same proportions figured 71% and 23%. Most interestingly evolution of drug use patterns tend to accelerate in terms of shorter time spans separating first non-iv use from first iv-use.

This acceleration is also observed as far as first treatment demands are concerned. PDUs tend to contact drug treatment facilities at an earlier stage, which may be due to a more diversified offer currently available.

The mean age of native and non-native problem drug users tends to balance. **Average age at first use of illicit HRC drugs** has decreased approximately 3 years from 1995 to 2004 and after an increase in 2006, decreases again in 2007 (2004:12Y8M; 2007:14Y10M). In 2007, the age of first use of cocaine (non-iv/iv) shows a weak decrease whereas for heroin (i.v.) it seems to stabilise slowly. The average age of first cannabis use (almost 1/3 of respondents were not older than 13 at the moment of first cannabis use) after a decrease during multiple years, tends to stabilise. In general, the proportion of PDUs aged more than 39 years and of users less than 19 years is increasing continuously as also the gap between these two groups.

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDUs. The proportion of **poly drug use** 89% has reached stabilisation after a record level in 2004 (92%). As already indicated, the switch to intravenous drug use occurs earlier. The ratio of **intravenous** opiates consume to the **inhalation** mode went from 2:1 over the last years to 5:3 in 2007. The prevalence of the use of cocaine as primary drug stabilised as did Ecstasy-like substances and ATS.

All indicators on cannabis use (problematic and recreational) have been on the increase for several years. Cannabis showing high **THC concentrations** (max: 31% in marijuana sample) is increasingly found on the national market, although the average purity of cannabis products during the same time period has only been increasing weakly.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use had known a sensitive increase at the beginning of the years 2000 but decreased again in 2004 and stabilised in 2005/2007. **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 residential status of indexed PDUs has improved over the last years. The **geographical distribution** suggests that the southern region (44,2 %) and the centre region (32,1%) are the most representative. The northern region, after a decrease in 2005 (11,5 %), shows a new increase during the last two years (2007:14,2%).

Recent data suggest that the employment status of respondents tends to be weakly improving, as the rate of people with a stable job has increased of 10% compared to 2006. The **unemployment rate** has decreased greatly in 2007 (23%). This is explained by the fact that only people receiving allocations of unemployment have been considered in 2007. The decrease of financial autonomy of PDUs is associated to an **increasing social dependency**. A stabilisation at the level of revenues of illegal origin has been observed during last years as well as a slowly but continuous stabilisation of the proportion of PDUs presenting major depths.

- TREATMENT DEMAND INDICATOR (TDI)

  - Profile of clients in treatment (characteristics, patterns of use)

From the clients in treatment, 73% are male against 27% of female clients. The mean age of this group has significantly increased during the last ten years (1997: 28 years/ 2007: 31 years) and this mainly because of an observed increase in average male age (1997: 28Y2M/ 2007:31Y5M). The mean age of the female clients is much lower (2007: 28Y5M). Respectively 68% of clients in treatment are natives against 32% of non-natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by Italians, Germans and French.
Concerning the educational level of the clients in treatment, 45% have finished primary school, 53% have completed secondary school and 1% even achieved a superior level. 58% of respondents reported stable employment (weak decrease - 1997: 65%) against 10% who are benefiting from unemployment allocations. Furthermore, 22% are students or engaged in a training contract.
Almost half of this group had at least once in their lifetime committed a suicide attempt (45%) and have been experiencing one or more overdose (47%). As far as the exchange of syringes is concerned, 76% reported that they never shared syringes. Polydrug use is the most observed consume pattern (89%) in drug treatment demanders.

Heroin as preferential substance is reported by 76% (54% i.v./ 22% non-i.v.), whereas cocaine is only in 12% of the cases reported as first substance of use (8% i.v./ 4% non-i.v.). Concerning the administration mode of heroin, a weak decrease is observed for the injection mode (1997: 60%/ 2007: 54%) in contrast to other administration modes, which show an increasing tendency (1997: 15%/ 2007: 22%). The average age at the first use of the preferred drug figures around 14Y3M, whereas the mean age of the first i.v. consumption is 19Y6M. More than half of the clients in treatment were injectors at the moment where they start a treatment (52.5%). 72% of the clients consume drugs more than once a day.

By substance used

The main substance involved in drug treatment demands is **heroin**. Prevalence rates fluctuate around 70% and 80%. In 2007, a decrease of 10% in preference for intravenous heroin use was noted compared to 2006. The heroin inhalation **mode** is highest since 1998. Polydrug use is the most observed consume pattern (89%). The i.v. heroin sub-population shows the highest mean age (31Y10M) of all treatment groups. 10% of the latter are **first treatment** demanders compared to 25% of non-iv heroin users.

Cocaine use as main reason of treatment demand showed a significant increase from 2004 to 2006 and decreased again in 2007 (12%). Mean age of preferential cocaine

using treatment demanders is 29 years and 6 month. With 15% (7%) of first treatment demanders, primary cocaine users show the highest lifetime first treatment rate. Cocaine prevalence as secondary drug has decreased from 43% in 2004 to 37% in 2007. **Crack** is never reported as main problem drug and very rarely (1%) as secondary or occasional drug.

The percentage of treatment demands related to **cannabis use** has passed from 4% in 1997 to 11% in 2002, has been decrease until 2006 (1%) and currently (2007) figures around 3%. 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, however, one has observed a **stabilisation of treatment demands in outpatient drug agencies** and an increasing demand for inpatient therapies and for low threshold offers. The proportion of **first treatment demanders** observed in 2007 was 13% (1998: 4%). In order to avoid repetition, more detailed information on services and user statistics is presented in chapter 6.

- Profile of PDUs from non-treatment sources

Data on PDU from non-treatment sources are mainly provided by the national specialized drug unit of Judicial Police. The profile of these users is similar to PDUs from treatment settings knowing that the national drug monitoring system indexes both sources.

The ratio of male and female PDUs is almost identical as PDUs from treatment sources (82% male, 18% female offenders). Their mean age is 30years 9months, women being slightly younger than men (31y4m for male 28y1m for female offenders).

42% of the offenders are natives and 57% are foreigners. As for the last year, most foreigners were Portuguese citizens (36%) followed by French natives (25%).

75% are recidivists (had more than one police record during their lifetime). 46% were arrested for dealing drugs, 54% are charged with illegal drug possession. Drug-law offenders (who are also problematic drug users) are mostly arrested for heroin and cocaine. 94% are reported polydrug users, which represents a higher proportion than PDUs in treatment. 82% of these PDUs had more than one treatment episode during their lifetime.

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'.[29]

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 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 interventions[30]:** refer to measures aimed at reducing the harm associated with drug use without necessarily requiring a reduction in consumption.

In recent years inpatient and outpatient drug treatment demand has been slightly increasing. The number of substitution treatment demands is stable whereas a very significant increase has been reported in low threshold care demanders during recent years. In general, a slow bur continuous increase of the number of drug treatment demanders is observed. A more recent trend is the increase of treatment demands for cannabis use related problems and combined alcohol abuse in youngsters at the national level and reported by the Medical Control Department in charge of referrals to specialised treatment centres abroad. Treatment demand related to cocaine use is difficult to assess as in most PDUs concomitant use of heroine is observed.

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.

As can be seen on map 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 via their respective psychiatric departments. In June 2005, the first 'consumption room' has been opened in Luxembourg City. Its has been integrated in the 'TOX-IN centre'' providing day care, night shelter and low threshold services to drug addicts.

[29] **SOURCE:** Classification of drug treatment in EU member states and Norway, Expert meeting, 8-9 February 2002
[30] 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 2007)

JDH : Counselling, substitution, low threshold and after care
TOX-IN (CNDS) : Low threshold
TOX-IN (CNDS): Night shelter, Injection room
SOLIDARITE JEUNES : Youth counseling
CENTRE EMMANUEL : Counseling and referral
CHNP : Treatment and referral
CTM : Residential therapy, reintegration measures
CTM : Aftercare, supervised housing
General hospitals providing detoxification

BELGIQUE

ALLEMAGNE

FRANCE

Dressée par l'Administration du Cadastre et de la Topographie
en collaboration avec l'Administration des Ponts et Chaussées - Luxembourg
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All drug treatment services, general hospitals excluded, are relying on governmental support and control. Most of specialised agencies have signed a **convention** with the ministry of Health that guarantees their annual funding. NGOs involved in drug treatment fall under the obligation of the so-called 'ASFT' law (8/09/98)[31] and the subsequent grand ducal decree of 10 December 1998[32], 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 a maximum of 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, 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 instrument of a standardised quality control. However, funding is not directly related to clearly defined evaluation requirements or outputs. 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 2007. **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.

[31] Loi du 8 septembre 1998 réglant les relations entre l'Etat et les organismes œuvrant dans les domaines social, familial et thérapeutiques (entry in force: 24/09/1998)
[32] 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 Drug related institutional contacts (Inter-institutional multiple counting included)

SETTING	NUMBER OF ADMISSIONS (A) AND/ OR CONSULTATIONS (C) AND/OR CONTACTS (CO)						NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)					
	98	2000	2002	2004	2006	2007	98	2000	2002	2004	2006	2007
DEMAND REDUCTION: SPECIALISED DRUG TREATMENT												
OUTPATIENT - Drug Free	1,089	2,185	3,412	4,312	4,597	4,833	535	636	828	916	928	1,143
- Substitution	/	/	/	/	/	/	986	1,002	1,040	1.,065	1,044	1,092
INPATIENT - Drug free	39	43	57	53	44	128	127	158	153	182	183	124
- Detoxification	/	/	/	/	531	550	243	316	429	476	484	500[33]
LOW THRESHOLD AGENCIES	9,499	13,083	29,536	39,526	55,808	60,405						
SUB TOTAL A: Number of drug treatment demanders (Multiple counts not excluded) (Multiple counts excluded)							**1,891** n.a.	**2,112** ***637***	**2,450** n.a	**2,639** n.a.	**2,639** n.a	**2,859** n.a
SUPPLY REDUCTION: LAW ENFORCEMENT INSTITUTIONS												
National prisons							167	161	101	92	243	212
Police - Judicial Police - Customs							1,170	1,758	2,217	1,808	1,573	1,687
SUB TOTAL B: Number of drug law offenders (Multiple counts not excluded)							**1,337**	**1,919**	**2,318**	**1,900**	**1,816**	**1,899**
TOTAL NUMBER OF PERSONS SHOWING DRUG RELATED INSTITUTIONAL CONTACTS (Multiple counts not excluded)							**3,228**	**4,031**	**4,768**	**4,539**	**4,455**	**4,758**

Source: RELIS 2007

Table 5.1 summarises drug related institutional contacts of PDUs. Inter-institutional multiple counts are not excluded meaning that a given PDU could be indexed twice and more. Hence, these data do not provide the national prevalence of PDUs but they allow following up the increase or the decrease of the latter.

Overall the number of persons showing drug related contacts with DR or SR agencies in 2007 is showing an increase after 4 years of slow decrease. This situation is mainly due to a sensible increase in drug treatment demands whereas contacts with law enforcement agencies do remain stable. The number of substitution treatment demands has also been fairly stable over the last 5 years. Outpatient counselling demand increased sensibly and so did the number of contacts in low threshold services, having reached 60.000 in 2007.14% (10%) of respondents are first treatment demanders, all treatment centres included.

If institutional contacts, including treatment demands and drug law offences, are applied as an indicator, it is reasonable to presume that the national PDU prevalence has not significantly increased since 2002.

[33] Estimated since ICD-10 episodes' data were not yet available at the time of editing

- 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 sake of completeness, low threshold, harm reduction services and detoxification have also been included. Distinction will be made between out- and inpatient treatment.

Outpatient treatment: adults

RELEVANT TREND: Stabilization of total number of clients. Increase of **first treatment rates. More female treatment demanders.** Increasing proportion of **clients over 30 and under 20 years. Currently stable number of underage treatment demanders and patients presenting for cannabis related problems to be seen in the context of** the implementation of specialised care offers for minors. A current trend is also to be seen in the increasing number of young mothers and child/children seeking out and inpatient treatment.

After several years of decrease, national outpatient drug counselling centres have been showing stable admission rates between 2004 and 2007 (477 clients) and increasing first treatment rates intra (55%) and inter-agency wide. Gender distribution shows a weak upward trend in female treatment demanders over the last 10 years (2007: 37% / 1997: 34%). Age distributions have to be analysed according to the geographical situation of treatment centres. All in all, however, the proportion of treatment demanders aged 30 years and more (2007: 60%) (2006: 57%) has sensibly increased, during recent years. The proportion of treatment demanders aged less than 20 years (6.5%) has been increasing in recent years (2006 (5.6%)). Underage clients tend to decrease mainly because specialised agencies for minors have been implemented meanwhile. Treatment demands for problem i.v. opiate use associated to multiple-use is the main demand pattern and has been on the increase for 3 years now (2007: 57% /2006: 51% / 2005: 47% / 1997: 72%). Cannabis-related demands have shown a clear upward trend since 2000 (2003: 15% / 1997: 1%) and are on the decrease since 2003 (2006: 13%, 2007: 6.3%), which has to be seen in the context of the development of specialised treatment offers for minors. The prevalence of problem cocaine use is showing a weak increase compared to 2006 data.

Available services and offers:
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. ‘The Emmanuel Centre’ implemented in Luxembourg-City is primarily a counselling and referral agency.

A third specialized outpatient service is also implemented in Luxembourg-City (Alternative Counselling Centre). The main objectives of the referred centre are the following:

• Establish a first contact with the drug-addicted clients
• Help the drug-addicted clients in the development of a therapeutic project with orientation either towards the intermediate-term structures, or towards residential therapy centres.
• Organization of detoxifications in local psychiatric services or further psychotherapeutic interventions
• Informative and therapeutic discussions with the drug-addicted clients and their families before and after the detoxification.

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.

Outpatient treatment: minors

RELEVANT TREND: Increasing number of clients due to development of new treatment capacities for underage users and/or offenders. The **rate of new treatment demanders** has discontinuously increased since the implementation of the referred agencies. The proportion of clients aged below 16 (30%) has decreased since 2002. Cannabis use is the main reason of treatment demands (67.7%) witnessing however a decreasing tendency. Instead the use/abuse of licit drugs and polydrug use is increasingly reported as reason of treatment. An increasing proportion of youngster presenting psychiatric symptoms and/or socially deviant behaviour in addition to drug abuse are reported by specialised field agencies.

Available services and offers:
Specialised drug care agencies for minors exist in the centre and since 2007 in the north of the country. A specialised residential centre for problematic youngster has been opened in the beginning of 2007 in the North of the country under the management of CHNP. A new project defined as a residential referral and rehabilitation centre for minors in a rural setting is supposed to be operational in 2009. The referred case management programme has filled a current gap in the care system for minors.

Inpatient treatment

RELEVANT TREND: The proportion of **first treatment demanders** (59%) has increased in inpatient therapy settings in past years but currently appears to be stabilising. An increasing proportion of patients (59%) in residential drug treatment are simultaneously on **substitution treatment**. The proportion of **male treatment demanders** has set around 70% as well as the observed mean age. The referred age distribution reflects the **overall trend** observed in most adult drug treatment demanders, that is, a decrease of patients under 25 and an increase of patients **older than 30 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..

Available services and offers:
The national residential drug care centre 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. The duration of a therapeutic stay 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 offer 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 map 5.1) in order to take advantage of training and social reintegration facilities offered by the CTM. Based on past experience, the 2005-2009 drugs action plan has foreseen the further development of these annexes. In 2008 a new annexe allowing providing therapeutic offers to specific target groups such as mothers with child/children or patients in the last therapy phase has become operational on the very site of the main centre.

The CHNP runs a residential facility with a capacity of 15 beds called "mid-term unit" in the North of the country. Its mission is defined as follows:

- Contribute to the physical and mental stabilization of the patient after clinical detoxification.
- Supervise the patient during the period going from the clinical detoxification to the admission in therapy or offer him a protected area to develop his project of social reintegration/rehabilitation.
- Free capacity of regional psychiatric services by admitting detoxificated patients for further care.

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. If approved, related costs are covered by the national social security schemes.

Table 5.2 Drug treatment demands abroad approved by Medical Control department (1996-2007)

AGE GROUP	1996	1998	2000	2002	2004	2005	2006	2007	*Males (2007)*		*Females (2007)*	
	N	N	N	N	N	N	N	N	*N*	%	*N*	%
< 20 years			3	5	3	3	1	5	5	14	0	0
20 à 25 years			33	33	37	29	41	32	10	28	22	25
> 25 years			66	63	72	89	74	86	21	58	65	75
TOTAL	55	71	102	101	112	121	116	123	36	100	87	100
Mean age			27Y9M	28Y	28Y5M	30Y7M	30Y	30Y1M	28Y		31Y	

Source : Administration du Contrôle Médical : Cures de désintoxication (drogues dures et polytoxicomanie) à l'étranger - Exercices 1996-2007

- PHARMACOLOGICALLY ASSISTED TREATMENT

    - <u>Detoxification, In-Patient</u>

<u>RELEVANT TRENDS</u>: Drug detoxification units throughout the country have been showing a continuous increase regarding number of admissions and patients (382 patients in 2004 vs. +/- 500 patients in 2007 showing sings of stabilisation). **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.

Available services and offers:
Physical drug detoxification is provided by 5 different hospitals via their respective psychiatric units. The most important detoxification unit implemented within a specialised department of the CHNP (15 detoxification beds) has been restructured and does not provide detoxification treatment anymore. The 'Hôpital du Kirchberg' has joined the list of national institutions providing detoxification treatment in 2005. 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 psychotherapeutic oriented institutions.

Detoxification treatment is provided by psychiatric units within five general hospitals:
Clinique St. Louis – Ettelbrück (North)
Centre Hospitalier Emile Mayrisch – HVEA (South)
Centre Hospitalier de Luxembourg – CHL (Centre)
Hôpital Ste. Thérèse (Centre)
Hôpital du Kirchberg (Centre)

- Substitution Treatment, Out-Patient

RELEVANT TRENDS: Stabilisation of number of patients in structured programme and in substitution treatment prescribed by licensed MDs - stabilisation of gender ratio (2 males/ 1 female) - Increase of substitution treatment demanders being aged 39 years+.

The **number of patients** admitted to the national substitution programme has been decreasing from 2000 to 2006 and stabilised at 113 patients in 2007, which is supposedly due to the increasing access to lower threshold substitution treatment provided by independent yet specially licensed MD's. The proportion of female substitution treatment demanders (30% stable) is higher than the proportion of female PDUs in the overall drug treatment population. The **mean age** of clients has significantly increased over the last 10 years, which is due particularly to the steep increase of the number of treatment demanders over 39 (39%). 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. The number of patients who did receive substitution treatment by prescription **from independent general practitioners** tends to stabilise [(979 patients in 2007 multiple counts excluded (2005: 970)].

Available services and offers:
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-digressive dose, 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 introduced a legal framework for substitution and maintenance treatment.

The grand ducal decree of 30 January 2002[34] regulates the practical modalities of substitution. The referred 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 prescribing MDs 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 – 113 patients in 2007) provided by specialised agencies (JDH) and **a lower threshold substitution treatment** offer provided by freelance state licensed MDs (MEPHENON ®, METHADICT ® and SUBUTEX ®).

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 an 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** may 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 more in-depth psychosocial counselling.

Diverted MEPHENON ® (methadone in pill form prescribed by accredited MDs) is also 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 prescribed a substitution drug by one or more of his/her colleagues. In that respect, a **central substitution register** is about to be implemented jointly by the 'Surveillance Commission on Substitution Treatment [35]', the national drug coordinator and involved specialised treatment centres. The permission for its creation has been granted by the national data protection commission in June 2006 and it has entered its test phase in November 2007. At the moment of writing, discussion have been ongoing with the national MD association in order to find the best way to make the implementation of the substitution register compatible with daily medical practice.

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.

[34] The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: http:www.eldd.emcdda.org

[35] 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, 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.

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

YEAR	1999	2000	2001	2002	2003	2004	2005	2006	2007
Number of indexed patients (double counting controlled)	745	844	849	820	913	/	970	939	979
Number of indexed patients (double counting included)	/	/	/	1,487	1,554	1,553	/	1,516	/
Number of prescribing GPs (double counting controlled)	125	145	147	157	154	158	163	121	122

Source : Union des Caisses de Maladie 2006

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.

Harm reduction offers

RELEVANT TRENDS: The **number of contacts** indexed by low threshold agencies has increased dramatically over the last ten years (2007: 60,405 / 2005: 47,739 / 1996: 6,456), and so has the number of syringes distributed by the same agencies, although the number of syringes distributed in 2005 has stabilised for the first time since the existence of the national NEP and even decreased in 2006 and again in 2007 (see Fig. 4.2.). 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 (currently 17%). Approximately 57% of clients are aged between 25 and 34 years, and an increasing proportion (28%) of clients aged 35 and more is observed. 56% (53%) of clients are native.

Available services and offers:
Currently two agencies offer harm reduction services in the Centre, the South and the North of the country including offers such as day and night shelter and supervised injection facilities (currently only in the centre). A new integrated low threshold centre for drug addicts is planned to be implemented in the main city of the South of the country.

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. As police forces are routinely informed by medical emergency services in case of a suspected overdose case, they are able to collect evidence at the site of the incident and confirm or not, in combination with post mortem toxicological evidence, the suspected overdose. 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'.

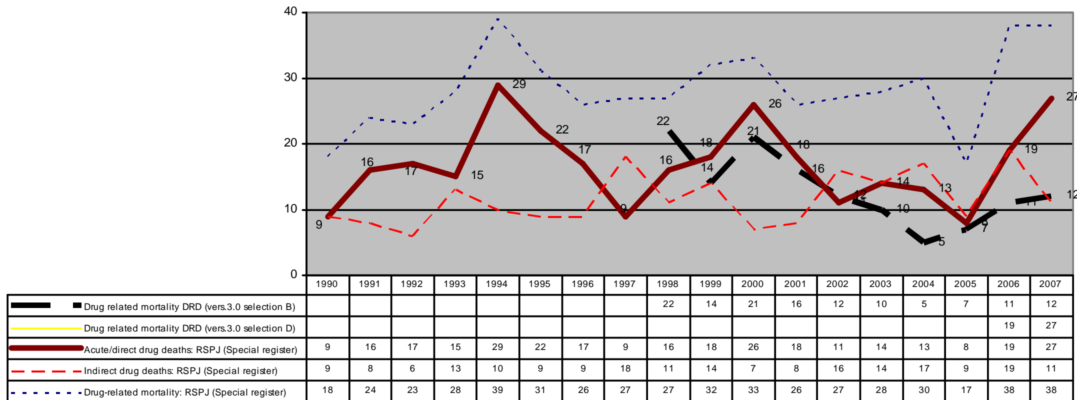
2. **The statistical department of the Directorate of Health maintains the General Mortality Register (GMR)** indexing all deaths that occurred on the national territory by means of death certificates provided by GPs. Since 1998 the GMR applies the 10th revision of the International Classification of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

Both sources are independent, meaning that for the SPJ register data collection occurs via police records and forensic evidence, while the GMR is updated according to information contained in death certificates. Discrepancies between the referred registers mainly originate from different encoding routines (e.g. death certificates often only mention primary cause of death) explaining the fact that the DRD v 0.3 systematically underestimates the SPJ based number of drug-related deaths as can be seen in figure 6.1.

Infectious diseases, including HIV and viral hepatitis have to be reported when diagnosed to the Directorate of Health (Ministry of Health) that compiles data and is in charge of nation wide epidemiological follow up. The national drug monitoring system RELIS provides self reported data on infectious diseases in PDUs. Furthermore specific studies provide complementary information. The report includes data from the latest study on infectious diseases in PDUs (Origer & Removille, 2007) based on serological test results to assess current prevalence rates and apply vaccination schemes if medically indicated.

- DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS
    - Direct Overdoses and (differentiated) indirect drug related deaths (see ST5 and 6)

Figure 6.1 Evolution of drug-related death cases (direct - indirect - total mortality) from 1990 to 2007 (Origer 2008)

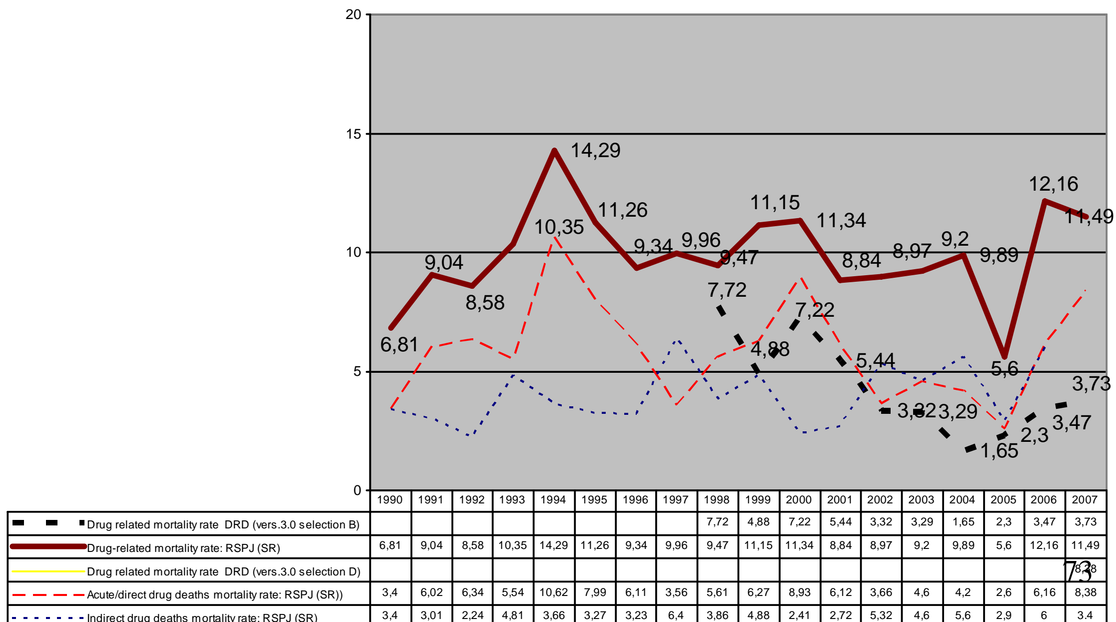


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Drug related mortality DRD (vers.3.0 selection B)									22	14	21	16	12	10	5	7	11	12
Drug related mortality DRD (vers.3.0 selection D)																	19	27
Acute/direct drug deaths: RSPJ (Special register)	9	16	17	15	29	22	17	9	16	18	26	18	11	14	13	8	19	27
Indirect drug deaths: RSPJ (Special register)	9	8	6	13	10	9	9	18	11	14	7	8	16	14	17	9	19	11
Drug-related mortality: RSPJ (Special register)	18	24	23	28	39	31	26	27	27	32	33	26	27	28	30	17	38	38

As can be seen in figure 6.1 the DRD v. 3.0 standard (selection B) appears to be fairly weak proxy of direct, indirect and total 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. A very high to perfect agreement is observed between the RSPJ register and selection D (DRD v.3.0)

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 2005, showing a peak in 2000 (26 cases) decreasing anew to a historically low level of 8 cases in 2005. A

Figure 6.2 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2007 (Origer 2008)



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Drug related mortality rate DRD (vers.3.0 selection B)									7,72	4,88	7,22	5,44	3,32	3,29	1,65	2,3	3,47	3,73
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	5,6	12,16	11,49
Drug related mortality rate DRD (vers.3.0 selection D)																		8,38
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	2,6	6,16	8,38
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	2,9	6	3.4

new upward trend is observed in 2006 and confirmed by 2007 data (27 cases).
This trend appears to be consistent with latest developments in most other EU Member states.

Compared to 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[36] 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. This observation has, however, to be considered with caution since methodologies used to determining prevalence of DRD deaths are not necessary comparable throughout EU as shows for instance by the structural underestimation of the number of acute drug death based on the EDMCDDA DRD v.3 standard. In 2007 overdose rates of 5.67 and 8.38 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed.

The overall discontinuous decrease of acute overdose cases from 1994 onwards has been associated to the regionalisation and extension of the methadone substitution programme as well as to the further development of low threshold facilities. The decreasing trend from 2000 to 2002 is thought to 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. The positive evolution of direct drug deaths is to be associated to the implementation of a drug consumption room in 2005. Considering that since the opening in 2005 of the drugs injection room more than 250 overdose victims could be assisted and reanimated in this same facility, the life-saving effectiveness of such an offer is proven. Without these facilities, the actual increase of overdose cases in 2006 and 2007 would be much more important and is associated to other factors that most other Member States seem to be confronted to, to a similar extend.

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).

[36] All age groups

- 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.

A retrospective study (1992-2006) on drug-related death cases performed in 2007 allowed a better understanding of risk and protective factors (Origer, 2008).

Forensic data by the department of National Toxicology Laboratory on Health[37] show that the most frequently involved substance in overdose cases is heroin, followed by methadone and cocaine. To stress that since 2000, methadone presence in blood samples of overdose victims has been increasing.

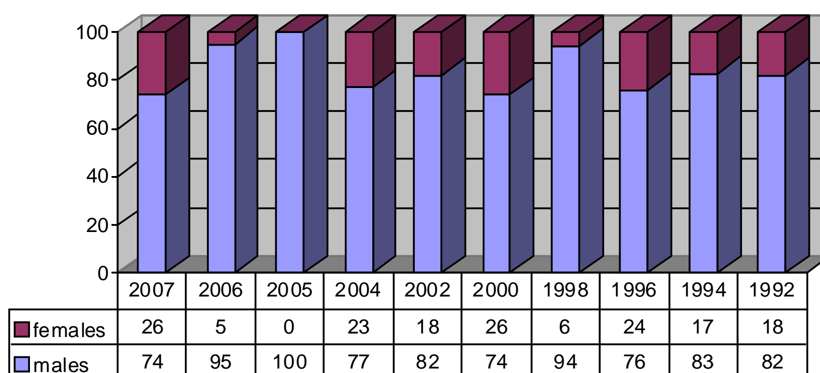
The vast majority of victims are male (83%) and their mean age at the moment of death shows an important increase over the past 10 years (in 1992: 28.4 years and in 2006: 32.5 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years remains relatively unchanged during observation period.

A confirmed majority of drug-related victims are natives. During the entire observation period Portuguese citizens stand in second place, followed by Italian and French residents. Recently, one could observe an increasing number of victims from the frontier zone (BE, DE, F) and a dropping number of victims of Portuguese origin.

Also worth mentioning is that a majority of acute drug death victims are known by law enforcement agencies (75%) for their drug user "career", which lasts for 10 years (in average). Furthermore over 80% of the known victims made at least one treatment before their death and half of the individuals had an accommodation that could be qualified as stable. As far as the place of death is concerned, since 2004 approximately 50% occurred at the victims' home, followed by public place and detention centre.

[37] Département de Toxicologie du Laboratoire National de Santé

Figure 6.3 Gender distribution of direct drug-related death cases (1992 - 2007) (%)



Source: RELIS 2007

Table 6.1. Age distribution of direct drug death cases indexed from 1992 to 2007

	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	Total
< 20	3	1	1				2	1	1			1		3	3		16
20-24	1	4	2	1		4	2	8	3	2	2	5	6	6	6	6	59
25-29	6	4	1	4	2	1	5	6	6	5	5	5	10	13	2	6	81
30-34	8	2	1	3	4	3	2	6	3	2	2	4	5	6	3	3	58
35-39	5	5	1	2	3	1	5	4	3	4		1	2	1	1		38
40-44	2	2	1	2	3		2	1	1	3			2			1	20
45-49	1			1	2	2		1					1			1	9
> 50	1	1	1									1					4
Mean Age	**32.33**	**32.5**	**31.48**	**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**	285
Male	34Y4M																
Female	25Y																

Mean age of female overdose victims is dramatically lower than for males. This may be due to several factors such as early start and evolution of drug carriers, higher risk behaviour in patterns of use and drug acquisition strategies (e.g. higher poly use with pharmaceutics and risk taking during prostitution), higher suicide rates in general population and in PDUs in women.

Also to be stressed that the youngest victim was aged 15 years and 11 months and the oldest reached 60 years and 8 months. Three underaged victims were reported in 2007. Duration of drug abuse figures 10 years for male victims and 7 years and a half for women. For more detailed data on 2007 drug related deaths please refer to standard tables 5 and 6.

- Mortality and causes of deaths among drug users

In terms of **drug-related mortality** (direct and indirect deaths indexed by RSPJ), 38 cases have been indexed in 2007 (38 in 2006); prevalence has been showing small variations since 1996 figuring roughly 17 to 38 cases per year.

The above mentioned study (Origer & Dellucci 2002)[38], 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

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

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 [37 in 2007 of which 19 direct/acute death cases (17 & 8 in 2005)].

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 **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 been indexed as follows: **X42.-, T40.-, T42.- T43.-** . At a more restricted level the code sequence: **X42.-, T40.-** includes around 70% of all reported overdoses.

Main **causes of indirect deaths between** 1996 and 2006 are, in order of importance: suicide (32%)[39], traffic accidents (22%), associated cardio-vascular or pulmonary complications (15%) undefined intoxication (11%), pharmaco-dependance (7%), liver failure (6%), HIV/AIDS (4%) and other (2%).

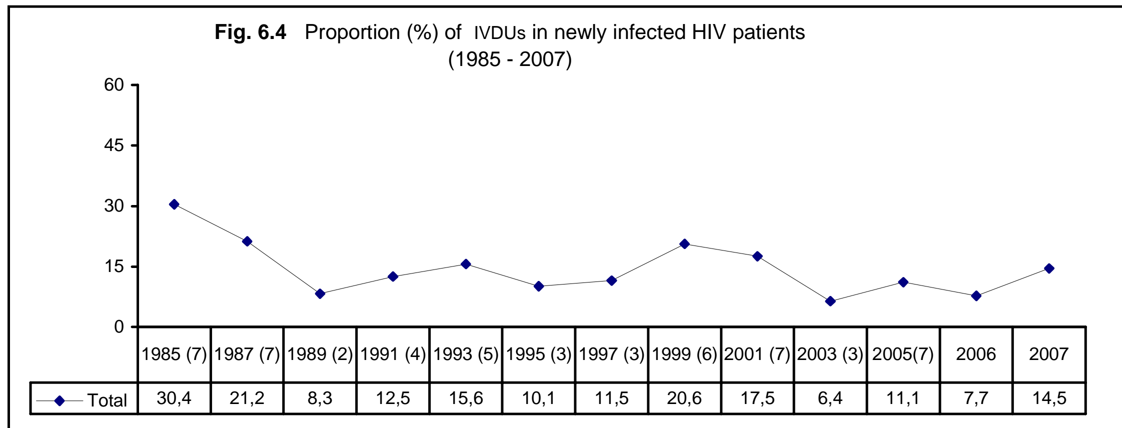
- DRUG RELATED INFECTIOUS DISEASES

    - HIV/Aids, viral hepatitis, STD, tuberculosis, other infectious morbidity

Data on drug-related infectious diseases are centralised at national level. No regional data sets exist. Official data from the national Retrovirology Laboratory of the CRP-Santé provide the number and proportion of IDUs in HIV infected patients. Between 1984 and 2007, 814 HIV infected persons have been registered at the national level; 110 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 13.51 per cent since the registration of the first HIV case in Luxembourg in 1984.

Currently intravenous drug use appears to be the third most reported transmission mode of new HIV infection since 1989 (homo/bisexual and heterosexual transmission are currently in first and second position respectively). The proportion of intravenous drug use transmission has noticeably decreased between 1998 (23%) and 2004 (5%). Post 2004 data show a discontinuous increase of IDU transmission mode figuring 14.5% in 2007.

[39] Valid percentage



	1985 (7)	1987 (7)	1989 (2)	1991 (4)	1993 (5)	1995 (3)	1997 (3)	1999 (6)	2001 (7)	2003 (3)	2005(7)	2006	2007
Total	30,4	21,2	8,3	12,5	15,6	10,1	11,5	20,6	17,5	6,4	11,1	7,7	14,5

Source : Laboratoire de Retrovirologie – CRP-Santé. 2008 (data formatting NFP)

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2007, (N=736) 81% 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 IDUs, occurred. Subsequently, **HIV rates in current IDUs have been increasing to reach 3.81% in 2007. IDUs treatment demanders** show the highest HIV prevalence rate (4.89%).

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.

A recent study by Origer and Removille (2007)[40] assessed the national prevalence via serological test results HIV, HCV, HAV and HBV in the population of problematic users of illicitly acquired drugs. Furthermore the authors performed a cross sectional analysis of the relation between the studied infections and selected observable factors, to increase the national vaccination coverage and to refer infected persons towards appropriated medical treatment centres. (See ST 9)

Eight month data collection in 2005 allowed establishing 1,167 contacts, of which 395 were conclusive and numerous new cases of infection have been identified. It is the first study of this type ever conducted at national level. Main results are the following:

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

Table 6.2 Prevalence of hepatitis B surface antigens (HBsAg), antibodies to hepatitis B core antigen (anti-HBc), hepatitis C virus (anti-HCV), and HIV (anti-HIV 1 and 2) in PDUs and ever-injectors according to national recruitment settings

	Total number of respondents	Anti-HBc and/or HBsAg N†, n (%; 95% CI)	Anti-HCV N n (%; 95% CI)	Anti-HIV 1 and 2 N, n (%, 95% CI)
Total sample	362*	310 67 (**21.6**; 17.1 to 26.2)	343 245 (**71.4**: 66.6 to 76.2)	272 8 (**2.9**; 0.9 to 4.9)
Ever injectors ‡	310	239 59 (**24.7**; 19.6 to 29.8)	268 218 (**81.3**; 71.4 to 91.2)	202 5 (**2.5**: 0.2 to 4.8)
Outpatient drug treatment centres	159	147 24 (**16.3**: 10.3 to 22.3)	158 92 (**58.2**: 50.5 to 65.9)	158 3 (**1.9**; 0.0 to 4.0)
Inpatient drug treatment centres	61	53 8 (**15.1**; 5.5 to 24.7)	61 46 (**75.4** ; 64.6 to 86.2)	49 0 (**0.0**; 0.0 to 0.0)
Prisons	135	110 35 (**31.8**; 23.1 to 40.5)	124 107 (**86.3**; 80.2 to 92.3)	65 5 (**7.7**; 1.2 to 14.2)

*Antibody prevalence of respondents for whom valid blood test serology for at least one infection (HBV, HCV or HIV) was available
† Number of respondents for whom valid blood test serology for HBV was available
‡ Respondents that have injected at least once in their lifetime a drug for non therapeutic reasons

Source: Origer ,A. & Removille, N. (2007)

Concerning HAV prevalence, no case has been identified in the referred study. It should be stressed, however, that 43% of the participating PDUs are not protected against hepatitis A. In terms of co-infections in PDUs with valid serological test results (N: 248) collected during the study, 2% show HIV, HCV (acute) and HBV (acute) infections and 3.2% are HIV positive and infected by HCV.

Among persons infected by HCV, HBV and HIV, respectively 96%, 95.2% and 71.4% are ever injectors. The highest prevalence rates were observed among the prison population. This has to be confronted to the fact that 56.1% of the respondents with current or past prison experience (N: 246) declare having consumed illicit drugs in prison whereof 54.3% report intravenous use during detention. Among these lifetime injectors in prison 20% reported exclusive use of new and sterile syringes, 53.3% declared never having exchanged syringes with other inmates and 26.7% report syringes' exchange in prison.

The study also refers to a series of determinants such as, inefficient disinfection methods such as cleaning injection paraphernalia with water or urine, inadequate syringe elimination, a high proportion of PDUs not using condoms during sexual intercourse, especially with new partners or irregular partners, the lack of or false knowledge of serological status and finally, protection strategies based on subjective criteria rather than on established knowledge.

Although strategies for risk reduction in the population of problematic drug users in the G.- D. of Luxemburg exist, this study underlines the high prevalence of certain infectious diseases in the target group and in particular hepatitis C (HCV).

The existing prevention efforts have to be completed putting particular emphasis on young and new drug users. Although the study confirms a low compliance of the target population, screening and vaccination facilities have to be further developed. In this context the authors put forward a series of approaches that may contribute to reduce incidence of infectious diseases and related risks in PDUs (see Origer, Removille, 2007).

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	2005	2006	2007
HIV rate in problem drug users (RELIS self-report)	3	2.9	2.9	4.3	4.07	4.49	3.88	3.98	3.31	2.9	3.39
HIV rate in problem drug users (serology-based**)** **(Origer & Removille, 2007)**									**2.90**	**/**	**/**
HIV rate in drug treatment demanders (RELIS self-report)	3.8	2.6	3.4	4.87	4.78	4.32	3.88	4.93	3.84	3.49	4.13
HIV rate in current IDUs (RELIS self-rep.))	3.6	3.5	3.3	3.6	3.41	4.08	4.17	5.10	3.96	2.76	3.48
HIV rate in current IDUs treatment demanders (RELIS self-report)	4.5	3.4	3.9	3.9	4.24	4.32	4.24	6.41	4.59	3.33	4.27
HIV rate in life-time IDUs (serology-based) **(Origer & Removille, 2007)**									**2.50**	**/**	**/**
HIV rate in current IDUs prisoners (Schlink 1998)	/	4.4	/	/	/	/	/	/	/	/	/

Source: RELIS 2007

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

YEAR	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
AIDS rate in problem drug users (RELIS)	2.5	2.5	1.25	1.35	2.03	1.72	1.71	2.13	1.81	1.19	1.86
AIDS rate in drug treatment demanders	/	/	**1.66**	**1.76**	**2.43**	**1.60**	**2.04**	**2.69**	**2.37**	**1.65**	**2.64**

Source: RELIS 2007

The prevalence of **HBV** infection in problem drug users has been showing a decreasing tendency during recent years based on self-reported data. The results provided by Origer and Removille (2007) study based on blood sample provide slightly higher yet consistent rates in PDUs. The **significant increase of the HCV infection rate** during the same period is particularly marked in IDUs, figuring 64.94% to 81% according to risk groups (current, ever -injectors) and applied methodologies (self-reports vs. blood tests). There are, however current signs of stabilisation.

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	2005	2006	2007
HBV rate in drug users (RELIS self-report)	29	30	30	28	25	22	20.51	21.34	18.67	17.21	17.81
HBV rate in PDUs (Origer & Removille)									**21.6**		
HBV rate in drug treatment demanders (RELIS self-report)	/	27	32	27	24	20	19.79	22.69	18.58	16.46	17.95
HBV rate in IDUs (RELIS self-reports)	/	33	35	30	30	25	22.76	23.93	20.08	18.32	20.16
HBV rate in ever-injectors (Origer & Removille)									**24.7**		

Source: RELIS 2007

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	2005	2006	2007
Self-reported HCV rate in drug users (RELIS)	26	25	32	46	50	49	59.92	64.55	64.94	64.95	64.06
HCV rate in PDUs (Origer & Removille)									**71.40**		

Self-reported HCV rate in drug treatment demanders	/	29	41	53	54	54	60.49	66.16	66.22	63.23	63.08
HCV rate in IDUs prisoners (saliva tests)	/	37	/	/	/	/	/	/	/		
Self reported HVC rate in IDUs (RELIS)		45	50	53	56	53	67.97	74.14	74.38	69.58	72.02
HBV rate in ever-injectors (Origer & Removille)									**81**		

Source: RELIS 2007 (Origer & Removille 2007)

Summarily, HBV infection prevalence in PDUs and in drug treatment demanders is fairly stable and HCV prevalence in PDUs appears to have reached a plateau at a high level. HIV infection rates show a decrease especially referred to IDUs in treatment settings.

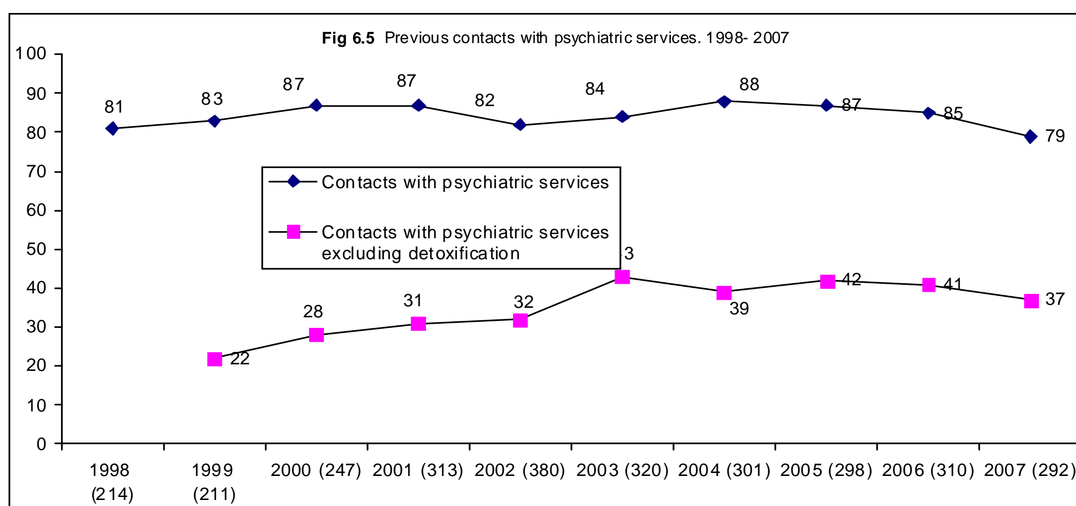
- PSYCHIATRIC CO-MORBIDITY (DUAL DIAGNOSIS)

    - Personality disorders, depression, anxiety, affective disorders

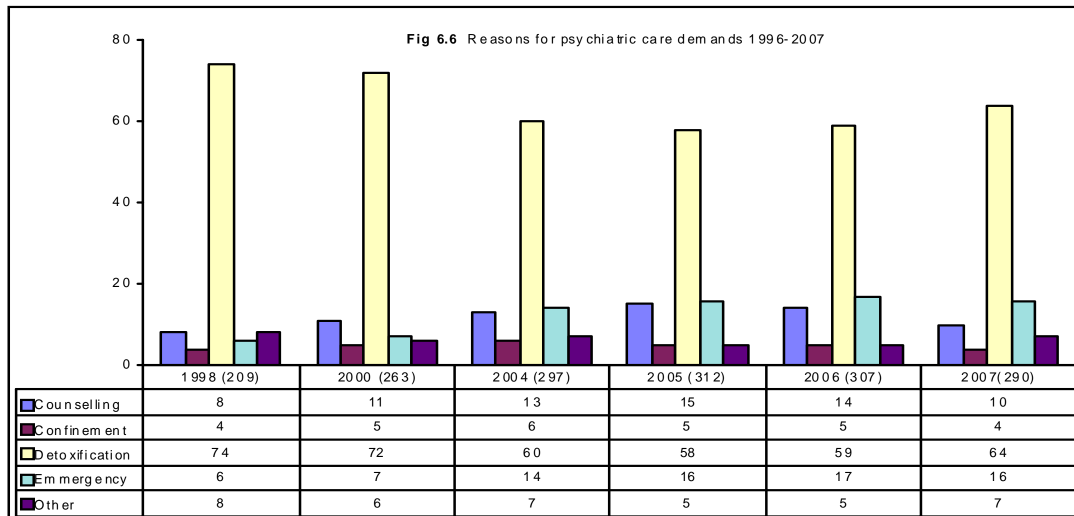
To date any genuine study on co-morbidity patterns in PDUs has been performed at the national level. Data presented in the present chapter have been provided by specialised drug agencies and the RELIS drug monitoring system and thus reflect experiences and trends as observed during recent years.

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:



SOURCE: RELIS 2007



	1998 (209)	2000 (263)	2004 (297)	2005 (312)	2006 (307)	2007(290)
Counselling	8	11	13	15	14	10
Confinement	4	5	6	5	5	4
Detoxification	74	72	60	58	59	64
Emmergency	6	7	14	16	17	16
Other	8	6	7	5	5	7

SOURCE: RELIS 2008

Figure 6.5 differentiates between all 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 2007 reveal a fluctuating but a fairly stable long term 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 if compared to what happened in the end of the nineties although stabilised around 40% since 2004.

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 care 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 a 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 exist 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.

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 professionals 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. Currently the previously referred to expert group "Therapeutic chain" performs a needs assessment and analyses treatment demands that resulted in referrals to specialised drug treatment centres abroad.

- OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

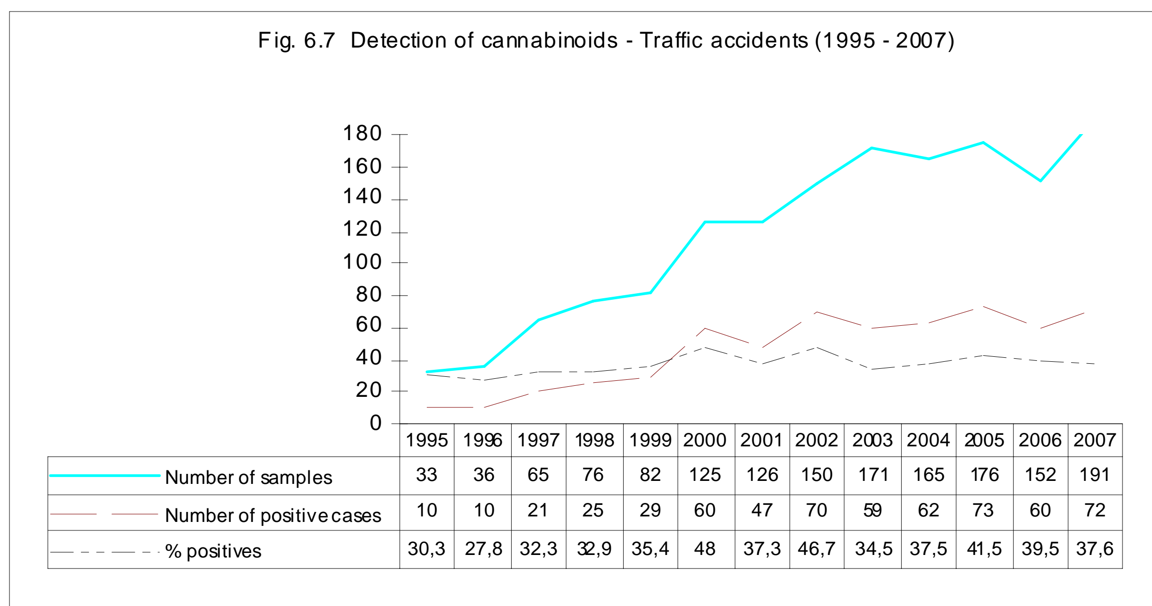
  - Somatic co-morbidity

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDUs except for HCV prevalence. In 2007, 82 (84) per cent of problem drug users reported a self-perceived satisfying general health condition against 53 per cent in 1997. Half of indexed PDUs report single or multiple suicide attempt(s) and non fatal overdoses during lifetime. No significant changes have been observed during last 6 years.

  - Driving and other accidents

Figure 6.7 provides data on cannabis exposure of persons involved in traffic accidents from 1995 to 2007. Around 40% of tested persons were positive on cannabinoids (which doesn’t mean that the effect of the latter caused the accident). This proportion has remained fairly stable over the last 4 years

Fig. 6.7 Detection of cannabinoids - Traffic accidents (1995 - 2007)



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Number of samples	33	36	65	76	82	125	126	150	171	165	176	152	191
Number of positive cases	10	10	21	25	29	60	47	70	59	62	73	60	72
% positives	30,3	27,8	32,3	32,9	35,4	48	37,3	46,7	34,5	37,5	41,5	39,5	37,6

  - Pregnancies and children born to drug users

See sub-chapter at-risk families in chapter 3.

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.

Health care offers to drug users are provided by specialised drug care agencies as well as by the general health care system. No reliable data and drug treatment demands from general healthcare providers are currently available with the exception of detoxification treatments provided exclusively by psychiatric departments of general hospitals and ambulatory substitution treatment prescribed by authorized MDs.

In May 2006 a new **national HIV/AIDS action plan** covering the period 2006 to 2010 has been launched by the Ministry of Health. The action plan is based on 8 pillars including prevention of infectious diseases and harm reduction in drug using populations. It complements or enhances measures included in the national drugs action plan 2005 – 2009. The document can be downloaded under http://www.ms.etat.lu

- PREVENTION OF DRUG RELATED DEATHS
    - Overdose prevention

The above mentionned Origer & Dellucci 2002 study recommended the following measures:
- opening of supervised injection rooms according to the national drugs action plan (1)
- medical controlled heroin distribution programme (foreseen by the national drugs action plan) (2)
- first aid training courses provided to users and their relatives and partners (3)
- gender and ethnic specific interventions (4)
- provision of morphine receptor antagonists to users and selected persons (5)
- creation of 'transition centres' for ex or current PDUs leaving institutional settings (6)
- development of reintegration programs for prisoners in the framework of the recent 'Global care programme for drug addicts in prison' (7)

At the time of writing, 5 of 7 of these recommendations have been put into action. Measures 2 and 6 are still in the planning phase. 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, including flyers on: 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 and risks of abscesses and endocarditis. Provision of first aid and harm reduction training to drug users and peers takes place in low threshold agencies.

As far as measure 1 is concerned, a **drug injection room** is defined as a facility allowing IDUs 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 IDUs and non IDUs 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 is included in the national drugs action plan 2005-2009 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 accommodation is not to be seen as a permanent housing facility; there is indeed a daily admission procedure. Target population for the consumption room are primarily IDUs. 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.

An expert group has been visiting similar projects in the EU in order to fine-tune the concept and implement quality control standards. The national drugs coordinator's office elaborated the operational concept of the injection room. All involved parties meet once a month (called' the Monday round') to assess the current situation and emerging problems related to the functioning of the consumption room. Opening hours are currently from 3 pm to 10 pm 7 days a week

According to the first two-years' evaluation of the injection room (June 2007), 381 injectors had signed the mandatory user contract and proceeded to 14,330 injections supervised by trained staff. The facility were mostly used by men (79%); the most commonly used drugs were heroin (81%), cocaine (12%) or both of them (6%); age category 25-34 is most represented (56%). No fatal overdose has occurred thus far but over 80 overdoses have occurred and due to the immediate intervention of ad hoc staff all victims could be assisted, reanimated and saved. No drug scene concentration and no disturbances or nuisance in the neighbourhood have been observed. Over 600 safer use counselling sessions have been provided to clients. In December 2007 over 482 contractual users were registered and 13,727 supervised injections took place during 2007. From January to July 2008, 104 additional users have registered (Total: 586 contracts) and 14,526 injections were reported exclusively for the first 7months of year 2008. The concept of the drug injection room can be ordered at the Ministry of Health (alain.origer@.ms.etat.lu).

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, discussions are currently ongoing with the community council of Esch/A in order to implement a similar facility in the latter city. The aim is to further decentralise low threshold offers and enhance local city authorities'

commitment in the management of regional and urban drug problems. Involved national and local authorities have recently found an agreement on the geographical location of this facility although the concept has still to be agreed on.

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 is supposed to reduce drug-related deaths occurring in consumer groups. Moreover the ICD has put on its agenda the implications of routine police forces' on site presence in case of a reported and/or suspected overdose case. Field workers believe that this routine has negative impact on the willingness of drug using witnesses, to call for help.

Based on the outcomes of the study (Origer & Dellucci 2002), the retrospective study (Origer, 2008) and a related analysis performed by drug field agencies (COCSIT) jointly with the Ministry of Health, a series of measures are to be further developed, such as information and peer education of drug users, ban multiple prescriptions of substitution drugs and consider interaction of substitution treatment and concomitant and persistent street drug use, ensuring trough-care especially for persons with drug careers leaving prison or residential treatment.

- 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 maintaining and to further developing 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.

The objective of these interventions is 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 IDUs 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[41]' for sniffing purposes witness a progressive switch from IDUs users to PDUs being considered as target groups. Furthermore infectious diseases prevention does not focus specifically on IDUs as shows a recent action-research project on HIV and hepatitis infection among PDUs (Origer & Removille, 2007).

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 2005**. However, the number of distributed syringes stabilised in 2005 and has been significantly decreasing from 2006 onwards. The possible reasons for this trend have been addressed by a special national working group. The hypothesis that syringes

[41] 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.

are increasingly acquired via out of NSP providers (e.g. pharmacies) could not be confirmed since over the last five years the proportion of syringes distributed by NSP points have increased in comparison to other providers. Following factors may have influenced distribution patterns:

- Relocation of the main drug counselling centre in Luxembourg city in 2006 and provision gaps due to it,
- intensive presence of the police at proximity of the railway station and in the direct environments of the Drop-In service,
- The syringes distributed to the clients of the consumption room are not included in the national statistics (127.975)
- the service K28 notices an increase of the distribution of aluminium sheets in 2007 (07 : 1.204/06 : 766) ; a renewed outbreak/upsurge of the consumption mode by inhalation is however not confirmed by the other services,
- the quality of the drugs on the illicit market widely influences the consumption behaviours and the injection frequency,
- the fact of having introduced a new type of syringes (where the needle is more solid) can have as result that the same consumer uses the same syringe several times/more often.

After years of increase, syringes return rates seem to have stabilised around 90%. Obviously automatic dispensers still show lowest return rates.

Table 7.1 *National needle exchange programme 1996-2007*

	Distributed syringes							Collected used syringes						
	1996	1998	2000	2002	2004	2006	2007	1996	1998	2000	2002	2004	2006	2007
TOTAL	76,259	109,743	189,413	254,596	435,078	332,347	**288,247**	28,646 (38%)	58,886 (46%)	112,625 (59%)	211,621 (83%)	376,491 (87%)	282,909 (93%)	260,252 (90%)

Source: RELIS 2008

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 sex workers within their daily work environment for HIV and hepatitis testing and subsequent health care, if needed.

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** with the objective to estimate HCV and HIV prevalence in PDUs based on medical diagnosis data (blood testing) and to implement required health care infrastructures (Origer & Removille, 2007).

The project relied 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. Additionally a quantitative questionnaire (questions based on socio-demographic, illicitly acquired drugs consumption, consume patterns, sexual behaviour, consumption in prison, piercing/tattoo) allowed analysing associated factors. Serological analysis identified 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 has been offered. Drug users meeting the selection criteria were recruited in LTS, NSEP,

Inpatient Treatment Centres, Hospitals and in the prisons of Luxembourg. The NFP has been granted a full financing of the project by the FLTS.

The final report has been published in September 2007 and may be downloaded at http://www.relis.lu .

The following recommendations of the report have been materialised thus far:

- increase knowledge of serological status among general population and risk groups,
- include drug users in the planning process of prevention strategies,
- reinitiate safer-use counselling for young and new drug users since they are often not aware of risks compared to older or more experienced users,
- insure availability and free access to the whole range of injection paraphernalia (e.g. spoons, stericups, filters) in order to neutralise a maximum of infection vectors (since 2007),
- increase syringes availability via NEPs (main low-threshold agency TOXIN enlarged its opening schedules to 7/7 days in June 2008),
- ensuring a better vaccination coverage and above all vaccination follow up by increasingly involving the specialised care network. A pilot project providing on-site serological testing and free Twinrix® vaccination in specialised drug care services was approved by national Health authorities and will be started by the beginning of 2009.

  - 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 the Ministry of Health and an important network of volunteers. AIDSBERODUNG is part of the RELIS network. Testing is provided by the CHL and the LNS and is free of charge. Furthermore, HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison.

A new project foreseen by the national HIV/Aids action plan 2006-2010 focuses on outreach measures in order to better reach target populations and in particular vulnerable groups. DIMS (Mobile intervention facility for sexual health) aims to access difficult to reach sub-populations and provide prevention counselling and infectious disease testing on site to various populations. The project will offer free rapid testing and outreach counselling and should be operational by the end of 2008.

  - 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 has no or no valid health insurance, treatment costs can be covered by state.

- INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY

The above referred working group 'Therapeutic Chain' has performed a needs assessment in terms of care for drug users presenting psychiatric co-morbidity. The group retained that current offers and services for double diagnostic (DD) patients are incomplete. Although the 2005-2009 national action plan foresees the creation of a

specialised therapy centre for DD drug patients, the CHNP has initiated no negotiations with the Union of Health Insurance thus far.

The number of confirmed DD patients is estimated at 40-50 people (adults). These patients show explicit psychiatric disorders, are often socially disintegrated and need individual follow up although they tend to be insensible to the existing care offers. There is a need of small supervised housing units for the target group. Furthermore, the staff of specialised associations must be specifically trained to take care of DD clients. Instead of creating a specialised and centralised care infrastructure, a better follow-up of patients within existing outpatient services is needed in the first place, knowing that the referred clients only integrate with difficulties in structures with compulsory residential character.

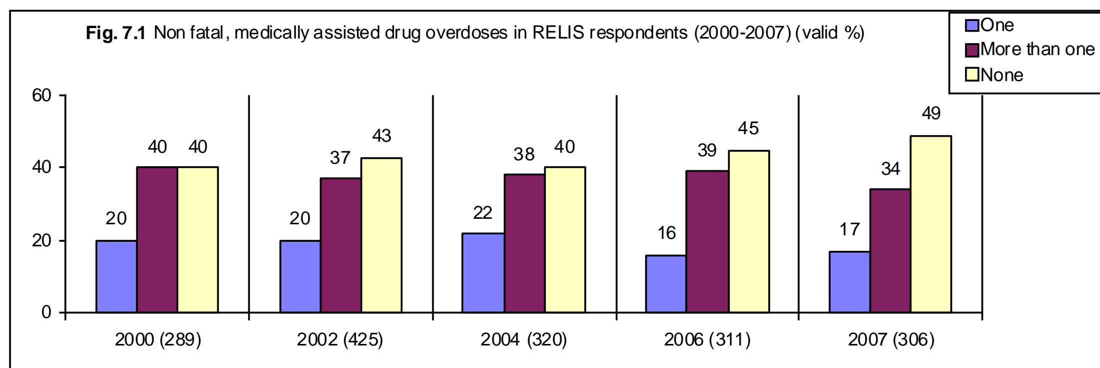
- INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

  - Somatic co-morbidity (NNIA)

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

No reliable data on drug related emergencies are currently available at the national level. Roughly estimated, 25% of emergencies are related to substance abuse (all substances included) (Rauchs 2006). Figure 7.1 refers to RELIS data on previous non-fatal and medically assisted drug overdose self reported by PDUs. The proportion of indexed drug users reporting at least one overdose (as defined) (51%) during lifetime has slowly decreased during the last seven years, which may be partly due to the further development of low threshold facilities such as the supervised drug injection room.



Source: RELIS 2007

  - Prevention and reduction of driving accidents related to drug use

The law of 18 September 2007 modifies the national traffic code and introduces testing of illicit drug use in vehicle drivers. The homologation of respective road side saliva tests (Drugwipe II) has still to be regulated by a grand-ducal decree. For more details on the new legislation please refer to chapter 1 (laws).

- <u>Other health consequences reduction activities</u>

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. As far as the latter is concerned the Inter-ministerial Group on Drugs agreed on the opportunity of a national heroin distribution programme in September 2007 and the national drugs coordinator has submitted a feasibility study and an operational framework concept, elaborated jointly with national experts, to the Minister of Health in May 2008. The main conclusion of the report (Origer 2008) are the following:

- The opportunity and feasibility of the conditional setting up of a controlled heroin distribution program (CHDP) in the Grand-Duchy of Luxembourg is given.
- The CHDP is to be seen as a high threshold offer. It is aimed at a limited group of heroin addicts, notably because of the multiple inherent constraints.
- The primary objectives of the CHDP are the improvement of the physical and mental health state of the beneficiaries, the reduction of the risks and damages for the drug(s) user, the access to "out-of-treatment" target groups for which existing offers are not adapted or attractive, the reduction of the public damages and the reduction of the delinquency and the criminality associated to drug use.
- There exists a consensus to qualify the controlled heroin distribution program as an offer of high threshold, which should be implemented within the general framework of the substitution treatment rather than in existing low threshold offers. Also, the creation of one or more substitution centre, which additionally to the traditional substitution offer includes controlled heroin distribution, is seen as a recommendable option.
- Diacetylmorphine (heroin) can be prescribed in injectable form, as tablets or for inhalation (in a second phase) depending on the medical and contextual indications.
- Instead of considering selection criteria for the admission to the CHDP, a catalogue of 'evaluating factors for the opportunity of a heroin treatment' has been elaborated. These factors have to be weighted according to their respective importance or pertinence at the moment of admission in order to assess the situation of each treatment demander in a holistic approach. The referred decision process, however, may also require that retained factors must be submitted to an explicit definition of the tolerance margins.
- A commission for admission and supervision of the CHDP (CAS) will be established. The CAS assesses admission opportunity to the program for each demander. The CAS also has to insure compliance of the programme functioning conditions to the approved concept and respective legal constraints. The CAS follows up the evolution of the heroin treatment programs at the international level and advices the Ministry of Health in case of need.
- The CHDP is conceived as a pilot project of 2 years followed by a comprehensive evaluation.
- The evaluation of the CHDP includes two parts, namely the evaluation of operational aspects of the program and the evaluation of its impact. The outcome of this evaluation will decide upon continuation of the programme and possible adaptations.

- Interventions concerning pregnancies and children born to drug users

Since several years and in the context of the development of social paediatrics at national level, child care professionals and paediatricians call for the implementation of specialised care structures for children at risk. The approach of social paediatrics considers a child in his global context including physical, psychological, social and cultural health, family and environmental context and promotes coordination and collaboration between different social and medical services.

Since 2003 the Youth-and Drughelp foundation (JDH) is running a parental project with the aim to provide psycho-social aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative abilities. This long term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. In 2007, 53 different family situations have been taken in charge, 56.6% of them being mono parental situations involving in all 83 children. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

In order to meet specific needs of children and parents at risk, especially children from drug addicted parents, the Ministry of Family and Integration has implemented a project of "out-of-hospital nursery" (Maison Françoise Dolto) targeting children aged 0 to 3 years whose parents are temporarily not able to ensure child care and education. The centre aims to provide temporary admission to these children and helps to compensate the lack of parents' involvement in child care. Besides, the structure offers therapy options, diagnostic testing and functions as a resource centre for parents. The project has a capacity for approximately 20 children and started in spring 2007.

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, focuses on supply reduction activities and the Ministry of Health implements measures targeting socio-professional re-integration aiming at reducing daily expenses and depths 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 record occurs. 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 leads to 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 (AMONG DRUG USERS AND DRUG USE AMONG SOCIALLY EXCLUDED GROUPS)

    - Social exclusion

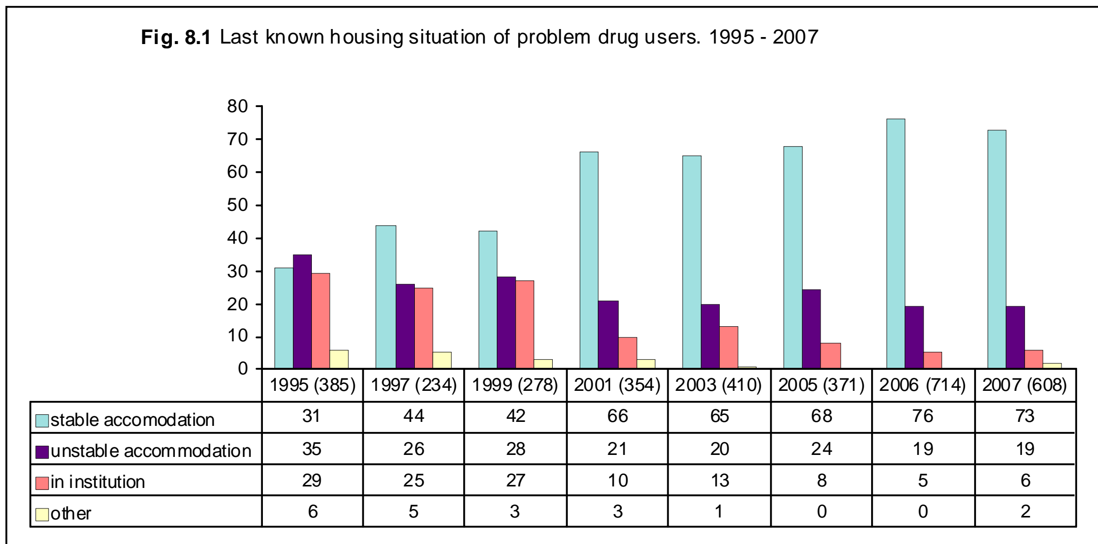
The question whether substance abuse leads to social degradation and exclusion or social factors (e.g. family situation, poverty, low education or job perspectives) lead individuals to substance use is an unsolvable one, although it tends to raise competence discussions between ministries. Fact is that a vast majority of homeless and socially excluded people living in Luxembourg also present to various extends licit and/or illicit substance abuse. Taking care of the latter is not enough as the social situation of these people needs to be improved before there is a chance to obtain sustained results in drug treatment. This said, the national strategy of care for socially excluded people is based on the principle on progressive reintegration trough capacity building and the improvement of the social abilities and environment. Associations as 'Stëmm vun der Strooss' (Street voice), financed by the Ministry of Health, try to implicate the target population again in active life by providing a safe and common environment and respecting individual capacities and resources by applying case management methodologies further described in the chapter 9.

    - Homelessness

According to latest estimations around 700 persons are currently homeless in the Grand Duchy of Luxembourg[42]. The study reported a proportion of 54% males and 46% females and a relatively young age of homeless population. Half of the population of homeless people is aged 18 to 34 years and only 9% are aged more than 55 years.

More specifically, housing status of registered drug users has markedly improved during recent years and tends to stabilise. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Currently 73 percent (76%) 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.

[42] Centre d'Etudes de Populations, de Pauvreté et de Politiques Socio-Economiques (2007). L'exclusion liée au logement des personnes prises en charge par les centres de jour, les foyers de nuit, les centres d'accueil et les logements encadrés. Luxembourg



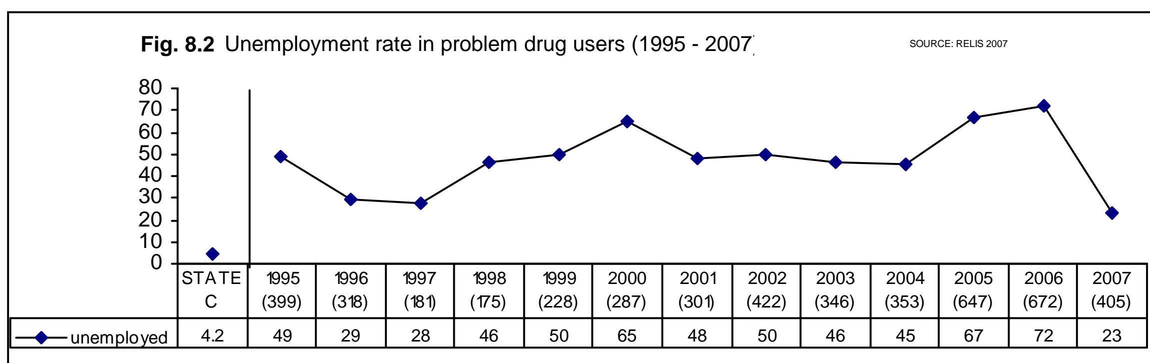
	1995 (385)	1997 (234)	1999 (278)	2001 (354)	2003 (410)	2005 (371)	2006 (714)	2007 (608)
stable accomodation	31	44	42	66	65	68	76	73
unstable accommodation	35	26	28	21	20	24	19	19
in institution	29	25	27	10	13	8	5	6
other	6	5	3	3	1	0	0	2

Source: RELIS 2007

Youngsters aged less than 25 and living on the street is referred to as a quite new phenomenon. Societal changes as the increase of mono parental families, an increased number of divorces, the decrease of married couples and the necessity to work for economic reasons for the two partners of a parental couple are likely to have a negative impact on youngster's psychological development and education.

- Unemployment

Recent data suggest that the **employment status** of respondents tends to improve, as the rate of people with a stable job has increased of 10% in 2007 compared to 2006. The **unemployment rate** has increased from 2004 to 2006 (72%). In 2007, the unemployment rate fell to 23%, which is due to the fact that only respondents who are effectively receiving unemployment allocations have been retained.



	STATEC	1995 (399)	1996 (318)	1997 (181)	1998 (175)	1999 (228)	2000 (287)	2001 (301)	2002 (422)	2003 (346)	2004 (353)	2005 (647)	2006 (672)	2007 (405)
unemployed	4.2	49	29	28	46	50	65	48	50	46	45	67	72	23

Source: RELIS 2007

Remark: STATEC: Statistical Department of State – Unemployment rate in active general population.

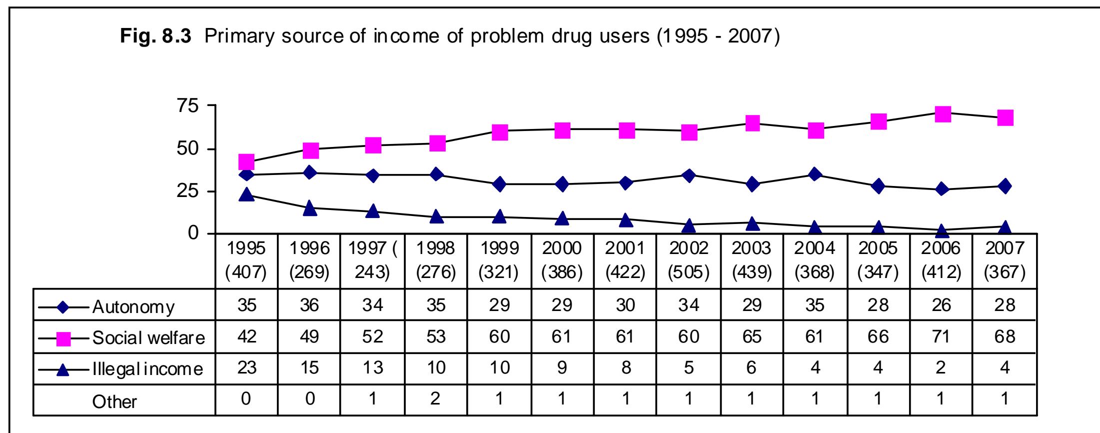
Data on revenues confirm observed trends in occupational status:

- 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;

- a high proportion of respondents reporting **major debts** (≥2,500 EURO) (36%).

Fig. 8.3 Primary source of income of problem drug users (1995 - 2007)



	1995 (407)	1996 (269)	1997 (243)	1998 (276)	1999 (321)	2000 (386)	2001 (422)	2002 (505)	2003 (439)	2004 (368)	2005 (347)	2006 (412)	2007 (367)
Autonomy	35	36	34	35	29	29	30	34	29	35	28	26	28
Social welfare	42	49	52	53	60	61	61	60	65	61	66	71	68
Illegal income	23	15	13	10	10	9	8	5	6	4	4	2	4
Other	0	0	1	2	1	1	1	1	1	1	1	1	1

Source: RELIS 2007

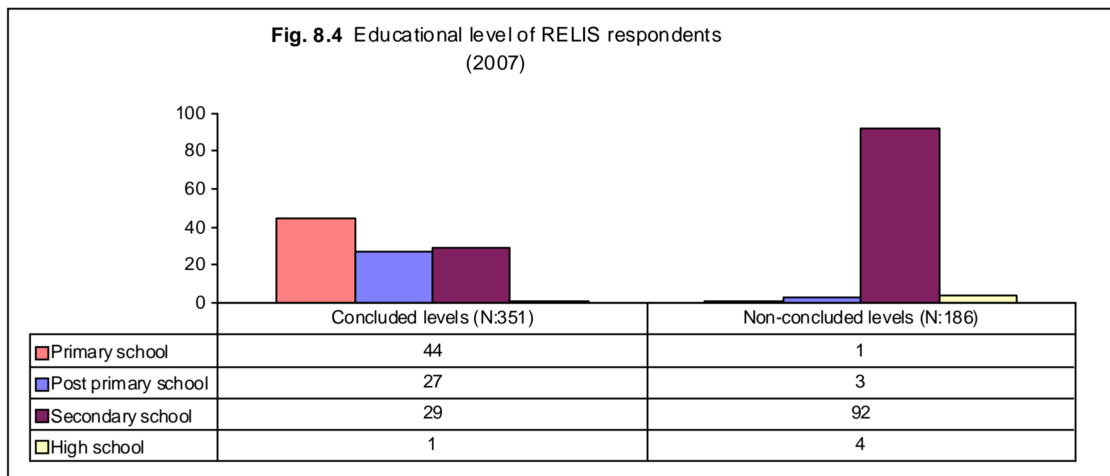
A new occupational project foreseen for 2008 and run by the 'Street voice' ('Stëmm vun der Strooss') association could have a positive impact on the observed situation, knowing that there is a current lack of occupational offers for drug addicts at the national level.

- <u>School drop out</u>

The study of "School leave in Luxembourg"[43] (2006) surveyed a population of 37,347 secondary school students during 1st November 2004 and 30 April 2006. A total of 2.422 students left school without a professional certification (temporary stay offs from school have also been taken into consideration). The study refers to a proportion of 6.5% of "school leavers". This proportion figures 3.6% if one is considering the total number of students having been reached but did not reintegrated a school in Luxembourg. Concerning this category of school leavers, composed of students attending courses abroad, being employed, following professional insertion measures and those without occupation (N=1,357), the situation was as follows: 41.2% of students who dropped school have integrated the job market (work or professional insertion measure), 39.8% didn't work nor went to school and 19% attended school courses abroad. In general boys, youngsters from abroad and aged more than 15 years (age of school obligation) are more vulnerable to the risk of early school leave.

[43]Ministère de l'Education nationale et de la Formation professionnelle (2006). Le décrochage scolaire au Luxembourg. Luxembourg

Regarding PDUs, the **educational level** of the latter is low and has been showing a creeping 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.



	Concluded levels (N:351)	Non-concluded levels (N:186)
Primary school	44	1
Post primary school	27	3
Secondary school	29	92
High school	1	4

Fig. 8.4 Educational level of RELIS respondents (2007)

Source: RELIS 2007

- ○ Financial problems

42% of the population of PDUs have major debts (1997: 54%). Over the last ten years, after a peek in 1997, the percentages stayed relatively stable (42%-46%) until 2004 (37%), where it reached a minimum of 43%.

The RMG (Guaranteed Minimum Income) (34%-42%) and the own salary (21%-28%) represent the main income sources of the PDUs. Between 1997 and 2007, weak variations were observed in relation with these two revenues. As for the RMG, a weak increase has been observed from 2003 onwards in contrast to the own salary, which decreased during the last three years.

Concerning secondary income sources, the first positions are occupied by money provided by parents (23%-34%) and the selling of drugs, although the last one has strongly decreased from 1997 (35%) to 2007 (15%).

Overall, the social dependence shows an increasing tendency during the last years. For the autonomy, in contrast, a decreasing tendency during the last six years must be observed.

- ○ Social network (NNIA)
- ○ Sex workers (See Chapter 9: DIM Project)

- 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.

- <u>Drug offences</u>

As can be seen in tables 8.1, the total number of arrests (226) has increased discontinuously during the last 10 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 (confirmed by 2005 data), followed by heroin and cannabis. Since 2004, charges on drug traffic have known an important increase. Data broken down by type of offence is not available for 2007 due to the upgrade of the RELIS database and the related non-operationality of a series of statistical functions.

Table 8.1 Arrests broken down by type of reporting institution (1995-2007)

	ARRESTS								
Year	**1995**	**1997**	**1999**	**2001**	**2003**	**2004**	**2005**	**2006**	**2007**
S.P.J.	27	25	27	7	25	38	26	39	49
Gendarmerie	8	15	15	45	82	103	94	124	79
Police	32	32	32						
Customs	61	82	34	40	28	37	35	62	41
Total	**128**	**154**	**108**	**92**	**135**	**178**	**155**	**225**	**226**

Table 8.2 Arrests broken down by type of offence and substances involved (1995-2006)

Substance	Offence	1995	1997	1999	2001	2003	2004	2005	2006
Heroin	Use & Traffic	68	57	48	41	21	32	28	40
	Traffic/Deal	21	53	18	8	22	19	14	29
	Use	24	7	27	8	4	20	20	26
	Total	**113**	**117**	**93**	**57**	**47**	**71**	**62**	**95**
Cocaine	Use & Traffic	20	27	21	27	19	21	21	26
	Traffic/Deal	7	23	9	9	30	64	42	38
	Use	10	6	12	4	3	9	15	21
	Total	**37**	**56**	**42**	**40**	**52**	**94**	**78**	**85**
Cannabis	Use & Traffic	25	18	32	23	52	16	17	42
	Traffic/Deal	1	11	8	1	17	20	27	36
	Use	4	4	3	15	9	14	25	15
	Total	**30**	**33**	**43**	**39**	**79**	**50**	**69**	**93**
Amphetamines	Use & Traffic		2	1	2	2	0	0	0
	Traffic/Deal				0	0	0	1	0
	Use	2			0	0	0	0	2
	Total	**2**	**2**	**1**	**2**	**2**	**0**	**1**	**2**
Ecstasy (MDMA, etc.)	Use & Traffic	3	3	3	1	1	1	3	4
	Traffic/Deal	1	3		0	0	1	6	1
	Use	1			0	1	1	3	2
	Total	**5**	**6**	**3**	**1**	**2**	**3**	**12**	**7**
LSD	Use & Traffic		1	1	0	0	0	0	0
	Traffic/Deal				0	0	0	0	0
	Use				0	0	0	0	0
	Total		**1**	**1**	**0**	**0**	**0**	**0**	**0**
Total number of *arrest* motives independently of involved substances	**Use & Traffic**				**59**	**57**	**48**	**46**	**85**
	Traffic/Deal				**13**	**61**	**93**	**63**	**87**
	Use				**20**	**15**	**35**	**45**	**47**
	Total	**128**	**154**	**108**	**92**	**133**	**178**	**154**	**219**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2006

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) and has been stabilising since then (2007: 1,372 rec.).

The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 1998 followed by a subsequent increase. From 2003 onwards, one observes a significant decrease (1,687 in 2007) in drug law offenders. The number of arrests on the same charge has decreased from 154 in 1997 to 135 in 2003 to increase and stabilise again (2007: 226 arrests).

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 2007.

Table 8.3 Number of national law enforcement interventions (1995-2007)

	DRUG LAW ENFORCEMENT RECORDS								PREVENUS (Offenders)							
Year	**95**	**97**	**99**	**2001**	**2003**	**2004**	**2006**	**2007**	**95**	**97**	**99**	**2001**	**2003**	**2004**	**2006**	**2007**
S.P.J.	123	137	343	216	239	267	190	177	152	182	434	321	369	336	248	203
Gendarmerie	198	255	782						319	335	916					
Police[44]	199	177	189	1,126	1,326	1,072	824	998	371	280	283	1,272	1,753	1,268	1,007	1,160
Customs[45]	244	236	173	113	95	129	186	197	421	408	306	182	148	204	320	324
Total	**764**	**805**	**1,187**	**1,455**	**1,660**	**1,468**	**1,200**	**1,372**	**1,263**	**1,205**	**1,939**	**1,776**	**2,270**	**1,808**	**1,575**	**1,687**

Source: Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 88% **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 2006/2007 data reporting a decrease from 808 in 2003 to 533 in 2007. Also the **percentage of minors** (< 18 years) among drug law offenders having increased between 1994 (4.9%) to 2000 (8.7%) shows a clear decrease in 2004 (5.7%) and tended to stabilize from there on (2007: 6.8%). Cocaine and heroin are the main drugs involved in first drug offences.

Table 8.4 Socio demographic data on 'prévenus' (1986-2007)

YEAR	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
AGE																
0-14	9		7	6	1	3	7	27	21	11	15	41	24	9	8	11
15-19	121	212	179	320	169	270	249	415	413	399	647	602	334	436	279	318
20-24	264	569	383	527	403	447	321	519	497	566	650	557	510	617	415	480
25-29	119	220	278	371	309	304	220	448	354	299	388	375	278	345	323	321
30-34	49	67	124	159	186	191	187	269	208	194	219	254	250	230	188	216
35-39	17	29	27	52	65	80	76	131	113	139	177	162	190	174	136	162
≥40	17	19	43	46	21	42	78	84	108	113	82	174	126	153	181	165
unknown	27	21	30	50	20	31	32	46	44	55	40	106	95	70	43	14
TOTAL	**623**	**1,137**	**1,071**	**1,531**	**1,174**	**1,368**	**1,170**	**1,939**	**1,758**	**1,776**	**2,218**	**2,271**	**1,808**	**2,034**	**1,575**	**1,687**

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

[45] 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/publications/informations_gouvernementales/rapports_activite/index.html

Male	503	970	851	1,248	938	1,138	958	1,658	1,415	1,546	1,905	1,935	1,581	1,751	1,319	1,484
Female	120	166	220	256	209	173	193	248	241	215	292	288	181	237	218	190
gender unknown	0	1	0	27	27	57	19	33	44	15	21	48	49	46	38	13

Source: Specialised Drug Department of the Judicial Police 2007.

Table 8.5 Distribution of 'prévenus' according to first offence and underage status (1992-2007)

	1992	1994	1996	1998	2000	2002	2004	2005	2006	2007
First offenders	697	382	508	422	608	828	585	657	471	533
Offenders underage	96	57	102	79	154	145	103	86	72	80
TOTAL ('Prévenus')	**1,531**	**1,174**	**1,368**	**1,170**	**1,758**	**2,218**	**1,808**	**2,034**	**1,575**	**1,687**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2007.

Table 8.6 Distribution of first offenders (use and use/traffic) according to substance involved ad minima (1992-2007)

	1992	1994	1996	1998	2000	2002	2004	2005	2006	2007
High risk substance involved ad minima										
Heroin	162	154	121	109	133	114	103	110	84	83
Cocaine	64	39	34	30	37	64	125	86	52	37
Amphetamines	5	15	11	18	9	12	2	3	3	1
Type ' Ecstasy '	1	9	20	26	11	34	8	17	4	4
Illicitly acquired medicaments	1	3	0	1	7	0	1	1	4	1
Substitution substances	0	1	0	0	0	1	0	1	1	0
TOTAL (substances HRC)	**233**	**221**	**186**	**184**	**197**	**225**	**239**	**218**	**148**	**126**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2007

- Other drug-related crime

The data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results summarise the situation in 2007:

- 92% of drug users indexed[46] by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime. 78% (stable) 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 been fairly stable in recent years (2006: 34%). In 2007 in contrary, a new increase of the interpellations for other reasons than presumed offences against the drug law can be observed (44%).
- 63% (69%) 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 (35% stable) has stabilised during the last years. Compared with 2006, an improvement of the penal situation of indexed drug users must be stressed in 2007; associated 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.

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

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 IVDU prisoners report life-time needle sharing in prison;
- 8% of current IVDU prisoners report last month needle sharing in prison;
- 70% of IVDU 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

The recent study "Prevalence of viral hepatitis A, B and C and HIV in problematic drug users of illicitly acquired drugs" (Origer & Removille, 2007) also addressed drug use and drug-related harm in prison settings. Results are reported in standard table 12. Referred to the total study sample (N:246), 56.1% of respondents who have had prison experience during the past ten years reported illicit drug use in prison; 30.5% reported intravenous drug use. 26.7% of lifetime IDUs inmates reported needle sharing in prison which is sensibly lower than the rate observed in 1998 by Schlink (1999). Among all settings (inpatient, outpatient treatment, low threshold, etc.) prevalence rates of HIV, HBV and HCV were highest in persons recruited in prison settings.

- SOCIAL COSTS

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). An update of the Origer 2002 study has been performed according to data requirements for 2007 selected issues. Between 1999 an 2005, total public drug-related expenditures went up from 23,345,000 to 35,345,000, which equals to an increase rate of 51%. More specifically, 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 217 % between 2000 and 2006. Concerning the 2006 budget 6,584,000.- EUR have been granted to involved services representing a progression rate of 6.27% compared to 2005. Further results of the referred study can be found in chapter 11.

In July 2006, the STATEC (Central service of statistics and economical studies) published **a study estimating the economic impact of the illegal drugs related activities in Luxembourg** over the period 1999 to 2004 (Statec, 2006). The study was carried out within the framework of a European project intended to improve the comparability and the coverage of national accounting.

One of the main aggregates of national accounting, the gross national income (GNI), is accounted for in the calculation of the contribution of the Member states to the EU budget. The concept of the European system of accounting (SEC95) also includes illegal activities. Due to methodological difficulties and a lack of reliable data, illegal activities have not yet been integrated at this stage in the national accounts of the EU Member States. The European Commission expressed the wish to include the illegal activities in the national accounts in view of equal treatment of its Member states.

Similar studies are underway in other countries of the EU. These studies must allow the Commission to decide upon the feasibility of the future inclusion of the illegal activities in the national accounts of the Member states.

Luxembourg had at its disposal for this exercise statistical data of high quality as far as problematic drug use is concerned (RELIS). However, the data allowing to assess consumption of drugs by the occasional/recreational users are insufficient given there are no regular surveys in general population covering this topic.

The economic and geographical situation of Luxembourg makes an extrapolation of statistical data on the seizures impossible and did not allow for a valid confrontation of drug supply and drug demand on the national market. Thus, the estimate on drug consumption has provided the main benchmark for the study.

The annual consumer households' expenditure for drugs is estimated at 37.8 million Euro over the period 1999 to 2004. According to information provided by field experts, it was possible to set down realistic hypothesis concerning the provisioning of the drug market in Luxembourg. Nevertheless these results must be interpreted with caution as they are rough estimates.

The impact of the illegal drugs-related activities for 2004 is estimated at 0.11% of the GDP (gross domestic product) and 0.08% of the GNI (gross national income). Although this impact is limited, it reflects those observed in the European Union countries having carried out similar estimates. Three substances have a major impact: heroin, cocaine and cannabis representing together more than 90% of the measured impact. Nonetheless, levels observed during the period 1999 to 2004 highly vary according to the evolution of the consumption and the traffic of heroin, which clearly has the most important economic impact in this field.

9. Responses to Social Correlates and Consequences

Overview

- 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 based on the previously described principle on progressive reintegration through capacity building and the improvement of the social abilities and environment.

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 which has evolved in an integrated low threshold care centre for drug addicts (TOX-IN) including day and night shelter offers, accommodation and a supervised drug injection facility.

A project called 'Les Niches' functions as a social real estate agency for drug addicts. Approximately 35 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, offer oral and written **language courses** in order to provide clients with basic language skills if necessary or to improve their writing skills.

"D'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 an in house magazine** addressing social matters is supposed to help clients 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 was supposed to open in 2009 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, information sessions with residents of the concerned village have been organised and the budget made available. Delays in authorising the construction plans will allow starting construction works only in 2009 at earliest.

- PREVENTION OF DRUG-RELATED CRIME

    - Assistance to drug users in prisons

The Grand Duchy of Luxembourg counts 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 (see above) provides the number of general admissions and number of admissions according to drug-related convictions in both prisons from 1989 to 2007.

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.

Following the law of 27 July 1997 concerning the modification of the penitentiary organisation, a pilot project named "Global Drug Care Programme in Prison" (2000-2005 - TOX project) was set up by a group of experts assigned by the Ministry of Justice in 1999. The concept was designed to implement, among other objectives primary, prevention measures in regard to drug consumption and infectious diseases. The overall aim of the project was to integrate drug dependant inmates into a medico-psycho-social drug care network in order to reduce recidivism, risks and criminality after release from prison. The implementation of the project had to be adapted to the two different prison settings. Joint financing by the Ministry of Justice, the National Fund against drug trafficking and the EU (regarding evaluation) was ensured.

The TOX program (previously TOX project) takes care of the drug dependant people in prison in the two state prisons of Schrassig (CPL) and Givenich (CPG). This service is run by a multidisciplinary stuff. The basic principles of the TOX program in the CPG are the voluntary participation, the cooperation, the transparency, the quality of service, the determination of realisable objectives, the empowerment of participants.

In 2007, the activities of the CPL were centred around three pillars:

• ***the psychosocial prevention :*** psychosocial *care* of drug-addicted inmates, in order to prepare their future after release from prison and to reduce risks of relapse and recidivism – intensive program without drugs to prepare post-release ambulatory therapy and/or individual preparation for release.
• ***the prevention of the STDs:*** this health service is proposed in individual and collective settings
• ***coordination of interventions:*** the drug-addicted platform was created in order to coordinate interventions of involved professionals.

The TOX program in the CPG has established psycho-educational activities. The group has focused on two axes:
• ***Health development and***
•***specific psycho-educational practice*** for the drug-addicted inmates within a collective pavilion without drugs (specific entourage of at least 4 month with an optional prolongation).
• creation of the section without drugs together with the « Program Charly » in May 2007, as preparation for multidisciplinary and intensive therapy: 11 inmates

Results 2007
CPL :
147 inmates asked to enter the TOX program
92 were provided with an individual psychosocial follow-up
28 clients have benefited from an individual counselling in prevention of STD
• creation of the drug addiction platform
• start of e-learning
CPG :
11 participants have benefited from the specific psycho-educative exercise and 8 different activities have been offered in 2007, including sport, “Feldenkrais”, 3 different speaking groups, individual conversations, leisure activities and an artistic workshop.
(extracts of the activity report of the CHNP 2007)

In 2007, the external evaluation report[47] of the TOX project has been published that recommended the continuation of the action. Discussions are currently held to include the project in the RELIS routine data reporting.

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

[47] TREPOS, J.-Y. (2007) Evaluation du projet global de prise en charge des personnes toxicodépendantes en milieu penitentiaire au Grand-Duché de Luxembourg, Univbersité Paul-Verlaine, Metz.

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 the prison release phase.

The future development of synergies with external drug care agencies aiming at a comprehensive concept of throughcare 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:

- 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 launched 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.

  - <u>Urban security policies in the prevention of drug related crime</u>

- <u>Collaboration between national and municipal levels</u>

In recent years involvement of major cities in the management of drug-related problems and nuisances has clearly increased. So called municipal "prevention committees" that

include local authorities, police forces and specialised NGOs are in place. These committees also address the social correlates and consequences of drug abuse at the city level. Ministerial representatives may be invited to assist these committees. The setup of the first national drug injection room in Luxembourg City obviously enhanced the involvement of municipal authorities. The Ministry of Health chairs a management group that is mandated to follow up developments with regard to the injection room and to react precociously to emerging problems. The national action plan clearly emphasises the importance of a visible involvement of major cities in the management of public order, urban nuisance and hygiene problems related to drugs to guarantee the necessary decentralisation of demand reduction offers and supply reduction interventions.

- 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 **Youth Solidarity** (Jongenheem asbl) 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 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 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. Youth Solidarity 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 institutions.

Table 9.1 Clients core statistics MSF SOLIDARITE-JEUNES 1997 – 2007

		1997	1998	1999	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
Number of episodes		27	46	99	132	195	208	231	267	249	322	352
Referral from the criminal Justice system			26.1%	26.3%	41.4%	44.1%	44.2%	37.2%			46.2%	44.4%
Gender distribution	Female	26%	28%	26.3%	34.1%	32.3%	34.1%	31.6%	31.9%	31.3%	30.1%	24.4%
	Male	74%	72%	73.7%	65.9%	67.7%	65.9%	68.4%	68.1%	68.7%	69.9%	75.6%
Age distribution	< 14							9.5%	4.9%	4.0%	4.9%	5.1%
	14-15							38.1%	28.5%	21.7%	28.8%	25.2%
	16-17							39.8%	47.9%	48.6%	49.3%	50.9%
	> 17							12.6%	18.7%	25.7%	17.0%	18.8%
Main substance involved	Cannabis							83.1%	72.3%	71.5%	73.3%	67.7%
	Heroin							3.5%	4.5%	5.6%	3.7%	2.5 %
	XTC/ Cocaine							1.3%	2.2%	0.4%	1.6%	1.1%
	Legal drugs							2.6%	3.0%	2.4%	3.1%	5.1%
	Polydrug							d.m.	1.9%	3.2%	3.7%	5.4%
	Other							1.3%	3.3%	2.0%	2.5%	2.5%
	None							8.2%	10.6%	10.4%	10.2%	9.6%
	Unknown							0.0%	2.2%	3.7%	2.5%	6.1%

Source: Solidarité Jeunes (Jongenheem). 2007

10. Drug Markets

Overview

Drug markets are of changing nature. They rely on factors such as supply mechanisms, on the economic situation of the country they develop in 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 special surveys have provided data for the present chapter.

Overall, the national **drug market has become of a more aggressive nature** in terms of selling techniques. 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 **cocaine and cannabis**. Dealers increasingly tend to actively approach confirmed or potential clients. More recently ethnic groups join to improve their drug distribution strategies whereas previously none of these criminal groups actively searched contact with other groups. Moreover it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible for police as for instance private flats or bars.

Asylum demanders implicated in illicit cocaine trafficking mainly originate from West African countries, particularly from the Ivory Cost. Their number tends to stabilise. 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. Numerous traffickers have changed from heroin to cocaine and currently are also involved in cannabis traffic.

Compared to the situation in 2003, **purity** of heroin and cocaine has remained fairly stable. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (over 30%) in herbal cannabis samples seized in Luxembourg in 2007. **Prices** show broad ranges for heroin and cocaine, and a still ongoing decrease for ecstasy like products. Cannabis and derivates however have known certain stability during the last 5 years as far as street prices are concerned.

In terms of quantity **seizures** of heroin have been fairly stable since 2000 for heroin and even decreasing as far as cocaine and cannabis are concerned. The number of seizures did not show significant variations during the same period, with the exception of cannabis going up. Also, the number of offenders involved in seizures has been showing an overall decreasing trend. This may suggest that greater quantities of drugs are trafficked by smaller groups of traffickers. A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

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

- AVAILABILITY AND SUPPLY

    - Availability of drugs

Law enforcement sources[48] 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 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 organised criminal associations has been reported. More recently different ethnic groups started to create synergies in drug distribution and traffic, whereas previously these groups have been operating separately. The proportion of non-natives involved in drug trafficking has been increasing until 2005 and has been decreasing quite sensibly although non-natives drug traffickers represent 60% (2007). Typically, involved dealers carry small quantities of drugs hidden in their mouth ready to be swallowed promptly 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. The national **drug market has been flooded by a high proportion of low quality injection drugs,** which has induced major changes in consume patterns of national drug users.

Little, however, is known on the provision sources of the referred distribution networks. They seem to rely on important stocks of cocaine. They are highly organised and have managed to significantly increase the supply and availability of drugs at the national level. In 2005 it was estimated that **0.5 kg of cocaine are sold daily** to drug users within the Luxembourg City drugs scene.

In 2007 no **clandestine drug-manufacturing laboratory** has been dismantled at the national level. In 2006 and 2007 relevant quantities of magic mushrooms and khat (60kg) have been seized on the national territory. Local cultures of cannabis remain, however, 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%

I

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

n May 2008, the Directorate-General Justice, Liberty and Security of the European Commission published a public opinion poll named “Young people and drugs among 15-24 years olds”(N°233) within the scope of Eurobarometer surveys. Questions were included on the ease of access to illicit drugs alcohol and tobacco:

The following figure presents the results of the question: “How difficult would it be for you to get hold of any of the following substances if you wanted to?”:

	Ease of access to heroin (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
Luxembourg	44	33	14	9	2
EU27	42	30	16	7	5
	Ease of access to cocaine (if desired)				
LU	37	30	22	9	3
EU27	35	26	22	11	5
	Ease of access to ecstasy (if desired)				
LU	34	31	25	9	2
EU27	31	25	26	12	5
	Ease of access to cannabis (if desired)				
LU	17	11	30	41	1
EU27	19	15	31	32	4
	Ease of access to tobacco (if desired)				
LU		1	10	88	
EU27	1	2	15	81	
	Ease of access to alcohol (if desired)				
LU		1	5	94	
EU27	1	2	17	80	

Concerning heroin, youngsters from Luxembourg considered it slightly more difficult (77%) to obtain or to have access to heroin than the European average (72%). Similar to the EU average, only 23% of interviewees thought that getting hold of heroin was easy.

Even if heroin was the substance considered to be most difficult to get hold of, also cocaine was quoted by 67% of young people from Luxembourg as more difficult to obtain than did the EU average (61%).

Ecstasy was considered being more difficult to obtain in Luxembourg (65%) compared to the EU average (56%). Only 34% of youngsters from Luxembourg considered the access to ecstasy as easy (EU average: 38%).

Concerning cannabis, less youngsters from Luxembourg (28%) declared the access to cannabis difficult than the EU average (34%). Access to cannabis was perceived easier (71%) than the EU average (63%). Four out of ten youngsters (41%) found it very easy to obtain cannabis (EU average: 32%, three out of ten).

Luxembourg’s youngsters considered the access to licit substances as tobacco and alcohol as easier than the EU average. Concerning tobacco, 88% of youngsters from Luxembourg found the access very easy compared to the EU average (81%). Also the access to alcohol was referred to as very easy (LU: 86%, EU: 80%).

In summary one may note that Luxembourg’s youngsters are of the opinion that licit drugs are very easily available in contrast to illicit drugs seen as very difficult to obtain with however the exception of cannabis.

- Production, sources of supply and trafficking patterns

- SEIZURES

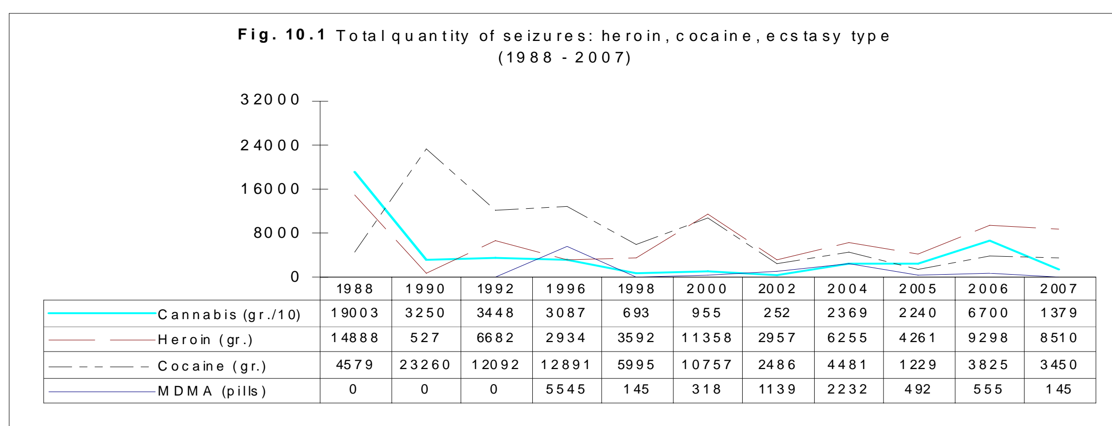
  - Quantities and numbers of drug seizures

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[49]. 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. Compared to 2006 data, quantity of seizures of all listed substances went down in 2007. This observation particularly applies to cannabis and XTC.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. Since 2000 the number of cannabis seizures has clearly increased but likewise the number of heroin and cocaine seizures tends to stabilise. Markedly, the number of cannabis seizures has risen from 167 to 643 between 1994 and 2007. The total **number of persons** involved in traffic has followed a constant upward trend until 2000 and stabilised afterwards (2007: 1,072 persons). A confirmed majority of offenders are involved in cannabis traffic and are non-natives. For detailed information, see standard table 13.

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 seizure data indicate, however, stabilization at very low level.

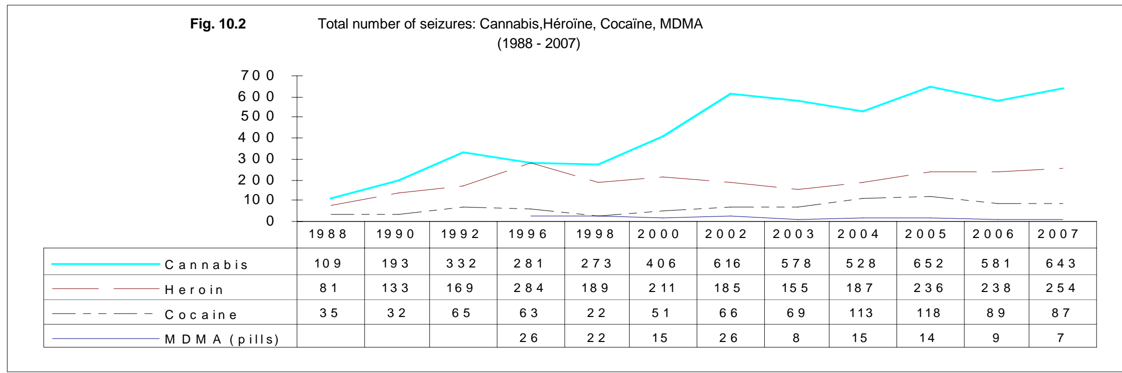
Fig. 10.1 Total quantity of seizures: heroin, cocaine, ecstasy type (1988 - 2007)



	1988	1990	1992	1996	1998	2000	2002	2004	2005	2006	2007
Cannabis (gr./10)	19003	3250	3448	3087	693	955	252	2369	2240	6700	1379
Heroin (gr.)	14888	527	6682	2934	3592	11358	2957	6255	4261	9298	8510
Cocaine (gr.)	4579	23260	12092	12891	5995	10757	2486	4481	1229	3825	3450
MDMA (pills)	0	0	0	5545	145	318	1139	2232	492	555	145

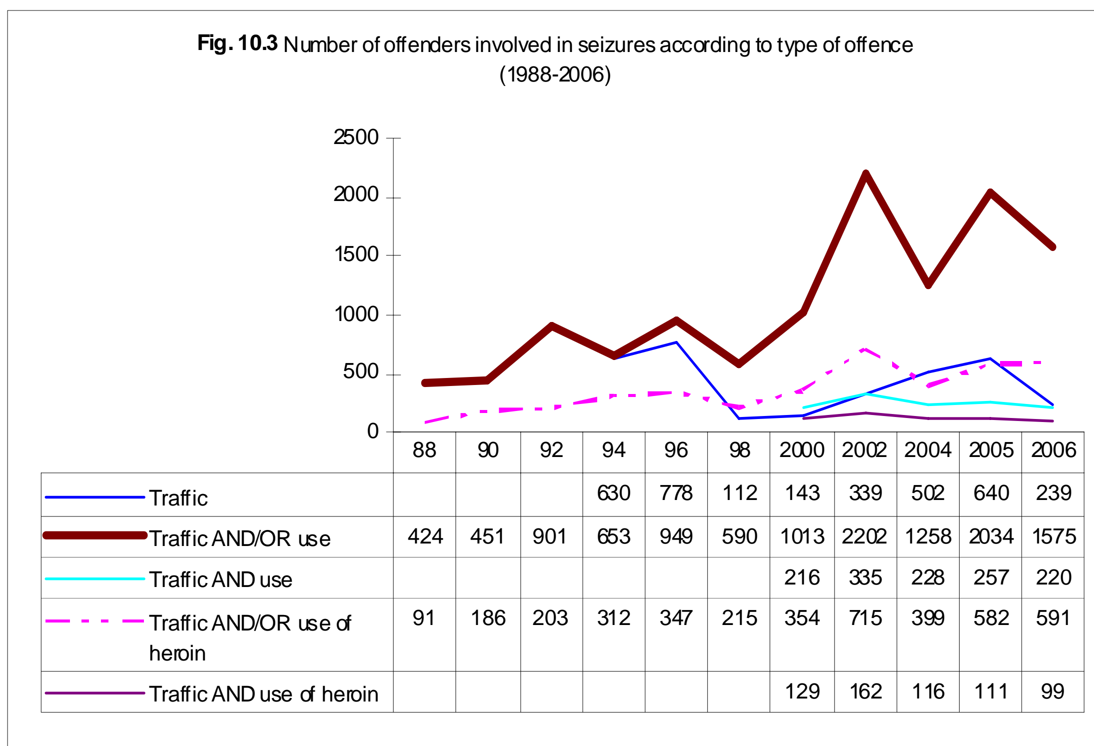
Source: Specialised Drug Department of the Judicial Police 2007

[49] Non –transit drugs destined to the national market



	1988	1990	1992	1996	1998	2000	2002	2003	2004	2005	2006	2007
Cannabis	109	193	332	281	273	406	616	578	528	652	581	643
Heroin	81	133	169	284	189	211	185	155	187	236	238	254
Cocaine	35	32	65	63	22	51	66	69	113	118	89	87
MDMA (pills)				26	22	15	26	8	15	14	9	7

Source: Specialised Drug Department of the Judicial Police 2007



	88	90	92	94	96	98	2000	2002	2004	2005	2006
Traffic				630	778	112	143	339	502	640	239
Traffic AND/OR use	424	451	901	653	949	590	1013	2202	1258	2034	1575
Traffic AND use							216	335	228	257	220
Traffic AND/OR use of heroin	91	186	203	312	347	215	354	715	399	582	591
Traffic AND use of heroin							129	162	116	111	99

Source: Specialised Drug Department of the Judicial Police 2006

- PRICE/PURITY

    - <u>Price of drugs at street level</u>

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen from 1996 to 2002/2003 but broader price ranges as well as higher maximum prices for cocaine and heroin have been observed since 2004, which is due to a high variability of purity. Cannabis and derivates however have known a fair stability during the last 7 years. Heroin is frequently sold as 'boule' containing 0.2-0.4 grams for 12-25. - EUR. Typical street retail cannabis is sold in pieces of 2.5 to 3 grams for 25. – EUR.

Table 10.2 Price per unit evolution at the street level (1994-2007)

	1994	1998	2000	2002	2004	2005	2006	2007
Cannabis Haschisch Marijuana	5-6	5 – 6 2.5 - 3	7.4 6.2	7	**7.3** **7.3**	**7.3** **7.3**	**8**	**8** **7.5**
Cocaine	100-150	120 -170	90	50	**20-120**	**20 – 110**	**30-100**	**30-100**
Heroin (brown)	65-150	90 -150	74.4	50	**82**	**80**	**50-90**	**50-90**
STA		25-30	?	25	**n.a.**	n.a.	**5**	**5**
Ecstasy		9 - 13	10.7	7	**10**	**10**	**5**	**5**
LSD	11-13	11 -13	?	n.a.	**10**	**10**	**n.a.**	**n.a.**

Source: Specialised Drug Department of the Judicial Police 2008
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.

- Purity at street level and composition of drugs/tablets

Average purity of cocaine, heroin and XTC type substances are low and have been decreasing since 2004. Attention has to be paid to the striking differences in maximum and minimum purities of all substances as well as to a historically high maximum concentration of THC in cannabis samples seized in Luxembourg. Marihuana showed very high maximum levels of THC concentrations (31.05% in 2007). For more detailed information please refer to standard table 14.

Table 10.3 Purity of drugs at street level (1994-2007)

	1996	1998	2000	2002			2004			2006			2007		
	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)			Pur. (%)			Pur. (%)			Pur. (%)		
	AVERAGE	AVRG.	AVRG.	MIN.	MIN.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.
Cannabis (THC)			8,03	0.6	0.6	**7.96**	0.64	14.0	**6.94**	0.15	25.85	**7.36**	2.2	31.05	**9.61**
Marihuana													*3.5*	*31.05*	***10.21***
Hashish													*2.2*	*18.02*	***8.52***
Cocaine	**60-90**	**60-90**	60,25	27.75	27.75	**62.99**	9.65	94.9	**62.37**	11.7	100	**61.78**	4.25	97.11	**54.65**
Heroin (brown)	**15-23**	**20-25**	17,59	4.85	4.85	**9.97**	5.0	41.55	**17.07**	3.6	40.9	**14.48**	3.85	22.75	**14.95**
STA				1.2	1.2	**15.09**	1.25	40.65	**9.44**	3.6	15.35	**7.1**	2.7	33.25	**13.81**
Ecstasy[50] (MDMA) (MDEA) (MDA)			35,5 6,8	1.75	1.75	**71.11**	22.35 6.25	39.5 6.25	**29.77** **6.25**	1.2	43.98	**26.44**	0.20 0.69	39.29 1.81	**20.52** **1.25**
Psylocine				/	/	**0.15**	0.26	0.57	**0.41**	**/**	**/**	**/**	/	/	**/**

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2008.
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.

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

Part B: Selected Issues

11. Sentencing statistics

The Luxembourgish police and justice system – An overview

The basic national drug law is the law of 19 February 1973, last modified by the law of 27 April 2001, regulates both, the selling of controlled medicaments and the fight against drug addiction.

Police

Until January 2000, 2 national law enforcement entities co-existed in Luxembourg, the National Police and the "Gendarmerie Grand-Ducale". The same year National Police and Gendarmerie have merged into a single entity: the Police of the Grand-Duchy of Luxembourg ("Police Grand-Ducale").

Its organisation, administration and surveillance are under the responsibility of the Ministry of Justice. The National Police includes a general directorate, central units and regional divisions.

Divided into 5 different branches, the General Directorate is the overarching national authority of the National Police.

The Criminal Investigation Department of the Gendarmerie was renamed "Service de Police Judiciaire" SPJ in 1992 and is in charge of conserving crime scenes and preserving evidence in cases of serious crimes and offences.

The 1999 Police law created 6 regional crime groups called "Service de Recherche et d'Enquêtes Criminelles" SREC competent for medium scale criminality, including the fight against drugs, and commissioned the SPJ with the overall coordination of the fight against crime at national and international level.

Organized according to the type of crime, departments include those focused on: General Crime, Organized Crime, Drugs, Financial and Economic Crimes, Protection of Minors, Police Records and Crime Analysis.

The Mobile Supply and Guard Unit is in charge of secure transport of prisoners from prison to court, medical examinations etc. It also allocates staff to reinforce different police units during wider police controls or public events (football, concerts, public disorder).

Thirteen Intervention Centres serve to preventing crimes and misdemeanours and to intervening if needed. Within its six regional police circumscriptions, Luxembourg has six primary and seven secondary intervention centres.

Forty-nine Proximity Police Stations provide both an objective and subjective police presence. These units have an essentially preventive mission and are also useful in collecting information or evidence.

Regional Special Police Units ensure supervisory control in the following areas: food and housing sanitation, trade and competition, environment and clandestine work.

Regional Traffic Police Units cover the regional surveillance of traffic and the road network.

Regional Investigation Units manage, at their regional level, lower crime investigations like drug trafficking and burglaries.

The Grand-Ducal Police as well as the customs are bound to inform the state prosecutor without delay of any crimes, offences and infringements which they are aware of. Once informed, the state prosecutor may order under his authority and instructions to criminal investigation officers and officials to carry out a preliminary investigation. Only in case of infringements of road traffic regulations police can caution an offender for minor offences. In this case, the state prosecutor does not have to be informed.

Courts and Tribunals

The judiciary power is independent from the executive and the legislative authority.

The judicial system consists of judicial courts and tribunals (3 Justice of Peace courts, 2 district courts, and 1 Supreme Court of Appeals); administrative courts and tribunals (State Prosecutor's Office, administrative courts and tribunals, and the Constitutional Court).

Minor cases generally are brought before one of the three "Justice of peace courts".

The three magistrates' courts have their seats in Luxembourg, Esch-Alzette and Diekirch. They have jurisdiction over minor cases, as defined by law, in civil and commercial matters. The District Courts is divided into the two judicial districts of Luxembourg and Diekirch, each of which has a district court. These courts hear and process civil, commercial and criminal cases in the criminal or correctional division.[51]

There are two branches of jurisdiction in Luxembourg: the judicial order (the magistrates' courts, the district courts and the Supreme Court of Justice) and the administrative order (the administrative tribunal and the administrative court). The Constitutional Court ranks on top of the judicial hierarchy.

Prosecution

Luxembourg has two public prosecution offices (parquet, a term that applies collectively to the institution of the public prosecutor's office and to the individual prosecutors), which are placed under the authority of State prosecutors (procureurs d'Etat): one is attached to the district court of Luxembourg, and the other to the district court of Diekirch. The General Prosecution Office (Parquet Général), which is attached to the Superior Court of Justice (which includes the Court of Appeals and the Court of Cassation of Luxembourg), and falls under the authority of the Prosecutor General (Procureur Général), supervises all State prosecution staff[52].

[51] The Government of Luxembourg – EU Presidency of Luxembourg (2005)
[52] Source : OECD – Report on the application of the convention on combating bribery of foreign public officials in international business transaction phase 2 – Luxembourg (2004)

11.1. Options available in the country

a) personal possession or use

Article 12 and 13 (2) of the Code of Criminal Investigation oblige the police to record offences and report to the public prosecutor. In case an offence of personal possession or use of illicit substances has been disclosed by the police, they have to inform the public prosecutor and have no option of further action as to confiscate the illicit substance(s).

As the public prosecutor has the opportunity to prosecute, the case may be closed (filed – ad acta), a written warning may be pronounced (often in case of first conflict with law), a therapy order may be proposed ("injonction thérapeutique"), a fine (ordonnance pénale - penal order, a penal order is an order taken by the chamber in council during a non-public hearing) may be ordered (police court) or the case is further prosecuted and brought before court (District Court: correctional division). Often the case is decriminalized and referred to the police courts which only can impose a fine. The choice of the public prosecutor is supervised by the General Public Prosecutor and the Minister of Justice who may order the public prosecutor to prosecute a case. He is only obliged to order an investigation in case of a crime.

As in the Grand-Duchy of Luxembourg a drug addict is not considered to be a criminal but a person in need of psycho-medical and social help, a case of simple use of drugs is rarely referred to courts.

At court level, a simple fine or a community service (TIG: travaux d'intérêts généraux) may be ordered, the sentence could be suspended with the condition to follow a treatment (sursis probatoire) and in rare cases a prison sentence may be pronounced (in case the drug addict has committed further serious offences).

b) production, dealing or trafficking

Any offence against the 1973 law has to be reported by the police to the public prosecutor.
In case an offence of production, dealing or trafficking of illicit substances has been disclosed by the police, they have to inform without further delay the public prosecutor and have no option of further action as to confiscate the illicit substances.

In case of production, dealing or trafficking of illicit substances, the public prosecutor often brings the case before criminal court. The culprit is often arrested and kept in custody and the investigative judge is mandated with the investigation.

The decisions of the court depend on the conviction record and the quantity of drugs involved. A first-time offender often is sentenced to community service or a suspended prison sentence. A recidivist may receive a prison sentence of several years without the possibility of suspended sentence. In case the offenders are very young, the sentence may only be a fine or community service.

c) driving after taking drugs

If a person under the influence of drugs causes harm to others and disturbs or threatens public order response is given according to the seriousness of the offence.

Police officers may order a blood analyses for each driver involved in traffic accidents in case of injuries and in case of strong suspicion of impairment due to alcohol or drugs.

Blood samples are taken at the police station and transferred to the National Laboratory of Health. The driving licence may be directly suspended.

The public prosecutor is immediately informed and to police, medical and testimony reports decides in the light of evidence and circumstances upon the further prosecution of the case.

The law of 18 September 2007 modifying the road traffic law of 14 February 1955 introduces rapid roadside saliva and sweat drug tests for the following concentrations:

- 2 ng/ml of tetrahydrocannabinol (THC),
- 50 ng/ml of amphetamins,
- 50 ng/ml of cocaine,
- 20 ng/ml of opiates.

Positive results of these drug tests have to be confirmed by a blood analysis to be admitted as legal evidence. It has to be noted that due to the fact that the referred tests are not yet homologated, they are currently not applied by the grand-ducal police. Evidence of a driving offence under the influence of drugs is given if a person shows behaviour characteristic of drug consumption and who is in breach with article 7 of the modified 1973 law regulating sanctions for illicit drug consumption.

According to article 16 of the modified 1973 law, courts can pronounce a driving ban for a period of 3 months to 15 years.

11.2 Data collection systems

Database for investigations

The **Judicial Police** (SPJ) provides data on arrests, broken down by type of reporting institution (SPJ, Gendarmerie, Police, Customs), arrests broken down by the type of offence and substances involved, number of national law enforcement interventions (drug law enforcement records and number of offenders), socio-demographic data of offenders – prévenus (age, gender), distribution of “prévenus” according to first offence and underage status and distribution of first offenders (use and use/traffic) according to substance involved ad minima.
This data on drug-related offences provided by the SPJ however is collected, aggregated and reformatted in collaboration with the **National EMCDDA Focal Point**. 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.

The national Police has implemented a central database on pending criminal investigations called FAC (fichier des affaires en cours, file for pending investigations). This software allows the management and the follow-up of cases treated by all sections of the SPJ. The objective of the FAC database is to ensure a better administrative and statistical management of pending investigations and a better coordination between concerned police services. The following inputs can be performed: categories of persons (suspects of criminal offences, victims, complainants, investigators, prosecutors, examining magistrates…), file references (input date, requesting authorities, national/international case, persons in charge of the file, categories of criminal cases…). Judicial and police authorities have access to this database. Convictions are not included in the FAC. Data is included when opening a case-file by the police and updated at all stages of the investigation, prosecution up to the final trial.

All databases have to comply with the provisions of the personal data protection law of 2 August 2002[53].

Database for prosecutions

All drug law enforcement records are communicated to the public prosecutor's office. The law of 16 June 1989 introduced the principle of discretionary prosecution into the Code of Criminal Procedure by inserting article 23: "The state prosecutor shall be informed of complaints and accusations and shall determine what action is to be taken".
The Grand-Ducal decree of 26 March 1988 authorized the creation and use of a nominative database, called "**chaîne pénale (penal chain)**" to the "Parquet" (prosecutors' offices) of Luxembourg. It is an operational tool and not a statistical software programme. The grand-ducal decree of 26 March 1994 extended the exploitation authorization of the "chaîne pénale" to the 31 December 2003. It has to be noted that a complete revision of the "chaîne pénale" is actually in progress so that in future it will be possible to register separately offences against the 1973 drug law, especially those against article 7 (abuse of dugs) and article 8 (drug traffic) and road traffic offences related to drug abuse.

The "chaîne pénale" database is divided into two parts; an administration part concerning data on ongoing penal cases and an archive part concerning data on cases which have not been object to a juridical decision or a decision by a magistrate of Public Ministry for a period of three years in terms of crimes and offences and one year in terms of infringement. The Public Prosecutor designates civil servants authorized to register and consult administration data. These authorizations are temporary and revocable. Each registration and consultation requires the registration of the agents' name, date and hour he or she accessed the database.
Also the Public Prosecutor designates civil servants authorized to have access to the archive part of the database. A supplementary personal password is attributed to them. These authorizations are also temporary and revocable and access routine are the same than for the administrative part. Moreover, each consultation needs a preliminary written consent from a magistrate of the Public Ministry. The reasons of access and consultation have to be indicated in written form in a special register. The "Centre Informatique de l'Etat (CIE)", the State IT authority, transmits on a monthly basis to the States' Prosecutor a catalogue of effectuated consultations from the archive part or the data base.

The data base contains data on:

- offenders (prévenus), accused (inculpés) or convicted (condamnés) persons of a criminal offence (infraction pénale),
- other persons implicated in a case,
- persons reported in the communications and reports addressed to the prosecutor in line with international conventions, laws and regulations in force.

The "chaîne pénale" includes the following data on persons:

- first and last names, gender, nationality, date and place of birth, address, profession and national identity number,
- number and date of opening of the record concerning the criminal offence, the name of the magistrate of the Ministry of Public Affairs in charge with the case, the dates of interventions proceeded.

[53] Loi du 2 août 2002 relative à la protection des personnes à l'égard du traitement des données à caractère personnel, Mémorial A, N°91 du 13 août 2002

The offender, the victim, the witness, the respective lawyers and insurer of civil responsibility may ask to be informed about the registered data and delivered in written form, in regard to the case they are implicated in with the exception of the national identity number. The minister of Justice and the General State Prosecutor have no direct access to the database but may obtain information about all data registered.

A series of data can also be given to legal persons of public law (personnes morales de droit public). Communication of data to a third person has to be authorized by the prosecutor or by a nominated magistrate and has to be asked for by written demand.
In case a third person requests data, his name and motive of request, date of request and date of authorization from the prosecutor or magistrate designated have to be registered. Police agents do not have access to this database. The CIE is in charge of the management of the database.

The “chaîne pénale” is not compiled to serve as a statistical tool and as such only informs about the number of cases of common law (droit commun) and cases concerning road traffic offences.

Database for convictions

Since 2007 the database on criminal records allows to extract statistics concerning the total number of persons convicted for possession/abuse of drugs, for drug trafficking and for “mixed” convictions including possession, abuse and trafficking.

All cited national databases are not linked. The main reason for this is that although in the Grand-Duchy of Luxembourg a series of links exist between the legislative and executive branches, but the judiciary is completely independent.

11.3 Data collected

Database for investigations:
The Judicial Police registers cases which are closed and assigned a status “no further action required”.

Database for prosecutions:
The “chaîne pénale” database records cases which are closed and the reason of closure is recorded as for example ad acta, cited or penal order. The reason for closure is recorded: doubt (doute), prosecution not appropriate (poursuite inopportune) and fine (avertissement taxé). The “chaîne pénale” however does not record in terms of numbers the drug related cases which are closed. Concerning the cases of voluntary started treatment, they are not recorded. In general, voluntary started treatments also occur very rarely. Treatment orders for alcohol and drugs are not compulsive, they only may be proposed (therapeutic injunction). As such they are not recorded.

Also driving outcomes for alcohol and drugs are not recorded separately.

11.4 Results available

Data on drug offences, possession, traffic and use are reported by Police as following:

	2001	2002	2003	2004	2005	2006	2007
Drug offences	1,077	1,321	1,133	1,342	1,326	1,201	1,448
possession	540	623	503	611	559	492	646
traffic	97	152	179	330	229	220	171
use	440	546	451	401	538	489	631

Source: Activity report 2007 of the Grand-Ducal Police

It is not possible to extract the exact number of offences related to driving after taking drugs. The Specialised Drug Department of the Judicial Police (S.P.J.) provides data on national law enforcement interventions:

	Drug law enforcement records								Offenders (prévenus)							
Year	**95**	**97**	**99**	**2001**	**2003**	**2004**	**2006**	**2007**	**95**	**97**	**99**	**2001**	**2003**	**2004**	**2006**	**2007**
S.P.J.	123	137	343	216	239	267	190	177	152	182	434	321	369	336	248	203
Gendarmerie	198	255	782						319	335	916					
Police	199	177	189	1,126	1,326	1,072	824	998	371	280	283	1,272	1,753	1,268	1,007	1,160
Customs	244	236	173	113	95	129	186	197	421	408	306	182	148	204	320	324
Total	764	805	1,187	1,455	1,660	1,468	1,200	1,372	1,263	1,205	1,939	1,776	2,270	1,808	1,575	1,687

Source: Specialised Drug Department of the Judicial Police 2008

The Specialised Drug Department of the Judicial Police shows the following number of arrests broken down by type of offence and substances involved (1995-2006):

Substance	Offence	1995	1997	1999	2001	2003	2004	2005	2006
Heroin	Use & Traffic	68	57	48	41	21	32	28	40
	Trafifc/Deal	21	53	18	8	22	19	14	29
	Use	24	7	27	8	4	20	20	26
	Total	**113**	**117**	**93**	**57**	**47**	**71**	**62**	**95**
Cocaïne	Use & Traffic	20	27	21	27	19	21	21	26
	Traffic/Deal	7	23	9	9	30	64	42	38
	Use	10	6	12	4	3	9	15	21
	Total	**37**	**56**	**42**	**40**	**52**	**94**	**78**	**85**
Cannabis	Use & Traffic	25	18	32	23	52	16	17	42
	Traffic/Deal	1	11	8	1	17	20	27	36
	Use	4	4	3	15	9	14	25	15
	Total	**30**	**33**	**43**	**39**	**79**	**50**	**69**	**93**
Amphetamines	Use & Trafic		2	1	2	2	0	0	0
	Traffic/Deal				0	0	0	1	0
	Use	2			0	0	0	0	2
	Total	**2**	**2**	**1**	**2**	**2**	**0**	**1**	**2**
Ecstasy (MDMA, etc.)	Use & Traffic	3	3	3	1	1	1	3	4
	Traffic/Deal	1	3		0	0	1	6	1
	Use	1			0	1	1	3	2
	Total	**5**	**6**	**3**	**1**	**2**	**3**	**12**	**7**
LSD	Use & Traffic		1	1	0	0	0	0	0
	Traffic/Deal				0	0	0	0	0
	Use				0	0	0	0	0
	Total		**1**	**1**	**0**	**0**	**0**	**0**	**0**
Total number of arrest motives independently of involved substances	Use & Traffic				59	57	48	46	85
	Traffic/Deal				13	61	93	63	87
	Use				20	15	35	45	47
	Total	128	154	108	92	133	178	154	219

Source: Specialised Drug Department of the Judicial Police (data formatted by the NFP) 2007

At prosecution level (“chaîne pénale”), no separate statistics by offence type (a, b, c) are recorded.

The national database of criminal records contains 73 cases (convictions) related to abuse and possession of drugs in 2007 (whereof one third are estimated cases of driving after taking drugs), 160 cases related to drug traffic and 161 “mixed” convictions concerning abuse/ possession and drug traffic. The follow up of the different types of outcomes (as prison/custody, fines, community work, driving ban, warnings, case closed etc.) is available nor by type of offence (a, b, c) neither by type of substance.

At national level in 2007, 1,157 drug related offences have been registered. The public prosecutor’s office of Luxembourg estimates that at national level 60% of all offences against the 1973 law – article 7, are not prosecuted (filed ad acta), that 10% consist of fines, 10% of appeals (avertissements) and 20% of the cases are brought before court. Of these 20% of court cases, about 50% result in prison sentences, thereof 20% of treatment orders in terms of therapeutic injunction (sursis probatoire), 25% of penal orders (fines) and 25% of sentences for community service (TIG).These figures are expert estimations and are not published.

Part C

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- Relevant data bases and information systems

a. <u>RELIS drug monitoring system</u>

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 <u>problem drug users</u> population in general as well as in <u>drug treatment demanders</u> 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. <u>Register on drug law offenders (SPJ)</u>

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. In 2008 the drug phone help line has been replaced by an drug help an-line service run by CePT (Fro NO)

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.

In addition to its function of documentation base, CLDDT also ensures 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://www.ecbap.net/
http://eddra.eu.int/
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.msr.lu
http://www.police.public.lu/PoliceGrandDucale
http://www.relis.lu/
http://www.statec.lu/
http://www.unodc.org/
http://www.who.int/

13. Annexes

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