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European Monitoring Centre
for Drugs and Drug Addiction

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by the REITOX National Focal Point

“GRAND DUCHY OF LUXEMBOURG”

**New Developments, Trends and in-depth
Information on Selected Issues**

Alain Origer

REITOX

THE STATE OF THE DRUGS PROBLEM IN THE GRAND DUCHY OF LUXEMBOURG

EDITION 2012

CRP-SANTE
POINT FOCAL LUXEMBOURGEOIS de l'O.E.D.T.

1A-B, rue Thomas Edison
L-1445 STRASSEN
LUXEMBOURG
Tél. : + 352 26 97 07 - 39 / 49
Fax : + 352 26 97 07 19

AUTHOR : **Alain ORIGER**

CONTRIBUTORS : **Sofia LOPES DA COSTA**
Céline DIEDERICH
Simone SCHRAM

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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)
CFSP	Common Foreign and Security Policy
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
EMA	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
HAT	Heroin Assisted Treatment
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 Drogenh��lf
LNS	Laboratoire National de Sant��
MSF	M��decins Sans Fronti��res
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 Coop��ration et de D��veloppement Economiques
OGD	Observatoire G��opolitique des Drogues
OLAF	European Anti-Fraud Office
ONDCP	Office of National Drug Control Policy of the White House (United States)
PECO	Pays d'Europe Centrale et Orientale
RELIS	R��seau Luxembourgeois d'Information sur les Stup��fiants
REITOX	European Information Network on Drugs and Drug Addiction
SADC	Southern African Development Community
SEPT	Semaine Europ��enne de Pr��vention des Toxicomanies
SID	Syst��me d'Information Douanier
SIS	Syst��me d'Information Schengen
SNJ	Service National de la Jeunesse
SPG	Syst��me de Pr��f��rences G��n��ralis��es
SPJ	Service des Stup��fiants de la Police Judiciaire
TRANSRELIS	R��seau transfrontalier d'Information sur les Stup��fiants
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 f��r Empirische P��dagogische Forschung – Universit��t Landau

Foreword

The 2012 edition of the national report on the state of the drugs problem in the Grand Duchy of Luxembourg aims to describe the framework in which drug use and drug trafficking evolve at the national level by providing a comprehensive overview of historical developments and recent trends.

Thanks are due to the following experts consulted in the framework of the 2012 edition of the report: Dr Arno Bache (Directorate of Health), Andrée Colas and Sophie Hoffmann (Ministry of Justice), Auguste Dicken (Customs Administration), J.-P. Juchem (CNS), Dr Ferdy Kasel (CHNP-BU-V), Dr Mühe (CHL), Marc Bamberg (Special Drug Department of the Judicial Police), J.-M. Schanck and Guy Reinart (Ministry of Health), Steve Schmitz (Judicial Police), Simone Schram (Directorate of Health), Robert Welter (Public Prosecutor's Office), Dr S. Schneider and Dr M. Yegles (National Laboratory of Health LNS) as well as heads of all national specialised NGOs and other data providers.

SUMMARY

Annual National Report on the State of the Drugs Problem (Edition 2012)

Summary

Drug policy: legislation, strategies and economic analysis

In 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 2009 governmental programme has set the framework for the elaboration of the third national strategy and action plan (2010-2014) for the fight against drugs and addictions. **The national strategy and action plan 2010-2014** 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 relevant issues from EU and EC treaties, **the EU anti-drugs strategy 2005-2012** and the **EU drugs action plan 2009-2012**. 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.

The national drug strategy relies on **two pillars**, namely on demand reduction and supply reduction and on **four transversal axes**: 1. Risk, damage, nuisance reduction, 2. Research and information, 3. International relations and 4. Coordination mechanisms. The national drug coordinator, jointly with the Interministerial Committee on Drugs (ICD), follows up and steers the implementation process of the national drugs action plan.

The **global budget of the Ministry of Health** granted to drug demand reduction related services and programs went up from 2,066,000.- EUR in 2000 to 9,745,925.- EUR in 2011, thus witnessing a progression rate of 372%. Overall public expenditures in the field of drug demand and drug supply reduction per year are currently estimated at 38,500,000.- EUR (Origer, 2010). Expenditures exclusively allocated to drug related treatment reached 15,688,739.- EUR in 2011.

Epidemiological Indicators

Globally, UNODC¹ estimates that, in 2009, between 149 and 272 million people (3.3 to 6.1% of the population aged 15-64) used illicit substances at least once in 2008. Globally, cannabis users comprise the largest number of illicit drug users (125 - 203 million people). Based on global estimates of the number of cannabis, opiate, cocaine and ATS users, it is estimated that there were between 15 and 39 million problem drug users in the world in 2009.

¹ Extracts from the World Drug Report 2011 (UNODC, 2011)

Cannabis remains the most widely consumed drug worldwide. Global annual cannabis use prevalence is estimated between 2.8% and 4.5% of the population aged 15-64. There are an estimated 14.2 – 20.5 million annual cocaine users (annual prevalence of 0.3% to 0.5%) in the world. Between 12 and 21 million people used opiates in 2009. UNODC further estimates that between 14 and 57 million people aged 15 to 64 had used an amphetamine-type substance (ATS) in the past year (0.3% to 1.3% of the population), including 11 to 28 million ecstasy users (0.2% to 0.6% of the population).

National drug prevalence in the general population

Drug prevalence in school population and in general population

Serial school survey data (HBSC 1999 – 2010) reveal a decrease in the prevalence of any illicit drug use from the end of the 20th century to 2010. In-depth analysis shows an overall decline in prevalence between 1999 and 2006 and a fair stabilization afterwards. All common illicit drugs follow declining prevalence trends with the notable exception of cocaine witnessing an increase, particularly in age group 15 to 16 years. Opiates' use in school-aged children has been consistently low over the last decade.

Even though cannabis is still the most used illicit drug by youngsters aged 12 to 18 years an obvious decline has been observed from the beginning of the 21st century as far as lifetime prevalence is concerned. Recent and current cannabis use prevalence rates have been declining remarkably between 1999 and 2006 and seem to have stabilised since then.

Also, the mean age at first use of cannabis and illicit drugs in general has increased (+/- 6 months) between 2006 and 2010. In 2010, 9.44% of youngsters aged 15 years reported first cannabis before having reached 15 years, whereas this same proportion figured 12.03% in 2006.

National prevalence of problem drug use (PDU)

Data on institutional contacts and drug treatment demands

The annual **number of PDU person-contacts** indexed by national institutions figured 5,209² in 2011 (2002: 4,701).

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 2011 the same agencies have indexed 2,806 and 2,403 persons respectively. Overall the number of persons showing drug-related contacts with DR or SR agencies has discontinuously increased until 2010 and witnesses a first decrease in 2011. This decrease is primarily due to a decrease of the number of contacts with law enforcement agencies. Worth mentioning is also a first decrease in 2011 of low threshold agencies' contacts since the beginning of the current century.

² 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.

Socio-demographic profile of PDU

The **male/female ratio** of the PDU population currently sets at 4:1. Over the last decade the proportion of indexed non-native PDU has been showing strong variations but a clearly increasing trend since 2003 and has shown signs of stabilisation from 2008 to 2010 (+/-51%) to increase again in 2011 (58%). The population of non-native drug users largely consists of Portuguese nationals (34% of total number of non-native PDU), representing a proportion that is higher than the one observed in general population (36.7%). Citizens of French and African origins occupy the second (24%) and third (14%) rank respectively. German citizens rank at 5th position (4%) and Italian citizens, who occupied the third place in non-native drug law offenders over many years, represented 3% in 2011 (rank 6).

The **mean age** of indexed PDU has been evolving from 28 years and 4 months in 1995 to 32 years and 8 months in 2011. Mean age of male PDU has been increasing faster than for females. The gap between youngest and oldest PDU has been stabilised in recent years, after years of increase as one observed a long-term increase of the population of PDU aged 40 years and more and a sensitive decrease in PDU aged less than 30 years. The mean age of native PDU is consistently lower than the one observed for non-natives. Worth mentioning is also the significant increase of the average age of overdose victims over the last decade and a decreasing proportion of minors among drug law offenders in 2011 (2011: 6%; 2010:9 %; 2009: 6%).

Problem drug use prevalence and consume trends

National data are provided by serial prevalence studies on PDU aged between 15 and 64 years performed in 1997, 1999, 2000, 2007 and 2009 data (Origer, 2012)³. The estimation study performed on 2009 data provides an absolute prevalence of problem drug users (PDU) of 2,070 persons (C.I. (95%): 1,553 to 2,623). In terms of prevalence rates estimates for the same age categories, 6.16 out of 1,000 habitants aged between 15 and 64 years show problem drug use. According to available serial data for the years 1997 to 2009, absolute prevalence and prevalence rates of PDU have been showing an increasing trend until 2000. After a brief plateau, a decrease has been observed from 2003 onwards. Absolute prevalence and prevalence rates of intravenous drug use (IDU) in the national population aged 15 to 64 years have been increasing between 1997 and 2007 to show first signs of decline in 2009.

Injecting heroin use associated to **poly-drug use** has been reported being the most common consume pattern in PDU. The ratio of injecting opiates use to the inhalation mode has reached 2:1 in 2011. The prevalence of the use of cocaine as primary drug increased until 2006 and from there on discontinuously decreased. In 2011, the prevalence of problem cocaine use did significantly increase compared to 2010.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use currently represents 13% (confirmed increase). **Amphetamine** type substances and ecstasy related treatment demands are only weakly represented, which, however, does not inform on their prevalence in general population as RELIS data refer to PDU and not to the overall population of recreational drug users. The proportion of **poly-drug use** (67% in 2011) has stabilised at high level.

³ **Origer A.** Prevalence of Problem Drug Use and Injecting Drug Use in Luxembourg: A Longitudinal and Methodological Perspective. *Eur Addict Res.* 2012;**18**:288-296.

Drug-related treatment

The number of adult out- and in-patient clients tends to decrease, while out-patient minor treatment demanders have been continually increasing. The most remarkable increases between 2008 and 2010 have been observed in substitution treatment demanders and in the number of contacts in low threshold facilities (2010: 140,093 contacts). In 2011, however, the number of OST treatment demanders has showed a stable trend and low threshold contacts have even declined. 7.5% of respondents are first treatment demanders, all treatment centres included. A confirmed trend has to be seen in the decrease of the proportion of substitution patients aged less than 25 years and the increase of the proportion of patients aged 40 years and more.

Health correlates and responses to consequences

The **HIV/AIDS prevalence**⁴ in PDU has been slightly decreasing in 2011 while the **infection of HCV (hepatitis C)** has been showing a fair increase in 2011. Data from the National Laboratory of Retrovirology suggest a long term and discontinuous decreasing tendency of the average proportion of IDU in newly diagnosed HIV cases. From 2004 to 2008 this proportion has been varying between 7 and 14 % and fell down to 2.77% in 2011. HIV infection rates in IDU situate around 4 percent, which also stands for a decrease, compared to 2010 data.

The implementation of the 2005-2009 and 2010-2014 action plans has been accompanied by a discontinuous but significant overall decrease of fatal **overdose cases** in the Grand-Duchy of Luxembourg (2011: 6 cases).

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 aged 15 to 64 years in 2005 (2000: 5.9 cases per 100,000 inhabitants and 2007: 5.67). In 2011, 1.17 acute OD cases per 100,000 inhabitants have been registered (2010: 3.5), showing a decreasing tendency. Forensic data from 1992 to 2011 show that the most frequently involved substance in drug-related death is heroin and methadone, followed by prescription drugs consumed in a polyuse context. 3 victims were male (50%) in 2011 and the mean age of victims has been showing a discontinued increase over the past 16 years (in 1992: 28.4 years and in 2011: 33.6 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years has remained relatively unchanged. One underage victim was reported in 2011.

As regards nationality of overdose victims, 83% (83%) were natives, representing an increase compared to previous years.

Social correlates and social reintegration

Social correlates of problem drug use are manifold and touch upon family, professional, financial and legal areas.

⁴ Peer reviewed article published in 2010:

Origer A., Schmit J.-C. Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. *J Epidemiol Community Health* doi:10.1136/jech.2009.101378

The educational levels of PDU are low and mostly incomplete. The **residential status** of the latter has improved over the last years. In 1995, 31% of the users reported stable accommodation; currently the same proportion situates around 70%. This improvement is partly due to various accommodation and housing offers for addicted people set up in the framework of the drug action plan. Recent figures tend to confirm that although specialised accommodation offers have been further developed, the current economic situation has created an even higher demand for this type of housing.

The **unemployment rate** (67%) tends to plateau. However, the proportion of active respondents reporting a stable job situation (e.g. long term contract) has sensibly decreased over the 3 last years, which should also be put in the context of the current economic parameters.

Harm reduction activities

The **number of contacts** indexed by national low threshold agencies has increased dramatically over the last ten years and decreased for the first time in 2011 (2011: 123,465 / 2005: 47,739). Approximately 45% of clients are aged between 25 and 34 years, and 47% of clients aged 35 and more is observed. Between 50 and 60% of clients are natives.

The number of **syringes** distributed in the framework of the national needle exchange programme (2011: 246,858 / 1996: 76,259), stabilised and has been decreasing from 2006 onwards. After a new upward trend in 2009/2010, the number of syringes distributed has decreased in 2011. Return rates of used syringes have been increasing during the referred period and reached 90% in 2011. An increasing majority of injectors (75%) procure their syringes in specialised agencies followed by pharmacies and automatic dispensers.

Law enforcement indicators⁵

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 from 2000 onwards indicates a general decreasing tendency of heroin and cocaine seizures, whereas cannabis resin seizures⁶ are showing a discontinuous increase. Quantities of herbal cannabis seized have increased compared to the situation observed in year 2000. Latest data however, show an important decrease of cannabis in terms of quantities and a very significant increase of cocaine seized.

The number of seizures does not show significant variations during the same period, with the exception of cannabis (resin and herbal products) going up significantly. Markedly, the number of cannabis seizures has risen from 167 to 897 between 1994 and 2011. Also, the number of offenders involved in seizures has been showing an overall decreasing trend. The total **number of persons** involved in traffic has followed a constant upward trend (2000: 1758 (2011: 2,210) persons). A confirmed majority of offenders involved in cannabis traffic are natives.

⁵ If not specified, data refer to 2011. Figures in brackets refer to 2010 if not otherwise specified.

⁶ Non-transit drugs destined to the national market

Crack (cocaine-base) seizures have not been reported to date by national authorities. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. The availability of ecstasy has been stable since 1996 but seized quantities increased remarkably in 2009 followed by a decrease in 2010 and 2011.

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 2,225 in 2011. A similar evolution has been observed with regard to the **number of drug law offenders**. In 2011, 181 **arrests** (225 in 2006) for presumed drug offences have been reported.

The population of drug law offenders is composed of 86% **males**; a proportion that has been varying between 79% and 89% during the past decade. 808 **first drug law offenders** were reported in 2003 and 913 in 2011. 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 confirmed by 2009 and 2011 data (6.4%). Heroin and cocaine are the main drugs involved in registered first drug offences.

Since 1998, **non-natives** (55% in 2011) have been representing the majority of drug law offenders (52-68%). 41% (38%) of the registered cases were **first drug law offenders**. National **prison data** of 2011 refer to 856 (927) new admissions of which 193 (22.55%) were related to drug law offences; a proportion that represented 42.6% in 1996.

Profile of the national drug market

The national production and culture of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2011 no clandestine drug-manufacturing laboratory has been dismantled at the national level. According to observational data provided by the Judicial Police and all decentralised national police units, a 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). Cocaine found on the national market is originating from Latin America and mostly transits South of Europe (Spain, Portugal) to reach the Netherlands via France, Switzerland, Austria and Germany. Heroin follows the main Balkan route and its derivate (Poland, Turkey, Belorussia).

In recent years more organised distribution networks have been developing nationally. The expansion of these structured distribution networks by criminal associations thus contributed to a significant increase in drug availability, and particular in the supply of cocaine and cannabis. More recently different ethnic groups have created synergies in drug distribution and traffic, whereas previously these groups have been operating separately. 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, bars or motorway rest areas in order to meet their clients halfway and sell gross quantities. The proportion of non-natives involved in drug trafficking has been stable in recent years.

Over the last 6 years, **purity** of heroin has remained fairly stable whereas average potency of cocaine is on the decrease for the last years, with a slight increase for 2010. In 2011, a new decrease in cocaine purity has been observed. 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 (35- 40%) in cannabis resin products seized in

Luxembourg in recent years. In 2010 and 2011, the maximum concentrations of THC show a decreasing trend. **Prices** move within broad ranges for heroin and cocaine. Cannabis and derivatives however have known certain stability during the last 8 years as far as street retail prices are concerned.

Most Relevant Trends

All indicators included, a decrease in PDU prevalence rates has been observed over recent years although results from latest prevalence studies suggest that IDU prevalence has slightly increased. Over the last decade an increasing number of PDU entered treatment or use low threshold offers and fewer come in contact with law enforcement agencies.

Injecting opiate use, combined with polyuse, is the predominant PDU pattern. However, overall quality of street drugs decreased, which resulted in an overall increase of polydrug use. The number of acute drug deaths went down to 6 cases in 2011 (27 cases in 2007).

Although current PDU prevalence shows a decreasing trend, new phenomena such as early drunkenness, binge drinking in youngsters and use of new synthetic drugs and products containing the latter must be monitored closely since they may have a relevant impact of PDU incidence in the future.

There is also great concern about infectious diseases in drug users and in particularly IDU. HIV rates in PDU have been low and stable from 2000 to 2008, but showed an increasing tendency in 2009 and 2010, to stabilise again around 3 to 5% in 2011 (as earlier in 2009). However, hepatitis C has been increasing continuously from 2000 to 2008 (slight decrease in 2009 and 2010) but a significant increase is observed in 2011. Latest research results based on serological testing (Origer & Removille, 2009) suggested HCV infection rates over 70% and even higher prevalence rates in prison populations in 2007.

The national drug market is 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 40%) in cannabis samples seized over the last years. Heroin purity has remained fairly stable over the last years, showing however an important decrease in 2011. Cocaine purity and MDMA purity in XTC-like products has been decreasing over the last 10 years. In 2010 however, MDMA purity peaked since its first seizure and is still very high in 2011.

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 documented consequence that PDU start treatment at an early stage of their drug career. Drug action plans have allowed disposing of financial means that have known an important 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 documented by latest RELIS data. Substitution treatment and low threshold offers have been decentralised and continue to be so.

Coordination mechanisms have been reinforced between NGOs and national authorities and evaluation mechanisms are in place. A first external evaluation of the national drugs action plan has been performed and outcomes have been integrated together with recommendations from a series of national expert groups and outcomes of user/clients surveys in the elaboration of the new drugs strategy and action plan 2010-2014.

Consistency between Indicators

Demand reduction indicators are mostly consistent with supply reduction data (see fig. 4.3). Indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies except for admission statistics in low threshold drug agencies from 2000 onwards and the number of fatal overdoses between 2005 and 2007. These trends are respectively to be linked to an increase in capacities of low threshold offers and better access to harm reduction measures at the national level and significant changes in supply and consume patterns.

Both indicators thus 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.

The number of drug law offenders has also stabilised between 1999 and 2009 but shows a peak in the 2 last years. This recent evolution might be partly explained by the fact that law enforcement agencies increased their presence and interventions, notably in the vicinity of the supervised drug injection and low threshold facilities in order to fight increased drug deal activities. Next years' trends of this particular indicator have to be interpreted in the light of further contextual data.

The number of fatal drug-related overdoses has peaked in 2007 but has been witnessing an obvious decrease since then.

Selected Issue 1 : Residential Treatment Centres in Europe

First residential treatment facilities for drug users in Luxembourg emerged in the beginning of the eighties. The therapeutic centre 'Syrdallschlass' of Manternach (CTM) remains to date the only residential treatment centre for drug users at national level. The CTM has a capacity of 25 patients including clients on substitution treatment prior to their admission since 1998. In the beginning of 2012 a short term residential stabilisation unit providing multidisciplinary care to drug users following detoxification treatment was implemented within the "Centre Hospitalier Neuro-Psychiatrique" (CHNP) which also manages the CTM. The CHNP is a member of the alliance of Luxembourgish hospitals (Entente des Hôpitaux Luxembourgeois - EHL). In 2006 the CTM has received the Luxembourgish Reward of Quality with the mention "*On the route of Excellence*". In 2010 the CTM was recognised for excellence in the framework of the EFQM.

Selected Issue 2: Recent trends of drug-related public expenditures and drug services

Budget lines covering labelled and non-labelled drug-related public expenditures and drug services have continuously been increasing between 2005 and 2010 and were not subject to national state budgetary austerity policies. Budget lines of 2005 have been compared if possible with 2010 figures and show a consistent increase of 35% over the referred period. Also, the annual progression of the budget of the Ministry of Health and human resources allocated to drug-related services between 2004 and 2010 has been witnessing an increase of approximately 40%. These increases are substantial enough to state that there have been no state austerity policy in drug-related budgets in place between 2005 and 2010.

1. Drug policy: legislation, strategies and economic analysis

Introduction

Given the complex nature of drug use and its correlates, national drug policies are based on shared political competencies and responsibilities. Furthermore, in terms of intervention strategies, the more holistic concept of addictive behaviour has gained in importance and influences increasingly policy debates. This tendency is reflected by the enlargement of ICD (Interministerial Committee on Drugs) competences and its increased external visibility as well as the general framework set by the new national drugs strategy 2010-2014 on addictions (and not exclusively on illicit substances' related problems).

The governmental programme 2009⁷, foresees to further develop the national drugs action plan and specifically refers to the decentralisation of care and harm reduction structures, to further improve surveillance mechanisms in drug substitution treatment, to the creation of a heroin assisted treatment programme and to the extension of post-therapeutic offers. Further efforts are to be invested in effectiveness and efficiency evaluations of drug treatment offers and services.

The 2010 – 2014 national action plan on drugs and addictions built upon the outcome of the external evaluation of the national drug strategy and action plan 2005-2009 performed by the Trimbos Instituut⁸ (NL) in 2009.

- GENERAL LEGAL FRAMEWORK⁹

Drug legislation and recent drug-related laws

The basic national drug law, namely: 'Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie'¹⁰ 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 27 April 2001¹¹. 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 treatment and harm reduction measures, namely, drug substitution treatment, needle exchange and shooting galleries (state accredited and, in addition to article 13 of the Grand ducal decree of 30 January 2002 (see below), Heroin Assisted Treatment (HAT).

No new law related to drugs or precursors have been voted in 2011 and 2012.

⁷ Gov. Declaration of 2009, <http://www.gouvernement.lu/gouvernement/programme-2009/programme-2009/index.html>

⁸ Trimbos Instituut (2009). Evaluation of the national drug action plan (2005-2009) of Luxembourg, Utrecht. Available at : <http://www.ms.public.lu/fr/activites/medecine-sociale-toxicomanie/index.html>

⁹ Legal texts prevail on selectively produced summaries. The integral national legislation on drugs and drug addiction is available under: <http://www.emcdda.europa.eu/eldd>

¹⁰ Official gazette A 1973, p.319

¹¹ Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001)

Grand Ducal Decrees

As regards regulation mechanisms on the control of substances and precursors, the national drug legislation mainly 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 1995¹²
- Grand ducal decree of 13 **February 2007** on the surveillance and commerce of drug precursors¹³

The full text of the current basic national drug law as well as recent decrees can be accessed through the following web sites: <http://www.legilux.public.lu> or <http://eldd.emcdda.europa.eu>.

CHANGES IN 2011: The grand ducal decree of November 18, 2011¹⁴ regulates the use, technical criteria and the homologation standards of devices used to determine the presence of certain illicit drugs in the organisms of vehicle drivers.

CHANGES IN 2012 (status August 2012): The grand ducal decree of July 21, 2012¹⁵ puts the following substances and plants under national control:

- *MDPV (3,4 methylene-dioxy-pyrovalerone)*
- *Salvia Divinorium (Salvinorine A)*
- *Mytragyna Speciosa, Kratom (Mytragynine, 7-Hydroxymytragynine)»*

Furthermore it regulates the modalities for the incorporation of certain cannabinoids in recognized medicaments as well as the cultivation of certain cannabis varieties for agricultural, non-psychoactive purposes.

Laws implementation

Legally speaking, police has no discretionary power: each 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.

¹² Official gazette A 2004 (Adoption: 13/02/2007, Entry in force: 22/02/2007). See also ELDD.

Règlement grand-ducal du 13 février 2007 relatif à la surveillance du commerce des précurseurs de drogues [...].

¹³ Official gazette A 2007 (Adoption: 30/01/2004, Entry in force: 13/02/2004). See also ELDD.

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.

¹⁴ Règlement grand-ducal du 18 novembre 2011 concernant les critères techniques et les conditions d'homologation des appareils servant à déterminer (...) la présence de stupéfiants dans l'organisme des usagers de la route (...). Official gazette A 246, p. 4164 (Adoption: 18/11/2010, Entry in force: 01/12/2011).

¹⁵ Règlement grand-ducal du 21 juillet 2012 modifiant :

- le règlement grand-ducal modifié du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie ;
- l'annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques ;
- l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;
- l'annexe du règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants

Official gazette A 157, p.1888 (Adoption : 21.07.2012, Entry in force : 30.07.2012)

Narcotic-related 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 law offenders, the following options exist.

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 disclosed, undertook treatment for drug addiction. Moreover, the public prosecutor can offer the offender the option of voluntary treatment of his/her addiction.

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 to 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.

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 law of 27 April 2001¹⁶ 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 2002¹⁷ 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 is a sound example of this holistic approach.

¹⁶ Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001) See also ELDD

¹⁷ Official gazette A 2002, p.232 (Adoption: 30/01/2002, Entry in force: 12/02/2002) See also ELDD

As a legal principal, the reaction to an offence committed by a drug user must be proportional to the harm it aims to prevent. 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.

- NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

Coordination mechanisms

The coordination of drug demand reduction, risk reduction and related research is a competence of the Ministry of Health. Since 2000 a National Drug Coordinator, appointed by the Minister of Health, has been mandated with the overall coordination (including interministerial coordination) in the domains of drug-related demand and harm reduction and represents Luxembourg at the international level. 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 coordination among the competent ministries takes place in the *Inter-ministerial Commission on Drugs (ICD)*, chaired by the national drugs coordinator. The ICD is composed of official delegates from involved governmental departments and constitutes the top decision level with respect to coordination and orientation of actions. Both, the ICD and the Ministry of Health are responsible for the implementation of national drugs strategies and action plans. The ICD, has an advisory role and addresses issues ranging from illicit drug use and “legal highs” to alcohol use and prescription drugs under the general heading of addictive behaviour and its consequences.

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 has been nominated chair of the national substitution treatment surveillance commission in 2010 and is member of the national AIDS surveillance commission.

National plan and strategy

Having taken into consideration the EU drugs strategy 2005-2012, the EU drugs action plan 2009-2012, 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. More precisely, it is designed to contribute to reduce initiation of drug use, to develop and maintain diversity and quality in care and treatment offers, to tangibly reduce drug use prevalence in the general population as well as health and social damage generated by illicit drug use and drug trafficking.

Furthermore the 2010-2014 national action plan¹⁸ 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 new governmental drugs strategy builds upon a more holistic approach than the previous ones. It addresses addictive behaviour as a whole and not only illicit drugs and

¹⁸ Ministère de la Santé (2010). Stratégie et plan d'action gouvernementaux 2010-2014 en matière de lutte contre les drogues et les addictions. Ministère de la Santé. Luxembourg. Available at : <http://www.ms.public.lu/fr/activites/medecine-sociale-toxicomanie/index.html>

drug addiction. Thus alcohol, tobacco and psychotropic pharmaceuticals dependence as well as addictive behaviour not associated with substance use are now an integral part of an unique strategy. Specific action plans have been conceived or are currently under preparation in order to integrate the framework of a global national policy on addictions.

Operational objectives are as follows:

1. To contribute to the maintenance of individual and collective well-being.
2. To increase means for action and to improve coordination mechanisms and synergies between available resources in order to guarantee their best possible use.
3. Reduce the burden for the community by promoting a rational culture of investments, allowing to generating sustainable achievements.
4. To adequately update drug-related legislation and other regulatory instruments according to emerging evidence on drugs and drug use pattern as well as on commercial strategies that are building upon new opportunities created by new consumer trends.
5. To increase the knowledge base on drugs and addictive behaviour by promoting research and the broadest possible diffusion of objective information to the general public and specific target groups.
6. To consolidate mechanisms that allow to critically analyse actions and achievements, and by doing so, improve drug policy making, action planning and implementation.

The national plan lists **60 separate actions** associated to a clear definition of tasks, involved management actors, financial requirements, deadlines and performance indicators. Some of the referred actions are submitted to a series of conditions to fulfil by the action manager in order to be proposed for financing. The action plan reflects priorities set by the government: primary prevention (4 projects), treatment and care (7), socio-professional reintegration (5), reduction of risks and damages (9), research, evaluation and information (8), supply reduction (18), coordination and international relations (9). Special focus is placed on primary prevention, offers of accommodation and housing, socio-professional reinsertion measures, diversification and access to therapeutic offers and quality management.

The selection of specific actions, projects or programmes has occurred on basis of a 6 criteria matrix including: pertinence, opportunity, feasibility, cost-benefice/quality factors, quality assurance mechanisms and measurability of results or impact.

Implementation of policies and strategies

The outcome of a national drugs action plan highly relies on the way it has been elaborated. The successive action plans reflect the general strategy of the Ministry of Health in order to optimize the overall interventions in the fight against drugs and drug addiction in the light of stated priorities, assessed needs and available resources. It constitutes an open framework meaning that complementary projects can be included if required.

In 2009, in order to best meet current needs in the elaboration of the 2010-2014 action plan, the national drug coordinator has launched a third multilateral consultation process involving ministerial departments, specialised NGOs and civil society. A special working group, chaired by the Ministry of Health, performed a needs assessment and elaborated national recommendations focusing on specialised drug care and rehabilitation offers. A more restricted group composed of representatives of the Ministry of Health and the National Addiction Prevention Centre drafted the action plan in the framework of primary prevention strategies. 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 an 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 / civil society from the very start of the conceptualisation work and consensus making prior to the implementation phase have shown to be a major criterion 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

The implementation progress of the drugs action plan has been on the political agenda since its start in 2000 and consequently the visibility of achievements 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 / civil society in the drug policies as they have been involved since the very beginning of the process. The general public has equally welcomed drug action plans since it enables them to follow up public efforts to fight a problem of great concern and to compare announced objectives with achieved actions.

Beside efforts made by all 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 300% of the budget invested by the Ministry of Health in drug demand reduction occurred between 2000 and 2011.

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 further 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 PDU, to reduce the rate of drug overdoses and finally to promote research activities in the field.

Over the last 10 years the concept of implementation follow-up, evaluation and external evaluation strategies have gained in importance in the field of drugs and drug addiction. In the beginning of 2010, the Minister of Health jointly with the National Drug Coordinator has presented the new drug strategy and action plan 2010 – 2014. The referred action plan is based on the evaluation outcome of previous action plans and the assessment of current and future needs. In this context and for the first time nationally, a final external output and progress evaluation of the national drug strategy and action plan 2005-2009 has been performed (Trimbos Instituut)¹⁹ in 2009.

The contractual scope of the evaluation was a critical analysis of the implementation of the National Drug Action Plan 2005-2009. It built upon the above mentioned mid-term evaluation of the Drug Action Plan. The aim was to serve policy relevant information to

¹⁹ Trimbos Instituut (2009). Evaluation of the national drug action plan (2005-2009) of Luxembourg, Utrecht

the stakeholders involved in making and implementing drug policy in Luxembourg. The following questions were addressed:

- **Priorities:** Does the Action Plan address in an appropriate way the priorities put forward by the different stakeholders, e.g. by clear problem definitions and clearly defined actions?
- **Conditions:** Were conditions given to realise the actions formulated in the Action Plan, e.g. by serving the necessary instruments and resources, and by dividing and defining the responsibilities and by facilitating cooperation between the different stakeholders? Has the existing coordination structure proved to be appropriate and efficient?
- **Results:** Did the implementation of the National Drug Action Plan result in the realisation of the envisaged actions?
- **Process:** Did the process of policy formulation and implementation go well (managed appropriately, allowing and taking-up input from all stakeholders, etc.)?

In implementing the evaluation the following guiding principles were applied:

- The evaluation is based on reliable and verifiable facts/results;
- The evaluation process is transparent to all stakeholders;
- All relevant parties are invited to participate in the evaluation process;
- All these parties must feel free to express their opinions;
- The evaluation is meant to formulate concrete recommendations that could lead to improvement of the quality, efficacy and efficiency of the Luxembourg drug policy;
- The evaluation does not take a stand in the political debate in Luxembourg.

The evaluation report also lists a set of recommendations regarding the new National Drug Action Plan, the coordination structure and the policy-making process. Main results and recommendations were presented in the 2010 edition of the national drugs report. In addition to the recommendations of previously referred to working groups, the final output of the external evaluation exercise has been serving the National Drug Coordinator and the Interministerial Commission on Drugs to elaborate the new national drugs action plan 2010-2014.

Other drug policy developments: Initiatives in Parliament and civil society

Drug-related parliamentary questions submitted during the reporting period mainly addressed needle exchange programmes in prison, road side testing (Drugwipe 5S) and possible consequences for patients using certain prescription drugs, drug testing in schools and the implementation of regional harm reduction offers.

No projects or propositions of law in relation with drugs or drug addiction were introduced in 2011 and no specific Parliamentary debates or initiatives in the field of illicit drugs are to be reported.

Special topics addressed by the GIT in 2011 were:

- regulatory means to prohibit the selling and use of substances able to reduce levels of drug concentration in urine or blood of drug users and thus to distort test results;
- the spread of shisha smoking;
- cannabis cultivation for agricultural, non-psychoactive, purposes;
- use of certain cannabinoids for pharmaceutical purposes;
- substitution treatment and diacetylmorphine assisted treatment;
- the phenomenon of research or designer drugs and their diversion. Creation of new legal instruments to fight the phenomenon of "legal highs". Regulation of selling and confiscation of psychoactive substances not yet controlled.

- ECONOMIC ANALYSIS²⁰

Public expenditures

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,
- 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)²¹,
- 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.

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

²⁰ See related chapter in Part B

²¹ 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)

(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. 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.

• Methodology

In the 2012 edition of the present report an overall estimation of direct public expenditures based on studies performed respectively in 1999 and 2009 are reported (Origer 2002b, 2010). Main results of these former comparative studies are summarised in tables 1.3 and 1.4. To date, they represent the only overall drug related public expenditures studies at the national level. As a matter of fact, exhaustive public expenditure studies are highly time and cost-consuming exercises and can therefore not be performed routinely. This said, trends surveillance of dedicated public budgets may rely transitionally on partial indicators such as direct public health expenditures for the fight against drugs and drug addiction (drug-related prevention and treatment costs).

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.

DRUG-RELATED TREATMENT: '*... any activity that directly targets individuals who have problems with their drug use and which aims to improve the psychological, medical or social state of those who seek help for their drug problems. This activity often takes place at specialised facilities for drug users, but may also occur in the context of/in general services offering medical and/or psychological help to people with drug problems*' (EMCDDA, 2000). The harm reduction approach directly targets drug addicted persons and aims to improve their psychological, health and social state or situation. In the national understanding, drug-related treatment therefore also includes harm reduction interventions.

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 data sources:

- 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 outputs and financial breakdowns of the CNS

Main reference documents:

Ministère des Finances (2011). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.

Ministère de la Santé (2012). Rapport d'activités 2011, 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.

Ministère de la Santé (2009). Stratégie et plan d'action national en matière de lutte contre les drogues et les dépendances 2010 – 2014. 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.

Origer, A. (2010). Update of direct economic costs of national drug policies in 2009. National Report on the state of the drugs problem in the Grand Duchy of Luxembourg. Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

National estimates of labelled and non-labelled public drug demand reduction expenditures (2011)

Table 1.1 provides an exhaustive overview of labelled and non-labelled drug-related public expenditures in the field of drug prevention, treatment and harm reduction. In case an attributable proportion key was required, a detailed description of the calculation procedures is provided in the last column.

Table 1.1: National estimates of labelled and non-labelled public drug demand reduction expenditures (Data year: 2011)

7. Ministry of Justice	S7.2/12.370 0.30 TOX PROGRAMME: Care and treatment programme for drug addicts in prison	823.420.-	<i>Extracted from the national state budget 2011</i>
10-11 Ministry of Education [...]	S 11.4 12.301 08.30 Drugs prevention campaigns in schools	2,000.-	<i>Extracted from the national state budget 2011</i>
14 Ministry of Health	S 14.1/33.013 05.23 – 33.015 05.23 Staff and operational costs of specialised drug agencies conventionned by state (40% non-specialised)	7,209,886.-	<i>Extracted from the national state budget 2011</i>
	S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	677,000.-	<i>Idem</i>
	S 14.2 12.301 05.20/12.801 05.20 Toxicological surveillance of drug addicts	150,000.-	<i>Idem</i>
	I52.000 05.22 Construction, and maintenance of drug treatment facilities.	100.000.-	<i>Idem</i>
	I52.002 05.22 Participation in equipment costs of drug treatment facilities.	50.000.-	<i>Idem</i>
14.1 Directorate of Health	S 14.1/33.014 05.23 Staff and operational costs of drug related activities of the National Aids counselling Centre	201,449.-	25% of total budget of the centre: average proportion of PLWHIV/AIDS infected via IDU in clients
17 Ministry of Social Security*	S 17.2 Staff, operational and mission costs for agents in charge of drug treatment referral abroad	80,000.-	Estimation by MSS based on analysis of work/mission/career
22 Ministry of Public Works	Maintenance work on/in buildings occupied by	20.000.-	<i>Extracted from the national state budget</i>

	specialised NGOs (not covered by other budgets)		2011
TOTAL LABELLED DRUG DEMAND REDUCTION EXPENDITURES: 9,313,755.-			
NON LABELLED EXPENSES			
Health/Social Insurance			
	A. <u>OST Substitution treatment</u>		
	Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (net, patient's contribution excluded)	442,538.-	Detailed breakdown by the National Health Insurance Funds (N Detailed breakdown by Union of Sickness Fund)
	Reimbursement of pharmacies fees generated by substitution medication preparation /delivery	30,067.-	Detailed breakdown by the National Health Insurance Funds (N Detailed breakdown by Union of Sickness Fund)
	Reimbursement of medical counselling costs related to substitution prescriptions	173,722	Number of substitution prescriptions (- free prescription JDH) X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)
	B. <u>Inpatient hospital drug treatment</u>		2010 data
	Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification)	2,312,265.-	ICD-10, F11, F12, F14, F15, F16,F18, and F19 hospital episodes X average cost per episode (adjusted CNS data)
	Medical counselling costs associated to hospital treatment episodes	205,000.-	Number of medical consultations X reimbursed fees according to duration of stay
	C. <u>Drug treatment abroad</u>		
	Reimbursement of drug treatment costs abroad/ e.g. residential therapy or therapeutic offer unavailable in Luxembourg	1,450,000.-	Year-adjusted breakdown provided by CNS

	<u>D. Inpatient therapeutic treatment extra-hospital</u>	813,660.-	Institution specific budget of 2001 adjusted for salary costs and inflation
	<u>E. Drug treatment costs subsidised by Min. Health</u>	143,732.-	Budgetary section 14.0.34.011: Breakdown of real costs generated by drug treatment not covered by the CNS
	<u>F. Cost of HIV/AIDS treatment provided to patients infected via IDU</u>	559.000.-	Number of HIV/AIDS patients infected via IDU x yearly average cost of HIV/AIDS treatment X reimbursable proportion
	G. Estimation of state revenue loss from low renting prices for real estates provided to specialised NGOs	240,000.-	Yearly sum of differences between paid rent and market value rent.
TOTAL NON LABELLED DRUG DEMAND REDUCTION EXPENDITURES: 6,369,984.-EUR			
TOTAL DEMAND REDUCTION EXPENDITURES 2011: 15,688,739.- EUR			

* Ministry of Social Security (Health expenditures)

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 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 in treatment during year X that might be provided directly by central social security department)
- B: Average cost of HIV/AIDS treatment/ year
- Total cost of PLW HIV/AIDS IDU Treatment = A X B

Table 1.2: Comparative analysis of drug demand reduction costs in Luxembourg 1999 vs. 2009 /2011(EUR)

Year	1999	2009	2011
Total expenditure	6,903,203.-	15,458,853.-	15,688,739.-
Expenditure per inhabitant per year	16.-	31.-	30,6.-
Expenditure per PDU	2,937.-	6,209.-	6,352.-
Percentage of GNP	0.03	0.04	0.03
Percentage of state budget	0.15	0.17	0.14

Source: Origer 2002, PF OEDT, REITOX report 2009/2011

National estimates of overall public drug related expenditures (2009) (Origer 2010)

Table 1.3: National estimates of non-labelled drug related expenditures (attributable proportions) (2009) (Origer 2010)

Ministry / Department	Budget / Title	Budget / Expense EUR	Attributable proportion	COFOG 1	COFOG 2	SECTOR
01 Ministry of Foreign Affairs and Immigration	S. 01.7 Staff, operational and mission cost related to drug related issues	21,400.-	Estimation by MFA based on analysis of work and mission reports and career of involved agents	Gf01	Gf0101	S1312
07 Ministry of Justice	S. 07.0 Staff, operational and mission cost of MJ related to drug related issues	25,000.-	Estimation by MJ based on analysis of work / mission / career	Gf03	Gf0306	S1312
	S. 07.1. 0 Staff, operational and mission cost of judiciary services (courts, etc) related to drug related issues	1,250,000.-	Total cost of judicial services x proportion of drug offences affairs (based on ad hoc register)	Gf03	Gf0303	S1312
	S. 07.2 Prison drug related expenditures	10,802,430.-	Total prison budget x proportion of drug law offenders in total prison population	Gf03	Gf0304	S1312
	S.07.4 Police drug related expenditures	1,200,000.-	Dedicated staff, operational and mission costs (Special drug units 100%)	Gf03	Gf0301	S1312
		3,780,000.-	+ Assessment by Police Directorate based on analysis of job descriptions and related operational costs	Gf03	Gf0301	S1312

12/13 Ministry of Family, Social Solidarity and Youth	S 13.1 / 12,140 06. 32 Information campaigns on drugs S 13.1 / 11.000 11.00 Staff, operational and mission costs of MF related to drug related issues	15,000.- 22,700.-	Internal budget breakdown Estimation by MF based on analysis of work / mission / career	Gf10 Gf10	Gf010 Gf1004	S1312 S1312
14 Ministry of Health <i>14.1 Directorate of Health</i>	S 14.0 Staff, operational and mission cost of MH related to drug related issues S 14.1 / 33.014 05.23 Staff and operational cost of National Aids counselling Centre	25,000.- 191,341.-	Estimation by MH based on analysis of work / mission / career 25% of total budget : average proportion of PLWHIV/AIDS infected via IDU in clients	Gf07 Gf07	Gf0704 Gf0702	S1312 S1312
<i>14.2 Public Health Laboratory</i>	S 14.1 / 11.000 05.00 / 12.010 05.00 Staff and mission costs of Directorate of Health allocated to drug related issues S 14.2 / 11.000 05.20 Staff, operational and mission costs of Laboratory related to drug related issues	250.000.- 25,000.-	Dedicated staff to drug issues + Estimation by MH based on analysis of work / mission / career Estimation by Laboratory based on analysis of work / mission / career	Gf07 Gf07	Gf0704 Gf0704	S1312 S1312
17 Ministry of Social Security <i>Health / Social insurance</i>	S 17.2 Staff, operational and mission costs for agents in charge of drug treatment referral abroad <i>A. Substitution treatment</i> - Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (Net, patient's contribution excluded)	75,000.- 647,604.-	Estimation by MSS based on analysis of work / mission / career Detailed breakdown by National Health Fund (CNS)	Gf07 Gf07	Gf0704 Gf0701	S1312 S1312

- Reimbursement of pharmacies fees generated by substitution medication delivery	32,913.-	Detailed breakdown by the National Health Insurance Funds (N Union of Sickness Fund (CNS)	Gf07	Gf0701	S1312
- Reimbursement of medical counselling costs related to substitution prescriptions	404,790.-	Number of substitution prescriptions (- free prescription JDH) X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)	Gf07	Gf0702	S1314
<u>B. Inpatient hospital drug treatment</u>	2,876,498.-	Detailed breakdown by National Health Fund (CNS) (extrapol.)	Gf07	Gf0703	S1314
- Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification) (2007)					
<u>C. Drug treatment abroad</u>	1,220,000.-	ICD-10: F11, F12, F14, F15, F16, F18 and F19 hospital episodes (CNS) (extrapol.)	Gf07	Gf0706	S1314
- Reimbursement of drug treatment costs abroad (e.g. residential therapy or specialized therapeutic offers not available in Luxembourg)					
<u>D. Drug treatment costs subsidised by Min. Health</u>	75,000.-	Extraction from the generic state budgetary section 14.0.34.011	Gf07	Gf0703	
<u>E. Cost of HIV/AIDS treatment provided to patients infected via IDU</u>	1,927,000.-	Number of HIV/AIDS patients infected via IDU	Gf07	Gf0702 Gf0703	

				in treatment x yearly average cost of HIV/AIDS treatment (+/- 20,000.- EUR) x reimbursable proportion			
TOTAL B	Non-Labelled Public drug-related expenditures	24,866,676.-					
TOTAL B	Labelled Public drug-related expenditures (not detailed)	13,571,807.-					
TOTAL A+B	Non-Labelled + Labelled public drug- related expenditures	38,438,483.-					

Table 1.4: Overall expenditure in fiscal year 2009 by 1st level COFOG functions

COFOG 1st level function	Labelled expenditures	Non-labelled expenditures	TOTAL
1 General public services	122,000.-	59,100.-	181,100.- (0.4%)
3 Public Order and Safety)	4,838,543.-	17,057,430.-	21,895,973.- (57%)
6 Housing and community amenities	627,430.-	0.-	627,430.- (1.52%)
7 Health	7,968,789.-	7,750,146.-	15,718,935.- (41%)
8 Recreation, culture and religion	0.-	2,000.-	2,000.- (0.01%)
9 Education	0.-	13,045.-	13,045.- (0.07%)
		TOTAL	38,438,483.-

Table 1.5: Comparative analysis of overall direct drug-related public expenditures in Luxembourg 1999-2009 according to various indicators (EUR) (Origer 2002, 2010)

	2009	1999*
Total expenditure	38,438,483.-	23,345,000.-
Expenditure per inhabitant	77.-	54.-
Expenditure per PDU	15,562.-	9,934.-
Percentage of GNP	0.1	0.13
Percentage of state budget	0.4	0.5

Budget

The NFP follows up the annual budgetary evolution by means of the most accessible and specific 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.

Fig. 1.1: Annual budget of the Ministry of Health allocated to drug demand reduction activities 2000 – 2012

Year	2000	2005	2011	2012
Budget (EUR)	2,066,000.-	6,196,000.-	8,321,620.-	9,745,925
Progression rate	Reference year	200%	303%	372%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2010. Volume 1. (Ministère des Finances 1999-2011)

Fig. 1.2: Annual progression of the budget of the Ministry of Health and human resources allocated to drug-related activities 2004 - 2012

Budget Year	2004	2006	2009	2011	2012
Budget (EUR)	5,771,000.-	6,584,000.-	7,991,583.-	8,321,620	9,745,925
Annual progression rate	Reference year	6.27%	9.65%	4.13%	17.12%
Annual cumulative progression rate	Reference year	14.09%	38.48%	44.20%	68.88%
Dedicated human resources Full Time Equivalent (FTE)	59.5	69.25	83.75	88.75	90.75
Annual progression rate	Reference year	9.06%	6.70%	1.7%	2.25%
Annual cumulative progression rate	Reference year	16.39%	40.76%	49.16%	52.52%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2006/2010. Volume 1. (Ministère des Finances 2004-2011)

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 so-called '**convention de collaboration**' with concerned ministries or are financed or co-financed on basis of regular subventions. A governmental delegate follows-up activities and functioning of a given NGO by attending a mandatory 'coordination platform'.

The funding of drug action plan is subject to an annual budgetary decisions process. 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.).

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 and results have been presented in the 2008 edition of the national report.

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. Results were presented in the 2009 edition of the national report.

National media coverage of drug-related issues

Relation with the media is an indispensable tool in communications strategies aiming at informing a broad public by providing up-to-date and reliable data on the numerous topics related to drugs and drug use. In 2011 the NFP performed an in-depth analysis of national written media base on an exhaustive press review and focusing on thematic areas touched upon and frequency of appearance. Of 354 articles on drug related matters, 53% were published by the most read national daily newspaper. Most represented topics in order of importance are: international short news, national short news, Mexico and doping in sports. Table 1.3 summarizes main results and covers the period from August 2010 to July 2011.

Fig. 1.3: National coverage of written media²² regarding drug-related topics from August 2010 to July 2011

Paper/ magazine	1	2	3	4	5	6	7	8	9	10	11	12	13	TOT	%
Topic															
SR, law enforcement														92	25.99
National short news item (arrests, seizures)	35							11					1	47	
Court news (convictions, sentences)	15													15	
National drug scene (perquisitions, etc)	14							5						19	
Prison related topics	3	1	1	2			1	2						10	
Road safety	1													1	
Research															
Statec, Ceps/Instead															
Substances and addiction														36	10.17
Addictions in general					1			1						2	
Cannabis	4							4			1		1	10	
Medicaments															
Doping	19							4					1	24	
Mephedrone															
Campaigns, prevention, laws														46	12.99
Drugs in general	4	1		1			3	1				1	1	12	
Alcohol	4													4	
Tobacco	12							7						19	
Infectious diseases	6							5						11	
Others															
Specialised drug agencies														10	2.82
NGOs	2													2	
TOXIN / Drug injection room	2				2	1		2					1	8	
EMCDDA National Focal point														11	3.11
Activities and publications	3	1		1	1	2	1	1					1	11	
Ministry of Health , Government, Parliament														19	5.37
EU drugs strategy and action plans			1											1	

²² Daily newspapers : 1. Luxemburger Wort, 2. Wox, 3. Zeitung vum Letzebuurger Vollek, 4. Journal, 5. Tageblatt, 6. La Voix, 7. Le Quotidien, 8. Essentiel
Weekly magazines : 9. Revue, 10. Telecran,
Weekly newspapers : 11. Letzebuurger Land, 12. Le Jeudi, 13. Contacto.

Health Commission, Questions to government, Interministerial Groups on Drugs	13			1			2						1	17	
Heroin Assisted Treatment								1						1	
Methadone															
External relations														140	39.55
Organised crime/ trans-border cooperation	2													2	
International Organisations	2	1		1	1		1	2						8	
Afghanistan															
Mexico	21							6						27	
HIV	6							2						8	
International short news	19							76						95	
Miscellaneous															
Readers' letters															
TOTAL	187	4	2	6	5	3	8	130	0	0	1	1	7	354	100
PERCENTAGE	52.83	1.13	0.57	1.69	1.41	0.85	2.26	36.72	0	0	0.28	0.28	2.0		100

Source: NFP 2011

2. Drug use in the general population and specific targeted groups

Introduction

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 derivatives are by far the most common illicitly used psychoactive substances in the national population followed by cocaine and Amphetamine Type Stimulants (ATS). Cannabis use in youngsters has been decreasing over the last 10 years but still shows the highest prevalence regardless considered age categories, whereas the prevalence of other psychoactive drugs varies according to age and data collection setting factors. Most recent school survey data presented in the present report stem from the HBSC study 2010.

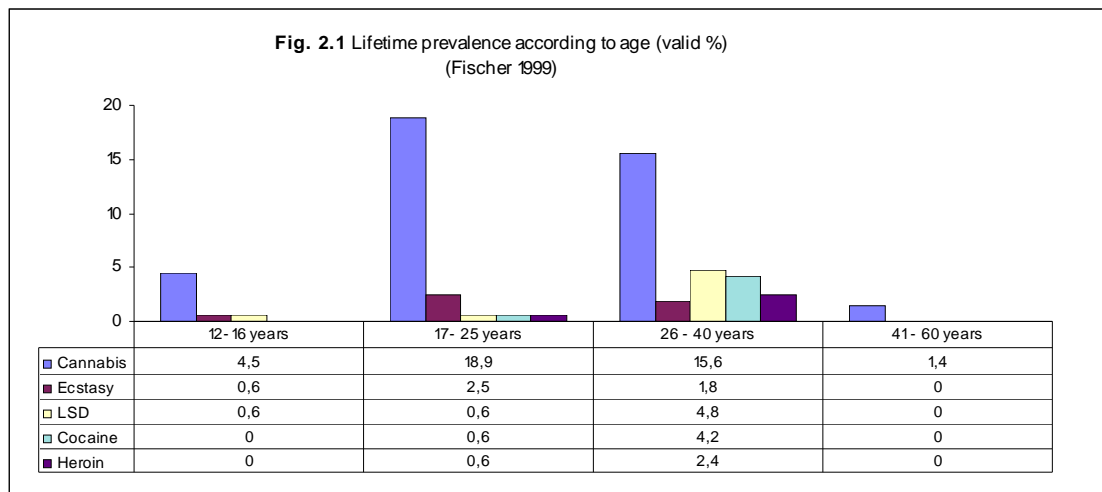
- DRUG USE IN THE GENERAL POPULATION

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

A primary prevention pilot project at community level was launched by the CePT in 1995. In 2000, 13 council districts participated in this project. In the framework of this project a non-representative survey on drug use in the general population (reference 1: “Fischer 1999 study”) was conducted.

REFERENCE 1. Fischer U. CH. & Krieger W. (1999). Suchtprävention 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

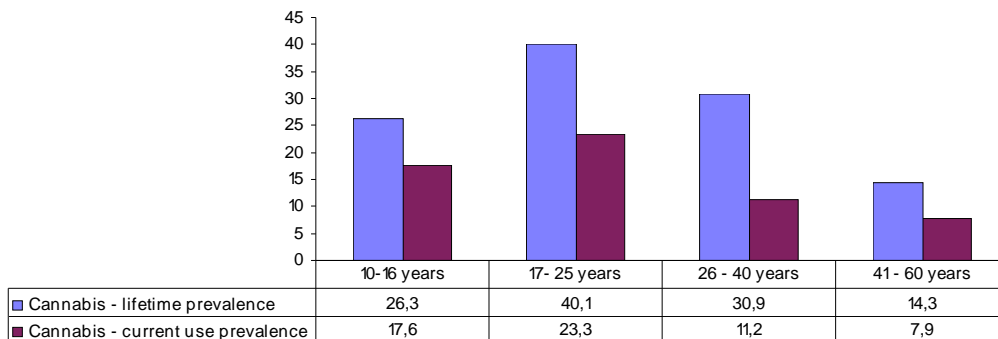


A second survey organized by the CePT was published in 2000 (“Fischer 2000 study”). Even though cannabis consumption was the main subject of the study, several other substances have been taken into account. The samples have been drawn on the one hand from a cinema visitor’s population in Luxembourg City (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

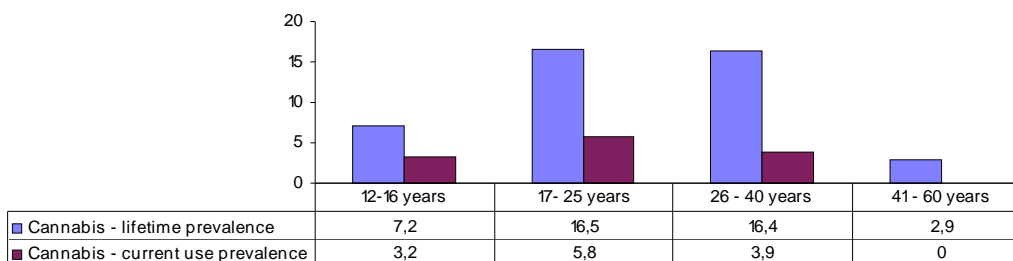
Fig. 2.2 Current and lifetime prevalence of cannabis use according to age: Cinema sample (valid %) (Fischer 2000)



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)

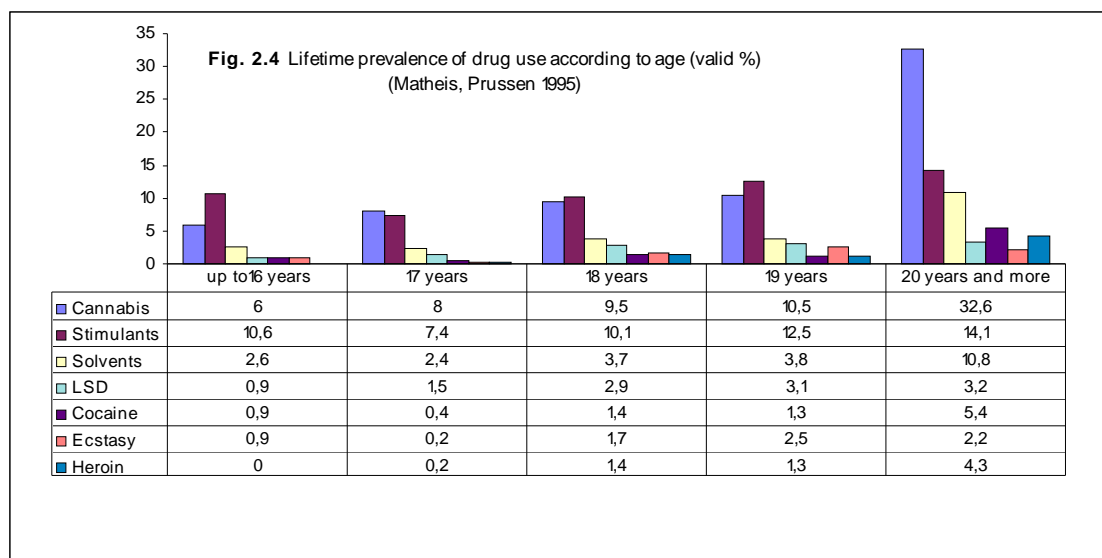


As can be seen in figures 2.2 and 2.3, cannabis prevalence rates show relevant differences according to type of recruitment settings.

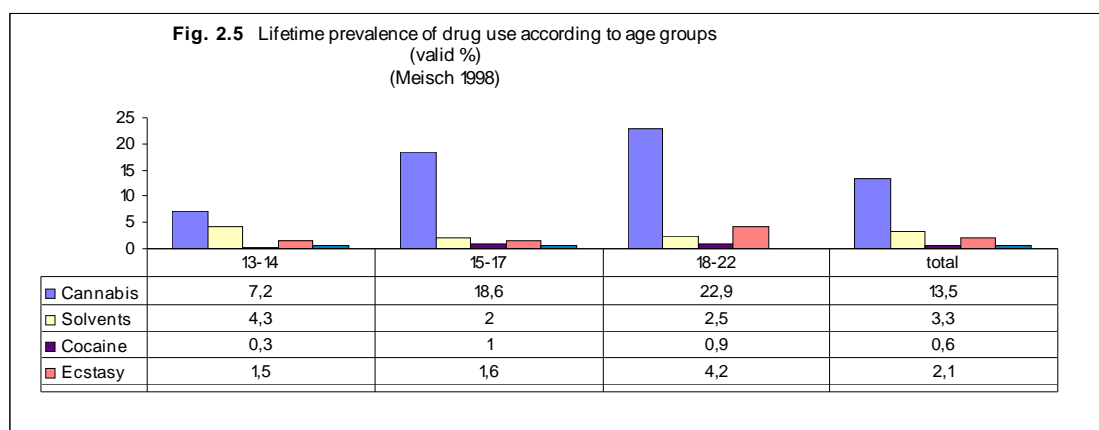
- DRUG USE IN THE SCHOOL AND YOUTH POPULATION

LIFETIME PREVALENCE: SCHOOL POPULATION

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	5 th years of all types of secondary school classes at the national level
Age range	16-20 years (AGE ENTERING 5 TH CLASS)
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	1,341

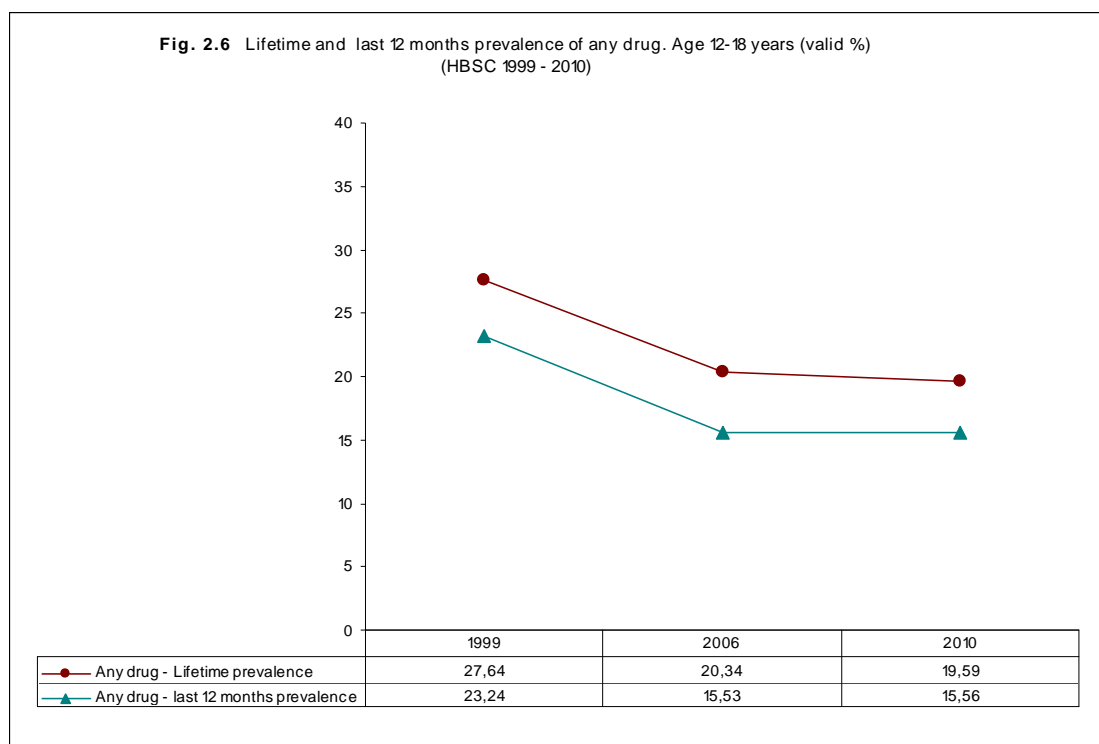


REFERENCE 2 :	Meisch, P. (1998) , Les drogues de type ecstasy au Grand-duché de Luxembourg, CePT, Luxembourg. EN: Ecstasy type drugs in the G. D. of Luxembourg
Year of data collection	1997
Single/repeated study	Single
Context	Public Health – primary drug prevention
Area covered	Nation wide
Type of school	2 nd and 6 th 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 3:		Das Wohlbefinden der Jugend – HBSC Studie (1999 / 2006 / 2010), Ministère de l'Education Nationale de la Jeunesse et des Sports, Direction de la Santé, Luxembourg. EN.: Health and Health Behaviour in School Aged Children.
Year of data collection	1999 / 2006 / 2010	
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	7,000 – 8,000	
Response rate (M,F,T)	Over 95 %	

A total of 8,685 secondary school students, aged 12 to 18 years, were included in the HBSC 2010 data set. The overall students' response rate was 73%.



Lifetime and last 12 months' prevalence rates of illicit drug use in youngsters, aged 12 to 18 years, have been showing a harshly decreasing trend between 1999 and 2006 and a fair stabilisation towards 2010.

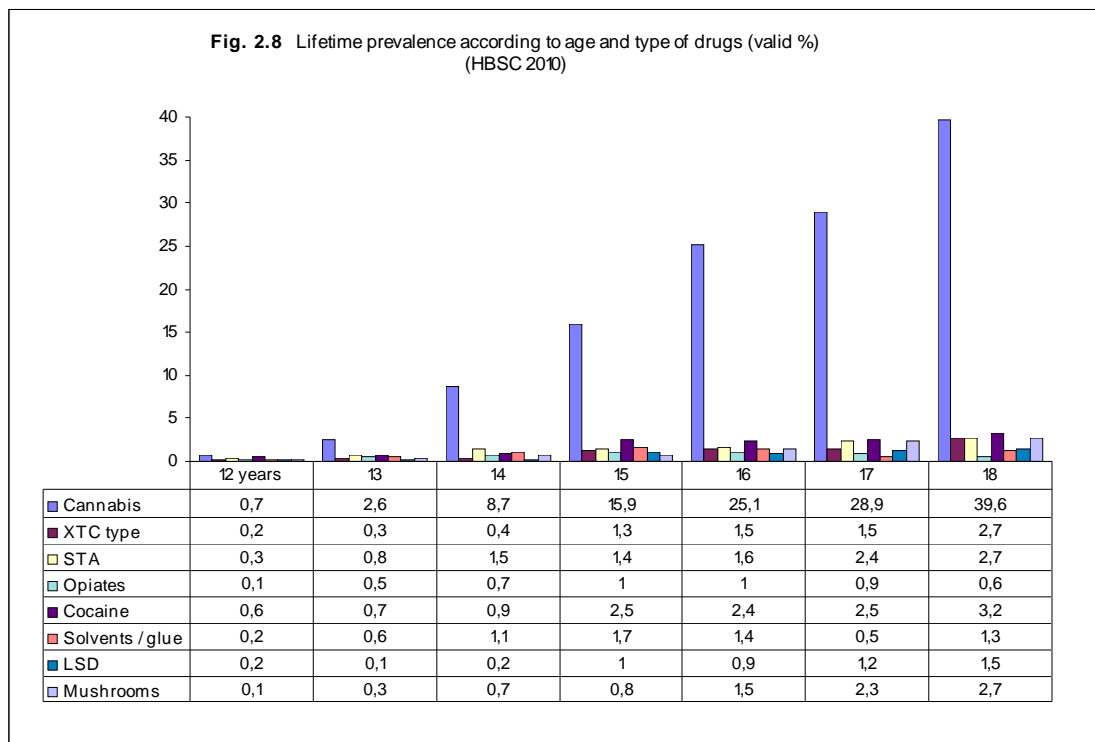
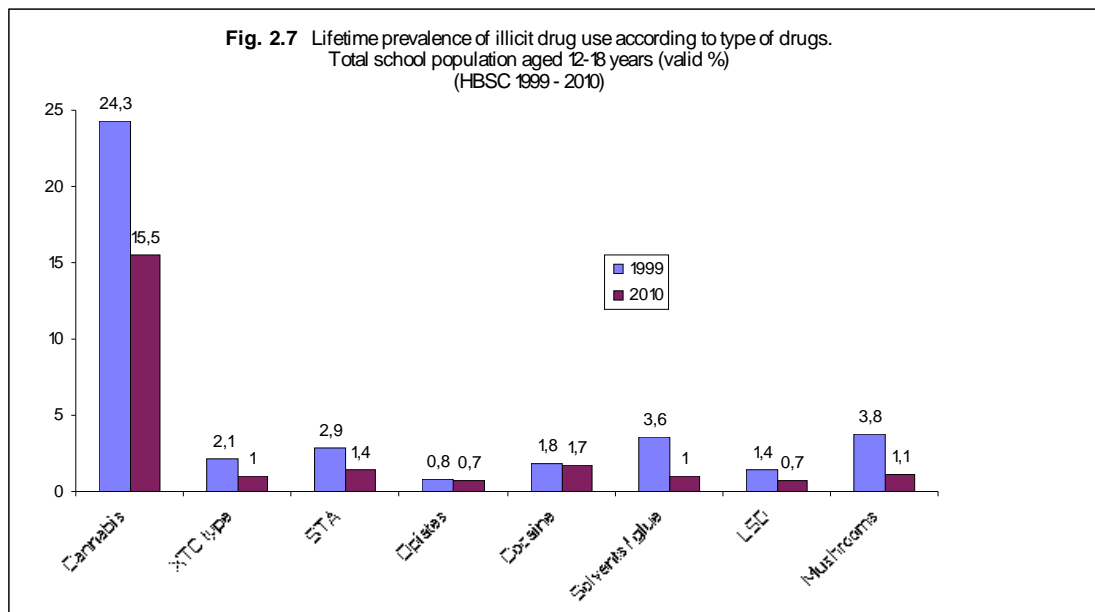
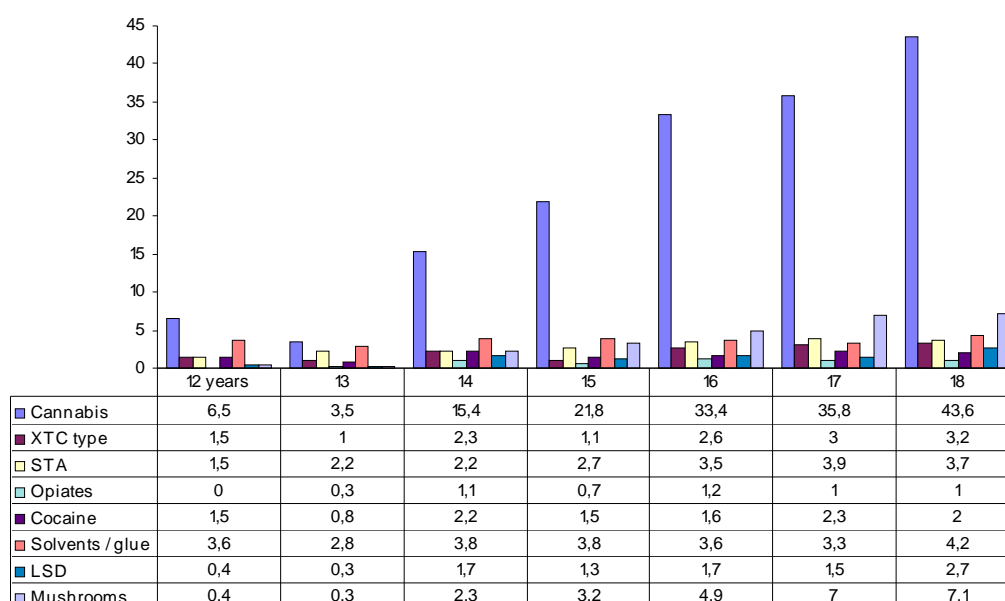
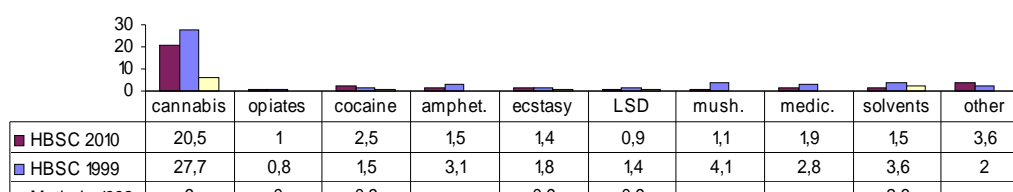


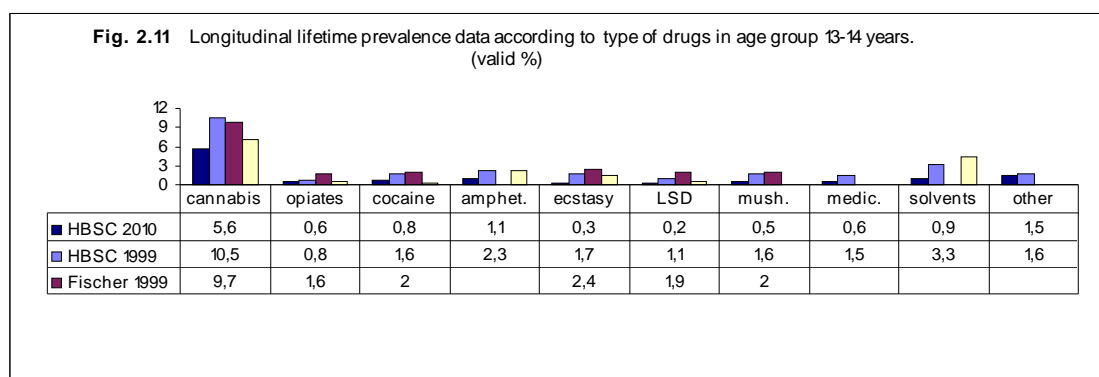
Fig. 2.9 Lifetime prevalence according to age and type of drugs (valid %)
(HBSC 1999)



A comparison of serial HBSC data from 1999 and 2010 reveals highest prevalence rates of cannabis use, irrespectively of age and year of survey. Lifetime cocaine use is the only to show a consistently higher prevalence in 15 to 18 years aged schoolchildren in 2010 compared to 1999. Opiates' use in youngsters has been remaining consistently low over the same period.

Fig. 2.10 Longitudinal lifetime prevalence data according to type of drugs in age group 15-16 years. (valid %)





The HBSC surveys (1999 / 2006 / 2010), the Fischer study (1999) and the serial surveys by Matheis (1985/95) provide trends in lifetime prevalence between 1992/1997 and 2010 applied to age groups **13-16**. Compared to the end of the 20th century, most recent data from HBSC surveys indicate decreasing lifetime prevalence rates for all substances with the notable exception of cocaine use in 15 to 16 years old students witnessing a tangible increase.

LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

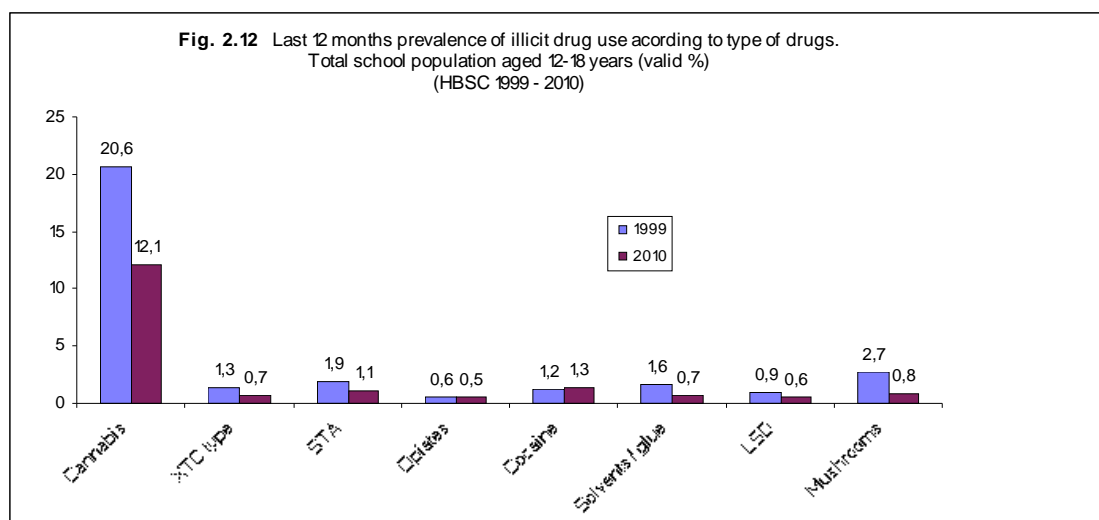
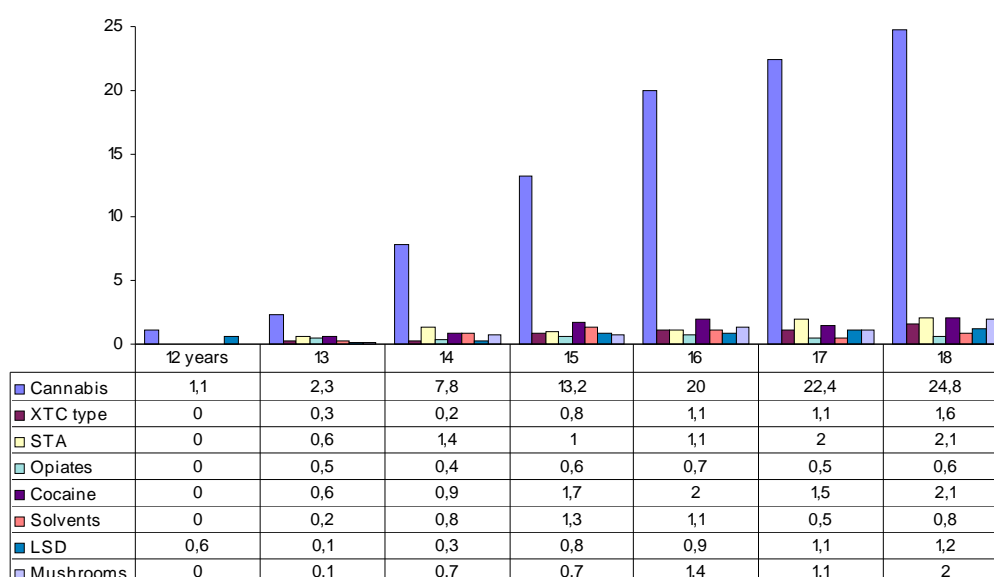


Fig. 2.13 Last 12 months prevalence according to age and type of drugs (valid %)
(HBSC 2010)



Latest 12 months' prevalence data (HBSC 2010) confirm highest rates for cannabis use followed by stimulant type amphetamines and cocaine in schoolchildren aged 12 to 18 years.

Table 2.1: HBSC 1999 / 2006 / 2010: Trend analysis according to age and type of drug (last 12 months prevalence)

	13			14			15			16			17		
HBSC / Year	2002	2006	2010	2002	2006	2010	2002	2006	2010	2002	2006	2010	2002	2006	2010
Cannabis	3,5	3,0	<u>2,3</u>	15,4	7,9	<u>8,0</u>	21,8	18,3	<u>13,2</u>	33,4	18,8	<u>20,3</u>	35,8	23,9	<u>22,5</u>
XTC	1	0,6	<u>0,3</u>	2,3	0,8	<u>0,2</u>	1,1	1,5	<u>0,8</u>	2,6	1,1	<u>1,1</u>	3	1,4	<u>1,1</u>
STA	2,2	0,8	<u>0,6</u>	2,2	1,3	<u>1,4</u>	2,7	1,8	<u>1,0</u>	3,5	1,5	<u>1,1</u>	3,9	1,0	<u>2,0</u>
Opiates	0,3	0,3	<u>0,5</u>	1,1	0,9	<u>0,4</u>	0,7	1,3	<u>0,6</u>	1,2	0,8	<u>0,7</u>	1,0	0,5	<u>0,5</u>
Medic.	0,6	0,8	<u>0,2</u>	2,2	1,3	<u>0,6</u>	2,1	2,4	<u>1,3</u>	3,6	1,6	<u>1,2</u>	2,9	1,9	<u>1,4</u>
Cocaine	0,8	0,8	<u>0,6</u>	2,2	1,4	<u>0,9</u>	1,5	3,2	<u>1,7</u>	1,6	1,4	<u>2,0</u>	2,0	1,6	<u>1,5</u>
Glue/solvents	2,8	0,9	<u>0,2</u>	3,8	1,5	<u>0,8</u>	3,8	2	<u>1,3</u>	3,6	1,5	<u>1,1</u>	4,2	1,3	<u>0,5</u>
LSD	0,3	0,1	<u>0,1</u>	1,7	0,4	<u>0,3</u>	1,3	0,8	<u>0,8</u>	1,7	0,6	<u>0,9</u>	2,7	0,7	<u>1,1</u>
Mushrooms	0,3	0,5	<u>0,1</u>	2,3	0,8	<u>0,7</u>	3,2	2,1	<u>0,7</u>	4,9	1,8	<u>1,4</u>	7,1	2,1	<u>1,1</u>

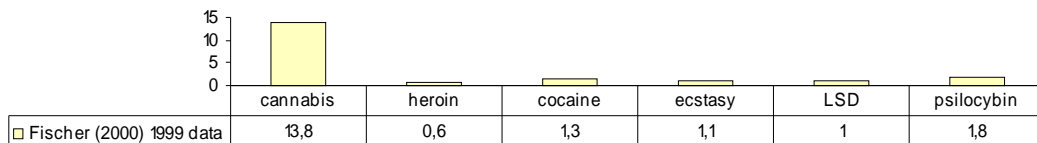
- downward trend 1999 - 2010 - upward trend 1999 - 2010

Serial HBSC surveys (1999, 2006, 2010) provide last 12 months national prevalence figures in 12 to 18 (respectively 13 to 17) years aged schoolchildren. Results mirror respective proportions of lifetime prevalence rates with particular emphasis on high cannabis prevalence in all age groups followed by XTC type products and cocaine.

Table 2.1 shows prevalence trends between 2002 and 2010. A vast majority of substances show declining last 12 months use prevalence rates in all age groups. Cocaine use in 15 to 16 years aged youngsters, however, has been showing a notable increase during the referred observation period.

LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

Fig. 2.14 Last 30 days prevalence according to type of drugs: school population - 13-20 years (Fischer 2000)



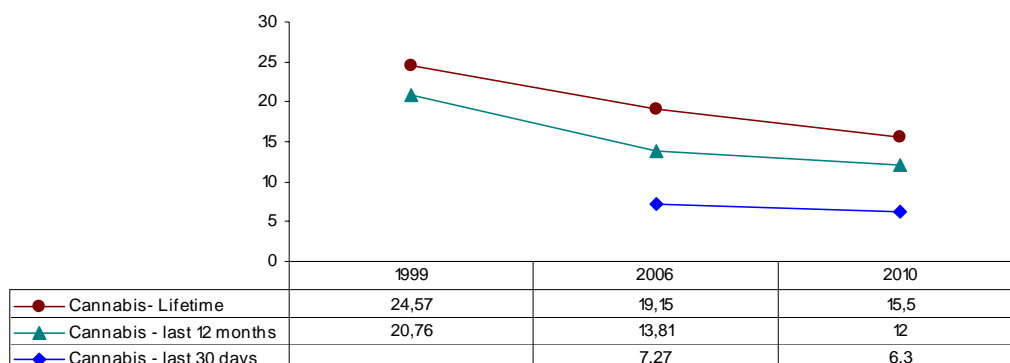
REFERENCE 4: Fischer U. CH. (2000), Cannabis – Eine Analyse der aktuellen Situation, CePT, Luxembourg. EN.: Cannabis – Rapid assessment of the current national situation.

Year of data collection	1999
Single/repeated study	Single
Context	Cannabis prevalence
Area covered	Nation wide
Type of school	2 nd and 6 th 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%

Fischer (1999) provides last 30 days prevalence figures for 13 to 20 year old school children. Cannabis and ecstasy prevalence figure 13.8% and 1.1%, respectively. Gender breakdowns are currently not available. HBSC surveys did not include questions on last 30 days use of different drugs, except for cannabis. Last 30 days cannabis use is addressed below.

IN-DEPTH DATA ON CANNABIS USE PREVALENCE IN SCHOOL-AGED CHILDREN²³

Fig. 2.15 Lifetime, last 12 months and last 30 days prevalence of cannabis use. Age 12-18 years (valid %) (HBSC 1999 - 2010)



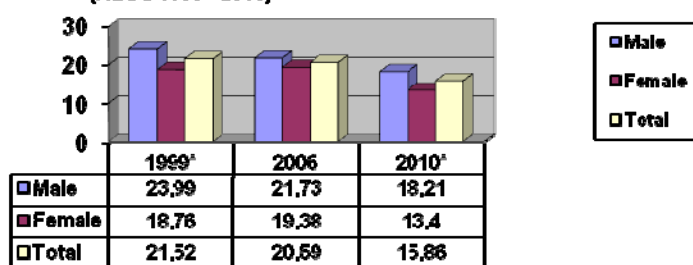
²³ Slight discrepancies between national data of 2010, presented in the present report, and the international HBSC report do exist and are mainly due to different procedures in age calculation, in incoherent answers' management and supplementary data not yet available at the time of data submission for the international report.

Table 2.2: HBSC 2010: Cannabis prevalence rates according to age categories 11 – 15 years

	11 years			13 years			15 years		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Cannabis life	0.8*	0,0	0,4	2.7	2.5	2,6	18.2*	13.6	15,9
Cannabis 12 month	1,0*	0,0	0,5	2.4	2.1	2,3	14.2	12.2	13,2
Cannabis 30 days	0.8*	0,0	0,4	1.6	1.1	1,3	7.7	6.5	7,1

* Significant gender difference at $p < 0.05$

Fig. 2.16 Lifetime prevalence of cannabis use according to gender. Age: 15 years.
(I DSC 1999 - 2010)



* Significant gender difference at $p < 0.05$

Fig. 2.17 Last 12 months prevalence of cannabis use according to gender. Age: 15 years
(HBSC 1999 - 2010)

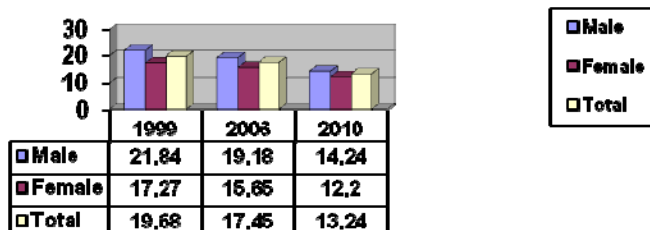
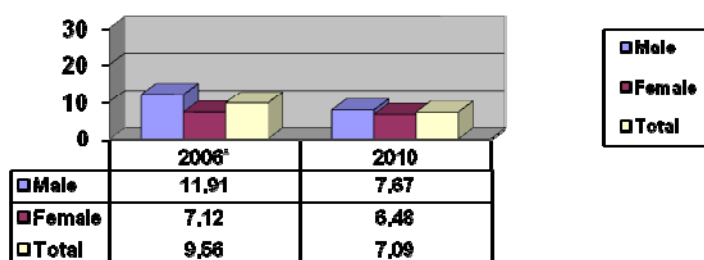
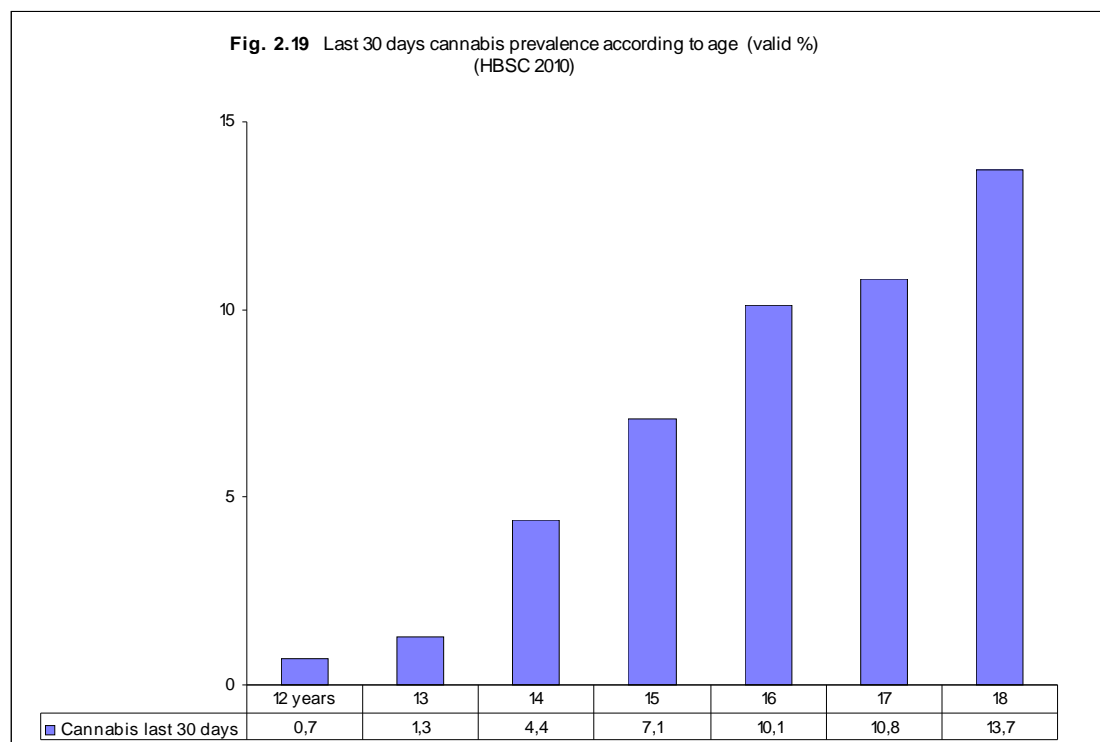


Fig. 2.18 Last 30 days prevalence of cannabis use according to gender. Age: 15 years.
(HBSC 2006 - 2010)



* Significant gender difference at $p < 0.05$



Lifetime, recent and current cannabis use prevalence rates in 15 years old youngsters have been declining remarkably during the first decade of the 21st century. The most relevant differences according to gender are lower cannabis prevalence figures for females. These differences appear to be statistically significant ($p < 0.05$) for lifetime and last 30 days prevalence in 2006 and for lifetime prevalence in 2010.

- DRUG USE AMONG TARGETED 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 / CRP-Santé. Luxembourg. EN: Prevalence study on HIV, HCV, HBV and HAV in PDU 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:	
<ul style="list-style-type: none"> - 67.21% of PDU 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 IDU in prison 	

Furthermore, a study on “*Drug addiction in the working environment: Prevalence of use of psychoactive substances use and its relationship to high-risk occupation and stress*” (S. Krippeler and F. Kittel, 2011)²⁴ has been published in April 2011. The aim of the study was to explore the prevalence of licit and illicit psychoactive substances use among employees aged between 18–39 years in the private sector in the G.D. of Luxembourg as well as its relationship to high risk occupations and other potential risk factors in occupational settings, (e.g. high-stress tasks). For this purpose, a self-administered questionnaire containing validated tools from the EMCDDA concerning street drugs, the AUDIT-C for alcohol use and the Siegrist Effort-Reward-Imbalance questionnaire on stress were distributed during occupational medical check-ups during June and July 2008. Alcohol, cigarettes, amphetamines, cocaine, heroin, ecstasy, LSD and psychotropic drugs use were investigated together with socio-demographic and professional factors. Among the 1358 respondents, 8.4% consumed illicit substances, cannabis accounting for 8.2%. High-risk occupations are significantly related to illegal substance use. Age (young), gender (men), smoking and family situation (bachelor living alone) show the same relationship. No effect was found for stress on illicit drug use while there was a significant effect on alcohol and prescription drug use in bivariate analysis only.

A new Flash Eurobarometer N°330 (for more details see chapter 3) was carried out in May 2011 on the request of the European Commission among young people aged 15-24. Among others, one item referred to self-reported use of cannabis and another to the experience with legal substances that imitate the effects of illicit drugs (“legal highs”).

	Q10. Have you used cannabis yourself?			
	Yes – in past year	Yes – but more than one year ago	No, I have never used	Don't want to answer
LU	11	10	77	2
EU 27	14	12	72	2
	Q5. In certain countries some new substances that imitate the effects of illicit drugs are being sold as legal substances in the form of – for example – powders, tablets/pills or herbs. Have you ever used such substances?			
	No, I never used		Yes, I have used such substances	
LU	93		7	
EU 27	95		5	

Concerning self-reported use of cannabis, more young people in Luxembourg (77%) declared not having used cannabis compared to the European average (72%). All in all, however, there was no significant variation with regard to self-reported cannabis use among Luxembourg youngsters and the EU average.

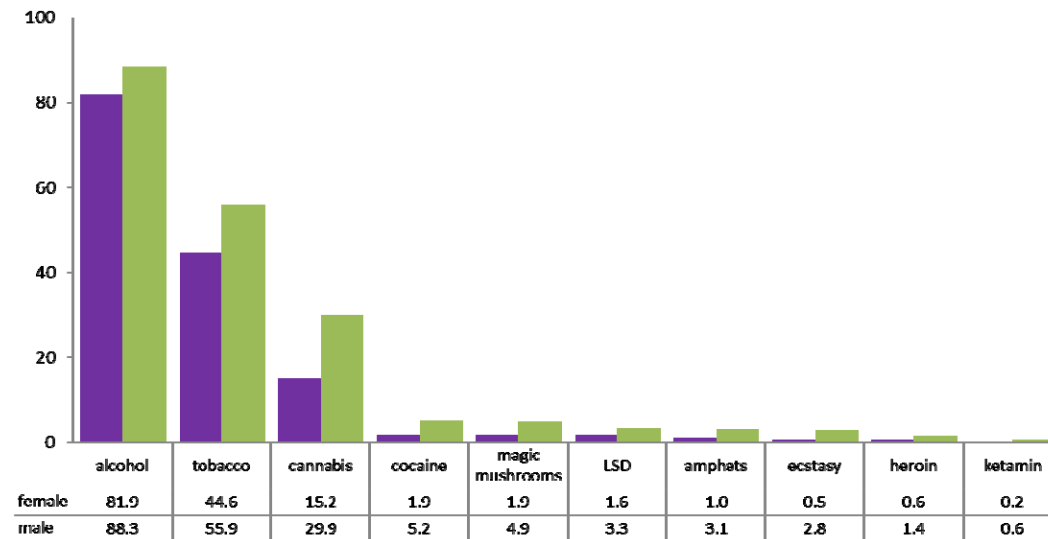
Concerning “legal highs”, in most EU countries not more than 1 in 20 young people reported having used legal substances imitating the effects of illicit drugs. In Luxembourg self-reported use was 7% and higher than the EU average (5%).

In the framework of the INTERREG IVA project MAG-Net, the CePT conducted an anonymous survey among partygoers on representative music events which took place in Luxembourg in 2011 (Duscherer & Paulos, 2012). 2.480 questionnaires were completed, 2.397 validated, the median age of the participants was 19 years. One question directly addressed participants’ drug use during the last two weeks: as can be seen in Figure 41, alcohol was by far the most frequent psychoactive substance

²⁴ Krippeler S, Kittel F. Toxicomanies en milieu professionnel : prévalence de l’usage de substances psychoactives et sa relation avec le poste de sécurité et le stress. Archives des maladies professionnelles et de l’environnement, 2011, vol.72, n°2, pp.181-188

declared (85.2%), followed by tobacco (50.5%) and cannabis (22.8%). All other drugs ranged below the 5% mark, like cocaine, magic mushrooms, LSD, amphetamines, ecstasy, heroin or ketamin. A follow up survey of these trends is in preparation for the upcoming party seasons.

Fig. 2.20: Use of psychoactive substances during the last two weeks by partygoers (valid %)



3. Prevention

Introduction

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 / Best practice database of the EMCDDA under: <http://www.emcdda.europa.eu/themes/best-practice/examples>.

The **national drugs action plan 2010- 2014** addresses primary prevention as a main intervention area.

The priorities of the drug prevention action plan and the GIT as approved in 2010 are as follows:

- Multidisciplinary training programmes and training of multipliers
- Interventions in school and youth environments, peer education;
- Prevention in homes for youngsters and socio-educative facilities;
- Intervention in recreational and festive venues
- Cannabis, alcohol, shisha and designer drugs use in youngsters;
- Mass media campaigns;
- Documentation strategies.

The National Addiction Prevention Centre (CePT), which has started its activities in 1995, covers drug addiction as well as the prevention of different types of addictive behaviour. Legally speaking the CePT is a foundation co-financed by the Ministry of Health.

Training interventions in drug demand reduction are increasingly developed at the national level. A special department named '*Trampolin*' has been set up within the CePT, to ensure the development of training activities and instruments covering national needs. Target groups are professionals from the educative, social, psychological and medical fields as well as parents and other interested stakeholders.

A second important player 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 2010 - 2014** (see 1.1).

Direct drug prevention expenditures reached 672,000.- EUR in 2000 and 990,000.- EUR in 2011. These figures include staff and operating costs of agencies and ministerial department specialised²⁵ in drug prevention.

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

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

- UNIVERSAL PREVENTION

School

Drug prevention programmes in schools are not mandatory. National drug prevention activities integrated within national school programmes have mainly resulted from **corporate actions** of different governmental and non-governmental actors: Ministry of Family and Integration – National Youth Service (SNJ), Ministry of Health - Division of

²⁵ 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.

Social and Preventive Medicine, Ministry of National Education – Psychological Care and Educational Orientation Department (CPOS) and since 1995, 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 2000, the CePT in collaboration with the SCRIPT started a pilot project called '*d'Schoul op der Sich*' (**School on quest**) (see EDDRA) running for two years and having been evaluated in 2003. The aim of this participative project consisted in creating so-called prevention groups among all participating secondary schools in order to initiate a process of reflection on drug related themes. In 2004, the CePT managed to set up a primary prevention tool adjustable to the needs of the different secondary schools. Prevention groups are now operating routinely in several secondary schools in order to find solutions that fit each particular context.

In this context a further development stage has been reached in 2009 by the launch of the **CePT Toolbox**. This 'box' includes the necessary tools to understand and promote life competences of children from 3 to 15 years and accompany them on their way to autonomy. The referred instruments are primarily meant to serve educators, pedagogues, psychologists and teachers to assist them in their professional activities. The CePT also offers trainings on how to use these tools. The CePT toolbox can be downloaded at: <http://cept.lu/fr/projets/548-cepttoolbox>

In the context of the MAG-Net in school, two primary schools have participated in this pilot project. At all, 13 members of the school staff, 120 students as well as students' parents were involved. Three modules of two hours were proposed to the students in class. The subjects touched upon during these interventions were the following: emotions and empathy, needs and capabilities, the strict use of rules and limits, as well as personal decisions and opinions. Between the modules, the teachers have revised the new notions with the students by proposing them creative activities and practical exercises. The interventions in class were evaluated by meetings between educational staff and the instructor, and by questionnaires for the students, the parents and the educational team.

As far as training activities are concerned, around 1,000 persons have participated in training sessions and conferences organized by the National Prevention Centre on Drug Addiction (CePT) during 2011, namely in the framework of the collaboration with the Service of Coordination of Research and of Pedagogical and Technological Innovations (SCRIPT) and the Luxembourg University, the City of Luxembourg, the national federation of School children' parents, the Police academy and specialised agencies.

In 2011, the CePT has offered trainings on psychotropic substances, methods and tools available for the prevention of addictions and the promotion of health or the communication with young people.

A new module was elaborated by the CePT in 2011, for the professionals acting in the education of children and adolescents. The aim of this training was the communication with youngsters regarding psychotropic substances.

In 2011, a training workshop was organised for the staff of the “Lycée Technique du Centre” and as advanced training for the staff of the psychiatric department of the “Centre Hospitalier du Kirchberg”. The CePT also offers an introductive training on prevention of addictions in schools and courses in the Luxembourgish Police academy.

In 2011, 126 participants attended the introductive training sessions of the CePT, 92 the advanced trainings and 57 the parenting sessions. The CePT continued organizing monthly, seminars addressing a professional public. Eight ‘Wednesday seminars’ were organized in 2011 for a total of 133 participants.

A conference on prevention of alcoholism in youth, took place on the initiative of the commission for equal opportunities, for family and seniors, the youth commission and the youth centre. After the introduction into the subject, the legal conditions were presented, followed by the consequences of alcohol on young people and in this regard the responsibility of adults. The slogan of the campaign “Keen Alkohol ënner 16 Joer” served as guideline of this conference. The law concerns all the selling points of alcohol over 1.2 percent, in which, youth, under the age limit of 16 years, are also forbidden the access to all kind of pubs, where alcohol is served, excepting youth events or when the young people are accompanied by a responsible adult.

New in 2011 were the exchange meetings of the social MAG-Net. Three thematic conferences were hold for the professional representatives of the social sector of the Greater region, assembling more than 220 participants. Topics addressed were substitution methods, low-threshold structures and the problematic of drug consumption in prison.

Various schools have also been involved directly in the elaboration of prevention programmes. Thus, a group of students from private schools have conceived, jointly with the prevention service of the local police, a project called ‘*Clean is cool*’ to draw attention on the dangers of cannabis abuse. The main objective was to incite youngsters to actively and autonomously seek for information and knowledge in order to promote self-motivated preventive attitudes.

In addition to its further education programme for teachers and professionals from the educative, social, psychological fields at school, the CePT offers trainings at the University of Luxembourg (Bachelor en Sciences de l'Éducation ; Bachelor en Sciences Sociales et Éducatives). In 2011, the CePT was also involved in the module of the pedagogical formation of the secondary school teachers, concerning the subject biology. A mobile interactive and prevention instrument called the ‘*Extra-Tour Sucht*’ and aiming to reach students aged 15 to 18 years in secondary school settings was further developed and adapted for instance to new trends such as shisha smoking. It was specifically designed for the Luxembourgish school settings by the German company KomPass. Interactive intervention modules are applied alternatively and allow for a participation of 60 pupils. Currently the following thematic sessions are proposed:

- Tobacco – Lust for life
- Dependence and pleasure
- Life skills – Fit for life
- Norms – New world
- Alcohol – To win and to loose

A brochure on cannabis specially designed for teachers and other professionals of the educational sector: « **School and cannabis – Recommendations for School staff** » was jointly developed with the STSJ. The Ministry of National Education-SCRIPT published the 1st edition in 2009, the second edition is on preparation to be published in 2012. It includes epidemiological data, recommendations on early recognition, prevention and intervention means and information on existing networks..

The project '*Nach ëmmer allcool*' was developed jointly by the CePT, the National Theatre of Luxembourg (TNL) and SCRIPT for the secondary schools. The outcome was a theatre play, addressing prevention of alcoholism presented in secondary schools from January to March 2009 reaching approximately an audience of 1,300 persons. After the 1st edition in 2009, a new edition of the project '*Nach emmer allcool*' took place in November 2011.

An evaluation by questionnaire took place in January 2012, to get feedback on the project. Results will be published in the annual report 2013.

Finally, trained police staff periodically visits various schools of the country, to inform students on drugs and their risks.

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 parents' associations at each education level does exist : Fédération des Associations de Parents d'Elèves du Luxembourg - FAPEL ; Kannerschlass Foundation - 'Parents' School' ; Ombuds-Comité fir d'Rechter vum Kand – OKR.

The CePT also offered a workshop on primary prevention in the context of stress management and which was addressing to the parents of adolescents and to the teaching staff. Furthermore, the CePT conducted an interactive workshop in the context of the general assembly of the commission of pupils' parents from the primary schools.

In 2001 CePT has released the so called '**prevention boxes**' 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. Also, the CePT collaborates with the Kannerschlass Foundation, in the framework of the project 'Parents' School'.

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 nationwide, 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 one agency focuses on interventions in recreational settings, namely the CePT (community project²⁶).

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 since then have fine-tuned and further developed the concept for national prevention tours. In 2008/2009 a performance tour was organised in Mondorf Group regions entitled 'The Quest of happiness'.

- SELECTIVE PREVENTION IN AT-RISK GROUPS AND SETTINGS

At-risk groups

In 2006, MDs without frontiers - Youth Solidarity (currently Jongenheem asbl) 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 the CHOICE team within two weeks and the latter inform the Public Prosecutor on the participation level. A certificate testifies the participation of the youngster.

In 2009 Aidsberodung Croix-Rouge in collaboration with the Ministry of Health and the CHL launched a project called '**DIMPS**' (Intervention mobile for the promotion of sexual health) in the framework of the national action plan on Aids 2006-2010. **DIMPS** is meant

²⁶ 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.

to inform on risk behaviour and provide free and rapid infectious disease testing in difficult-to-access populations. Among other interventions, rapid tests for HIV and HCV and HBV are proposed. Currently the *DIMPS* van visits low threshold drug agencies, gay meeting places, red light spots and asylum seekers facilities. During 2011, the *DIMPS* reported 38 interventions. 109 individuals were contacted during this time and 146 counselling sessions have been held. 39% of clients were IDUs. Budgetary means allocated by the Ministry of Health to the DIMPS project were increased in 2012 compared with 2011.

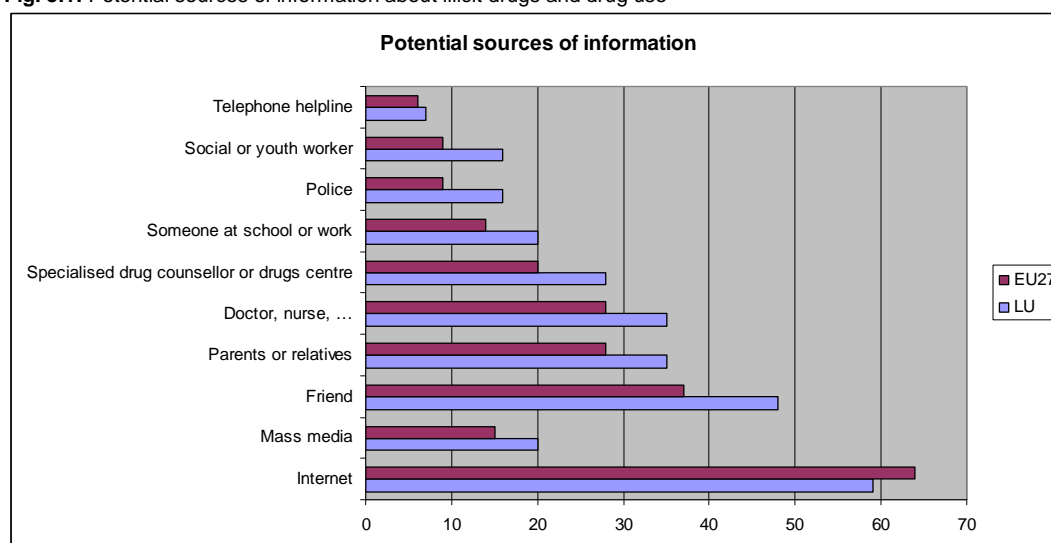
From 2010 to 2013 the CePT participates in an EU project called '*Promotion of social and personal competences in socially unprivileged persons*' – PRO SKILLS in the framework of the Grundtvig - Programme, that aims to promote personal and social skills in socially disadvantaged young adults. Its objective 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. Jointly with nine other institutions from eight European countries a train-the-trainer concept with a lot of didactic material was developed in 2011. In 2012, a European workshop in Luxembourg and national pilot trainings in all eight countries will be organized.

Finally, a targeted survey '*Youth attitudes to drugs*' (Eurobarometer, no 330) was conducted for the European Commission, from the 9th to 13th of May 2011. Telephone interviews were conducted in each of the 27 EU countries. Each national sample was representative of the general population between 15 and 24 years. Sample size varied between 250 and 500 respondents. The main results are briefly presented hereinafter:

° *Information on illicit drugs and drug use - Potential sources of information*

Likewise results from the previous 2008 Flash Eurobarometer study, **the internet** was the most popular source of information, with 64% (EU) (LU: 59%) of 15-24 year-olds, who said they would use the Internet when looking for general information about illicit drugs and drug use. The second preferred source were **friends** (EU: 37%; LU: 48%) and on third position, **parents or relatives** (EU: 28%; LU: 35%) as well as **doctors or nurses** (EU: 28%; LU: 35%). The same order has been observed in the Luxembourgish sample.

Fig. 3.1: Potential sources of information about illicit drugs and drug use



Source. Eurobarometer 330

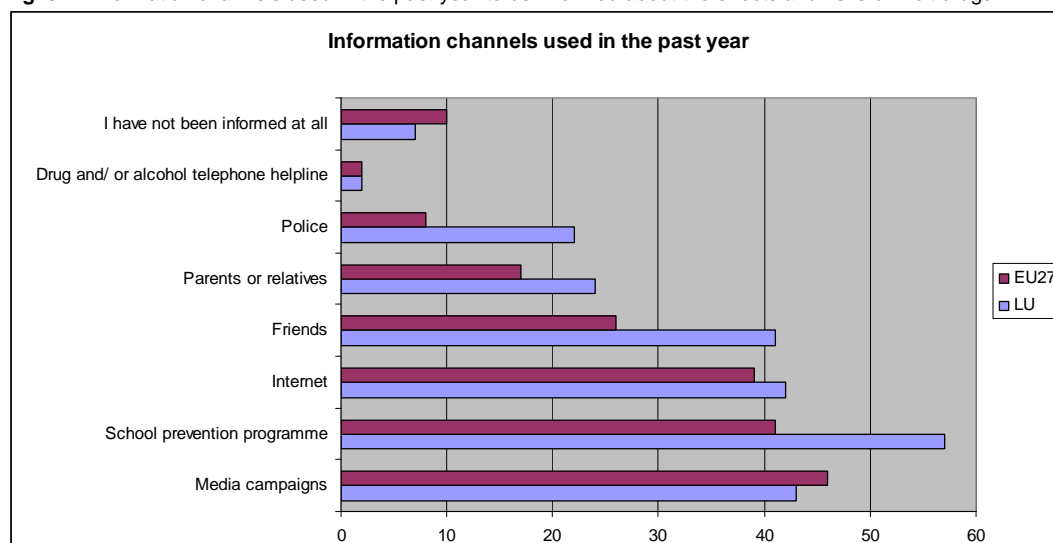
° *Information channels reaching youngsters in the past year*

When asked through which information channels young people had been informed on the effects and risks of illicit drug use during the past year, 39% of respondents referred to **the internet** (LU: 42%), compared to 46% who reported **media campaigns** (LU: 43%) and 41% who mentioned **school prevention programmes** (LU: 57%).

Twenty-six percent said they had discussed these issues with **friends** (LU: 41%) in the past year, and roughly a sixth (17%) of respondents had been informed by their **parents or other relatives** (LU: 24%). A minority of respondents said they have been informed on effects and risks of drug use by **police** (EU: 8%; LU: 22%) or via **drug and/or alcohol helpline** (EU: 2%; LU: 2%). Finally, 10% of respondents reported **not to have been informed at all** (LU: 7%) about the effects and risks of illicit drug use in the 12 months prior to the survey.

In both surveys, conducted in 2008 and 2011, the most frequently mentioned information channel was media campaigns, followed by school prevention programmes and the internet. Compared to 2008, the gap between the proportion of young people who mentioned school prevention programmes and those who referred to the internet has decreased – this suggests that the internet has become somewhat more important as a source for drug-related information. Most popular information channels for the youngsters in Luxembourg are: school prevention programmes, followed by media campaigns and the internet.

Fig. 3.2: Information channels used in the past year to be informed about the effects and risks of illicit drugs



Source. Eurobarometer 330

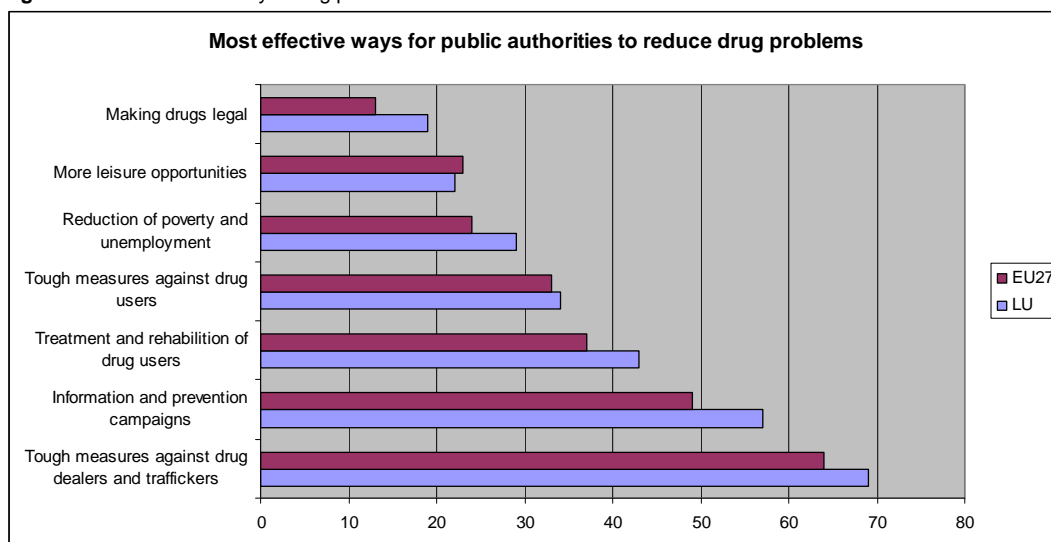
° *How should drug problems be tackled?*

As in the 2008 Flash Eurobarometer, the largest proportion of respondents considered that public authorities should tackle problems on the supply side: 64% mentioned **tough measures against drug dealers and traffickers** (LU: 69%) as one of the most effective ways to reduce drug problems.

As far as drug demand reduction is concerned, young people thought that other measures, such as prevention or treatment and rehabilitation of drug users, would be more effective than repressive measures. Nearly half of respondents (49%) referred to **information and prevention campaigns** (LU: 57%) as one of the most effective ways of reducing drug problems; the **treatment and rehabilitation of drug users** followed, with 37% (LU: 43%) of respondents choosing this as an effective measure. By comparison, **tough measures against drug users** were considered to be a valuable way of dealing with drug problems by a third of respondents (EU: 33%; LU: 34%).

Reducing one of the possible primary causes of drug abuse – i.e. **poverty and unemployment** – was mentioned by 24% (LU: 29%) of interviewees. A similar proportion (EU: 23%; LU: 22%) thought that offering **more leisure opportunities** would be an effective way of dealing with drug problems. As in 2008, **legalisation of drugs** was thought of to be the least effective way of fighting drug problems: 13% (LU: 19%) of young people, however, put forward this measure as one of the most effective ones.

Fig. 3.3: How should society's drug problems be tackled?



Source. Eurobarometer 330

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 2011, these interventions have reached 110 parents as well as 64 children living with their parent(s) and 51 children, who did not live with their parent(s). 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 the CePT, 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**, which was renamed "**1- 2- 3 lass**" "1-2-3 go!" in 2009.) In 2011, 7 training modules of 135 minutes took place.

Recreational settings

Youngsters do spend an important share of their time in leisure, recreational or social activities and 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 coordination 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**²⁷' 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 programme 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.

In 2011, the Mondorf Group organized an inter-regional project for youth in difficulties, called "Between liberty and dependence". The objectives were to stimulate interaction with youngsters, the prevention of addictions and to promote the reinforcement of their personality and especially their social skills.

The CePT continued its close collaboration with the National School for Physical Education and Sports (ENEPS) in the framework of a project called 'Give strength to children'. Sportive activities are used as a framework and a tool for preventive action. More information is available under: <http://cept.lu/fr/projets/376-kanner-staark-maachen-am-sport>.

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.

²⁷ See EDDRA

The National Addiction Prevention Centre (CePT) is an active member of the several networks on the topic of health promotion and harm reduction in nightlife settings, like in the Club Health project (<http://club-health.eu/>) or the Club Health network (<http://www.clubhealthsf2013.org/>). The main objectives of these networks are to improve existing interventions reducing drugs related harm in nightlife and party settings and to facilitate their transferability, evaluation and implementation.

Since May 2008, the National Prevention Centre on Drug Addiction (CePT) is an active member of the working group on health promotion in festive environment and this especially for the project 'Democracy, Cities and Drugs II', a project derived from a collaboration with the European Forum for the Urban Security. CePT has participated as associated partner in the elaboration of the project called 'Club Health- Healthy and Safer Nightlife of Youth' (www.democitydrug.org/safernightlife).

A new European project, **Nightlife Empowerment and Well-being Implementation project** (NEWIP), financed by the EC in the context of the health program (2011-2013), brings the actors of the European fields, active in nightlife activities, together. The CePT has joined the working group of the NEWIP in December 2011 (<http://www.safernightlife.org/>).

In the framework of the INTERREG IV Programme: Grande Région 2007-2013 Project 52 GR 3 3 100 the CePT participates in the project **MAG-Net**: <http://cept.lu/fr/projets/442-mag-net> - Promotion of well-being and prevention of addictive behavior in school and recreational settings by youngsters and risk groups. The referred project includes the creation of a network of experts from Germany, France, Belgium and Luxembourg aiming to develop preventive measures for school, recreational and social settings. The duration of the project covers June 2009 to May 2012. In the framework of the MAG-Net project, a directory of all the counseling and help services related to drugs and addictions was published for the Greater Region. This directory can be accessed electronically at : www.mag-net.eu. In July 2011, the portal www.mag-net.eu was presented to the general public during an interregional press conference in Luxembourg.

As the nightlife setting provides a privileged environment for recreational drugs use, the CePT launched under the name of MAG-Net Party, under the INTERREG IV A Programme: Grande Région 2007-2013, Project 52 GR 3 3 100 (www.mag-net.eu) a harm reduction project targeted at recreational drug users in the party scene of Luxembourg and the surrounding Greater Region. Related interventions focus on keeping in line with the party spirit of events while adequately managing risky situations. Besides information on psychotropic substances, the recreational Mag-Net point of presence also provides earplugs and information on auditory risks, condoms with and without lubricant, breath tests, but also disinfecting soap, sunscreen or potable water. The public also can find time schedules of public transports or contact details of the facilities available in the region. The main focus is on information and is provided in situ by a team of trained peers. Fancy trilingual postcards are made available to the public, including information on alcohol, cocaine, cannabis, synthetic cannabinoids, tobacco, XTC, LSD, ketamine, GHB/GBL, heroine, speed and information on road safety and risky sexual behaviours in relation to drug use. In 2011, the Mag-Net stand was present at the most national music festivals, which were attended by a total of 32.000 visitors. As in 2010, a survey was organized with the public of the main festivals. 2,480 questionnaires were collected. These data will allow the CePT to best aim the programmed actions for 2012, concerning the age of the public, the used languages as well as the psychotropic substances recently consumed by the public met at the different festivals.

The governmental programme of 2009 puts emphasis on the phenomenon of binge drinking and its increasing prevalence in youngsters. A special working group chaired by the Ministry of Health has received a mandate to continue its work. Measures implemented according to recommendations from the referred group 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 group currently elaborates an action plan on alcohol to be integrated in the general framework of the national strategy to fight addictive behaviour. The CePT's mandate in this working group is to lead the prevention group.

The campaign "Keen Alkohol ënner 16 Joer – Mir haalen eis drun" ("No alcohol under 16 years – We stick on it!"), in collaboration with the Ministry of Health started in 2007 foremost in community settings and was re-launched with a press conference, in June 2011. The accent was put on the responsibility of the vendors of alcoholic drinks and the prohibition of selling alcohol to minors under 16 years. This year, the CePT appealed to the responsibility of the adults on the verge of the summer festivities and especially the festivity of the national holiday. The evaluation of this campaign in 4 municipalities by the University of Luxembourg will be finished in 2012.

With the "European Action on Drugs" the European Union wants to approach a growing problem, concerning the whole European society, in a determined, balanced and coordinated manner. For this purpose a charter was created, in which national and local public authorities, schools, public services, consortia or organisations of any size campaign for elucidation and take a concrete approach against drug abuse. In Luxembourg, the European action plan is coordinated by the 'Responsible Young Drivers'. Interventions do not only address youth, but also people at risk of dependence, of all age categories.

Occupational settings

In cooperation with the human resources department of the City of Luxembourg, the CePT runs 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

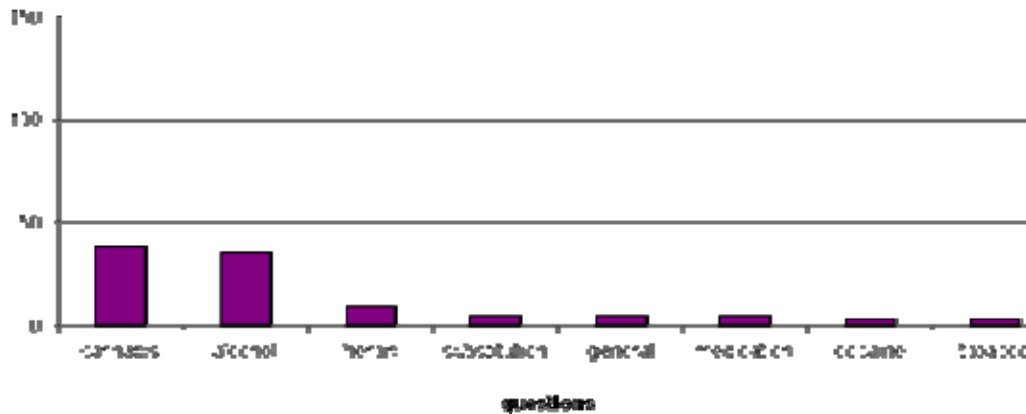
Three basic mechanisms are in place in order to prevent the onset of problem drug use related to behavioural problems including for instance ADHD. Outpatient psychiatric care by trained psychiatrist or by specialist consultation centres is a first option. In more severe cases the national juvenile psychiatric service may provide in-patient care. More specifically targeting drug use the parentality service of JDH is aiming to assist drug dependant parents to take care of their children and to build up capacities helping them to deal with potential related problems.

A special CD-Rom has been developed by the Ministry of Education providing information on ADHD in school settings and to parents. Teachers are also trained to recognise ADHD symptoms and to react adequately.

- NATIONAL AND LOCAL MEDIA CAMPAIGNS

A special department of the CePT, called « Fro No » (i.e., *Check It*), offers since September 2007, a phoneline (+352 49 77 77 55, accessible every working day from 9:00 a.m. to 1:00 p.m.) as well as an online service (frono@cept.lu). The Fro No department can be contacted concerning all matters related to drugs, addictions and prevention work.

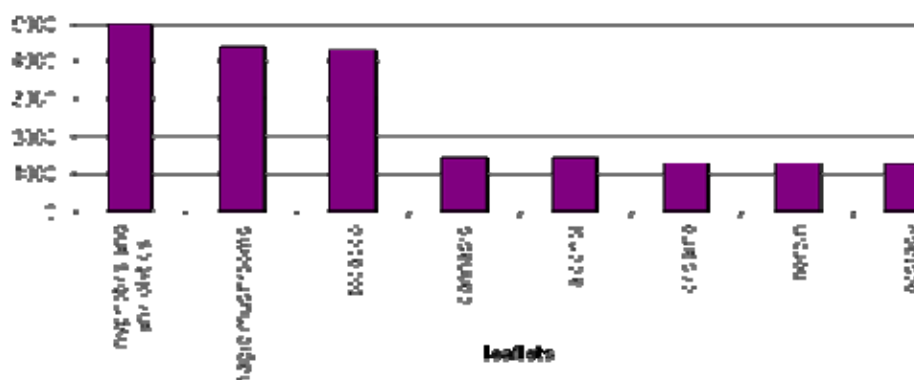
Fig. 3.4: Number of drug related questions coming in through the Fro No lines (telephone and email) in 2011



The service FRO NO registered 237 demands during the year 2011, compared to 209 contacts in 2010. The majority of the demands have been formulated by females (n=172). A great deal of the demands (n=149) originates from persons who looked for information related to their job. 53 demands originated from family members who were worried about the drug use of a third person, while 35 demands were linked to the proper drug consumption of the caller.

Furthermore, a series of leaflets about drugs (hypnotics and anxiolytics, magic mushrooms, tobacco, cannabis, alcohol, cocaine, heroin and ecstasy) informing the general public on the effects, legal status and risks were dispatched through counseling services, MDs (i.e. neurologists, psychiatrists) and secondary schools. These leaflets were available in French and German since 2009 and are edited since September 2011 also in English and Portuguese. The leaflets and a large collection of specialized literature on drugs, addictions and addiction prevention are available at the CePT's library.

Fig. 3.5: Number of dispatched leaflets on drugs and psychotropic medications in 2011



Additionally, the Fro No department edits two directories listing all the counseling and help services related to drugs and addictions (*Les services spécialisés dans le domaine des drogues et toxicomanies au Luxembourg*) and to childhood, youth and parents (*Les services de consultation pour enfants, jeunes et leurs parents*). All this information is also available through the CePT homepage cept.lu, which facilitates the access to even a broader public.

A flyer on solvent abuse was exclusively addressed to adults taking care of children and adolescents. A rapid assessment survey within different professional groups conducted by a newly created department of CePT (2009) (MeSH <http://cept.lu/fr/projets/342-mesh-un-nouveau-service-du-cept>) provided a better insight in this phenomenon in Luxembourg. 2,700 short questionnaires were sent out to MDs, teachers in primary schools, counselling services in secondary school and Police district offices. The return rate only reached 5 % and the non-published results are therefore to be considered with caution.

The survey report concluded: *'In contrast to the alarming scene depicted by the media, our results show very localised and isolated occurrences of inhalant abuse in the Grand Duchy of Luxembourg. Furthermore, very few reports concern primary school pupils. Well intentioned dissemination of information and hazard warnings can easily backfire and, instead of preventing inhalant abuse, turn into a publicity stunt for these products. On the basis of our results of this poll we refrained from launching a widespread information campaign and decided to publish instead a fact sheet for professionals working with children and teenagers.'*

In June 2009, CePT launched a new awareness raising campaign on what dependency actually is about. Without further explanation, yoyos with the inscription *'I make dependent'*, the phone number and the e-mail address of the national prevention centre were distributed next to the central railway station and in the pedestrian area of Luxembourg City. Additionally, newspaper articles with provocative questions on different consumption behaviours were published: Chocolate makes dependent? Cannabis makes dependent? Mobile phones make dependent? Alcohol makes dependent? Yoyos make dependent? The main objective of this campaign was to tackle interest of the general public, to motivate them to ask questions and to realise the versatility of the concept of addiction.

4. Problem Drug Use

Introduction

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 PDU 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), law enforcement agencies, national prisons and since 2009, psychiatric departments of general hospitals nationwide.

According to the latest serial and multi-methods prevalence study (Origer, 2012²⁸) performed on 2009 data, national prevalence of PDU situates at 2,470 persons (C.I. (95%): 2,089 to 3,199). A decreasing trend in PDU prevalence has been observed from 2003 onwards. A similar evolution occurred also for problem heroin use (2007: 1,900 PDU: 5,90/¹⁰⁰⁰). Although absolute prevalence of intravenous drug use (IDU) has slightly increased compared to the situation observed at the end of the 20th century, IDU prevalence rate in the national population aged 15 to 64 years shows an obvious decreasing trend over the referred period. Almost all indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies.

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDU. Low quality cocaine use in combination with heroin continues to be observed. Ecstasy-like substances and ATS are still popular even though seizure figures did suggest an inverse trend. Methamphetamine use in Luxembourg is very limited but ATS seizures have obviously increased in 2011. No evidence exists thus far on the presence of crack or desomorphine on the national market. The use of most 'new synthetic/emerging substances'²⁹ recently detected in other EU Member States has not been reported thus far with the exception of mephedrone and 4-MA seized in 2010 and methylone seized in 2012. Cannabis use in clients in contact with services (institutional contact indicator) have been on the increase for the last 2 consecutive years. Also, cannabis showing high THC concentrations (in 2008 max: +/- 22% - in 2009 max: +/- 40% - in 2011 max: +/-27%) is increasingly found on the national market.

²⁸ Origer A. Prevalence of Problem Drug Use and Injecting Drug Use in Luxembourg: A Longitudinal and Methodological Perspective. *Eur Addict Res.* 2012;**18**:288-296.

²⁹ 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.

- PREVALENCE AND INCIDENCE ESTIMATES OF PDU

NATIONAL PREVALENCE DATA

Data presented in the present chapter have been provided by serial drug prevalence study on PDU aged between 15 and 64 years performed on 1997, 1999, 2000, 2003, 2007 and 2009 data (Origer, 2001, 2012)³⁰. The latest study, published in 2012, was performed on 2009 data and allowed to assess the evolution of PDU prevalence over the last decade, by means of comparable methodologies and data sources.

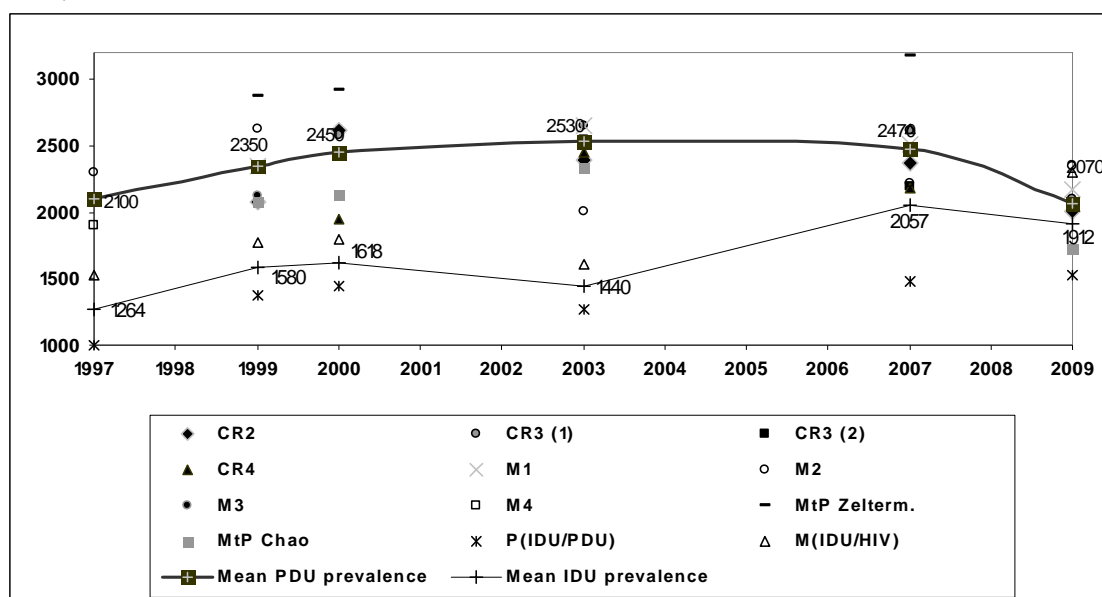
The research strategy relied on the methodological framework of the Luxembourgish Information System on Drugs and Drug Addiction (RELIS), set up in 1995 by the national focal point of the EMCDDA. RELIS stands for a nationwide multisectorial information network and was built upon the methodological assumption that data exclusively from drug treatment settings may not provide an accurate picture of problem drug use as these notably exclude out-of-treatment users whose drug use has generated conflicts with law enforcement only. Hence, to approach the genuine heterogeneity of the drug misuse phenomenon, RELIS routinely compiles data from all existing specialised in- and out-of treatment sources, in- and outpatient service sources, low threshold agencies, psychiatric departments of general hospitals, substitution treatment programme, prison, and law enforcement agencies. Also, RELIS relies on the 'institutional contact indicator', as an alternative to the more commonly used 'treatment demand indicator'. As such, it provides for the most comprehensive and reliable data on problem drug users indexed by national institutions.

In compliance with RELIS case definitions, the present study specifically aims at the prevalence estimation of problem use of illicitly acquired high risk drugs (HRC) in the national population aged 15 to 65 years.

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)

³⁰ Downloadable at <http://www.relis.lu>

Fig. 4.1: Absolute prevalence estimates of problem drug use and injecting drug use – Grand Duchy of Luxembourg (1997 – 2009)¹



¹CR2 / CR3 / CR4: capture-recapture methods on 2, 3 and 4 sources.

M1: multiplier method; police and drug-related deaths registers.

M2: multiplier method; number of drug law offenders / law enforcement contact rate of drug offenders.

M3: multiplier method; number of fatal overdose cases / drug related mortality rate.

M4: extrapolation from treatment data.

P(IDU/PDU): multiplier method; PDU estimates / IDU rates.

M(IDU/HIV): multiplier method; number of HIV infected IDU / rate of HIV infections among IDU.

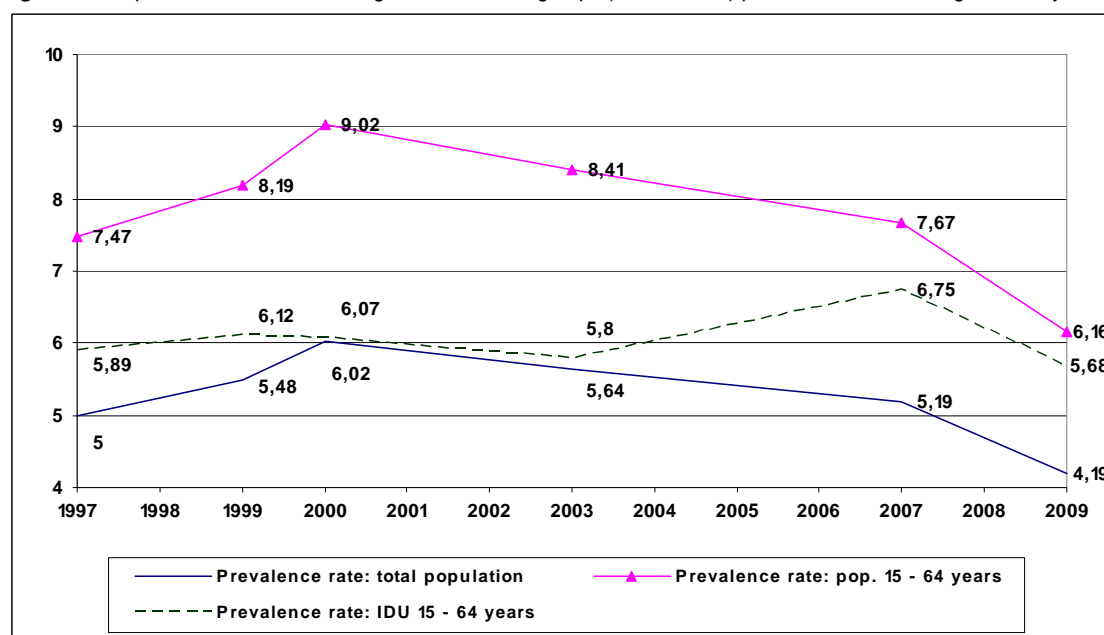
Source: Origer, 2012

Table 4.1: Absolute prevalence and prevalence rates according to selected sub-groups – Grand Duchy of Luxembourg (1997 – 2009)

	1997	1999	2000	2003	2007	2009
GENERAL POPULATION						
National population on 1 st January	418300	429200	435700	448300	476200	493500
National population aged between 15 and 64 years on 1 st January	281100	287100	291000	300800	322000	336015
PROBLEM DRUG USERS (PDU)						
PDU mean prevalence	2100	2350	2625	2530	2470	2070
Mean C.I. (95%)	1900-2300	1994 – 2758	2246 – 3295	2144 – 3293	1945 – 3343	1553 – 2623
Total mean prevalence rate - PDU	5 / ¹⁰⁰⁰	5.48 / ¹⁰⁰⁰	6.02 / ¹⁰⁰⁰	5.64 / ¹⁰⁰⁰	5.19 / ¹⁰⁰⁰	4.19 / ¹⁰⁰⁰
Total mean prevalence rate - PDU-age:15-64	7.47 / ¹⁰⁰⁰	8.19 / ¹⁰⁰⁰	9.02 / ¹⁰⁰⁰	8.41 / ¹⁰⁰⁰	7.67 / ¹⁰⁰⁰	6.16 / ¹⁰⁰⁰
INJECTING DRUG USERS (IDU)						
IDU mean prevalence	1656	1757	1765	1745	2173	1907
Estimate margins	1528 - 1785	1686 - 1828	1610 - 1920	1735 - 1755	1924 - 2422	1524 - 2301
Total mean prevalence rate - IDU	3.96 / ¹⁰⁰⁰	4.09 / ¹⁰⁰⁰	4.05 / ¹⁰⁰⁰	3.89 / ¹⁰⁰⁰	4.56 / ¹⁰⁰⁰	3.86 / ¹⁰⁰⁰
Total mean prevalence rate-IDU-age :15-64	5.89 / ¹⁰⁰⁰	6.12 / ¹⁰⁰⁰	6.07 / ¹⁰⁰⁰	5.80 / ¹⁰⁰⁰	6.75 / ¹⁰⁰⁰	5.68 / ¹⁰⁰⁰

Source: Origer, 2012

Fig. 4.2: PDU prevalence rates according to selected sub-groups (1997 – 2009) per 1,000 inhabitants aged 15-64 years



Source: Origer, 2012

The mid-point estimation performed on 2009 data provides an absolute prevalence of problem HRC drug users (PDU-HRC) of 2,070 persons (C.I. (95%): 1,553 to 2,623). In terms of prevalence rates estimates for the same age categories, 6.16 out of 1,000 habitants aged between 15 and 64 years show problem drug use.

According to serial data available for the period 1997 to 2009, absolute prevalence and prevalence rates of PDU-HRC have been showing an increasing trend until 2000. After a short stabilisation phase, a decreasing trend has been observed from 2003 onwards.

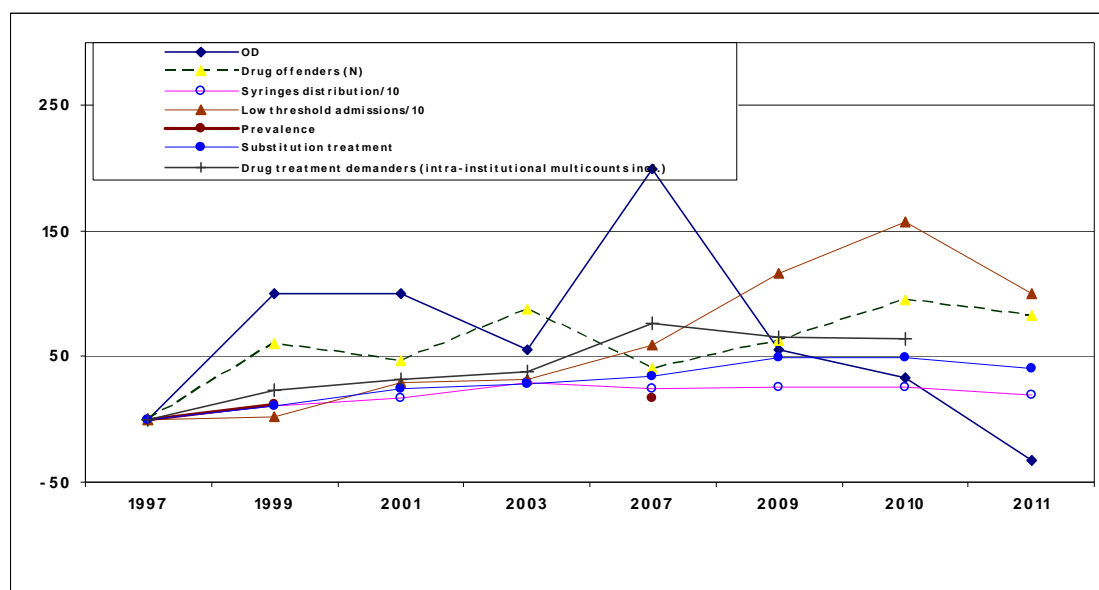
Absolute prevalence and prevalence rates of intravenous drug use (IDU) in the national population aged 15 to 64 years have been increasing between 1997 and 2007 to show first signs of decline in 2009.

The stabilization and subsequent decrease of national PDU prevalence occurred within the implementation phase of the first and second national drug action plans, having started in 1999. The observed trends are also confirmed by most of pertinent indirect indicators related to demand and supply reduction.

INDIRECT INDICATORS OF PDU PREVALENCE TRENDS

In order to validate PDU estimates and follow up prevalence trends between two successive prevalence studies a set of indirect indicators have been compiled and analysed.

Fig. 4.3: Prevalence estimates (problem use of high risk drugs) and evolution of selected indirect indicators



Source: Origer 2011

Indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies. Most of these indicators show declining trends 2009 onwards with the notable exception of low threshold drug agencies and the number of drug law offenders, which showed first downward figures in 2011.

As for the first contradictory indirect indicator (low threshold contacts), its inversed evolution until 2010 might be explained by the fact that since 2000 major efforts have been invested to increase capacities of low threshold offers and to facilitate access to harm reduction measures at the national level. This positive evolution, in terms of public health, had as a result that those users never in touch with drug agencies got into contact with the national care system. This said, the increasing use of low threshold offers resulted primarily in an increase of the visibility of previously hidden users and does not allow to conclude that the absolute prevalence of PDU user has increased since the beginning of the 21st century.

The number of drug law offenders has also stabilised between 1999 and 2009. The peak observed in 2010 might be partly explained by the fact that law enforcement agencies increased their presence and interventions notably in the vicinity of the supervised drug injection and low threshold facilities in order to fight increased drug deal activities. Upcoming years' trends of this particular indicator have to be interpreted in the light of these intervention strategies.

The number of fatal drug-related overdoses has peaked in 2007 but has been witnessing an obvious decrease since then. Likewise other EU Member States, the evolution of the referred indicator is known to show fairly important variations due to factors such as quality of available drugs, consume patterns, availability of harm reduction services, etc. A national expert group studied these variations 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 a significant increase of the PDU prevalence in general.

Moreover, although annual variations are observed, the trend line of recent years clearly shows a decrease in acute overdose death rates which is in concordance with national prevalence figures.

A new research project has been launched in 2009 on the consolidation and validation of PDU estimates by indirect indicators. A correlation matrix including 18 indirect trend indicators has been conceived to follow-up trends and strength of association between these indicators and between PDU/IDU prevalence figures and the latter. First results will be available in the course of 2013.

LOCAL OR REGIONAL 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.

CHARACTERISTICS OF INDEXED PDU

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 PDU person-contacts** indexed by national institutions in 2011 figured 5,209 (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).

More precisely, 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 2011 the same agencies have indexed 2,806 and 2,403 persons respectively.

Table 4.2: Main characteristics of PDU indexed by the national drug monitoring system, RELIS (valid percentage)

	2000	2004	2008	2009	2010	2011	TREND
Gender							
Male	77%	78%	77%	83%	80%	82%	↗
Female	23%	22%	23%	17%	20%	17%	↘
Nationality							
Natives	54%	54%	48%	48%	49%	42%	↘
Non-natives	46%	46%	52%	52%	51%	58%	↗
- of which							
Portuguese	51%	58%	38%	49%	39%	34%	↘
French	17%	11%	28%	16%	23%	24%	↗
Others	32%	31%	34%	35%	38%	42%	↗
Mean age							
Male	29Y4M	31Y2M	31Y8M	31Y9M	32Y4M	33Y4M	↗
Female	26Y10M	28Y4M	28Y5M	28Y3M	28Y9M	30Y1M	↗
Total	28Y9M	30Y6M	30Y11M	31Y2M	31Y7M	32Y8M	↗
Primary drug							
Opiates	84%	76%	72%	78%	80.6%	67.7%	↘
Cocaine	7%	16%	17%	9%	9.5%	18.1%	↗
Others	9%	8%	11%	13%	9.9%	14.2%	

Polydrug use	87%	93%	89%	74%	76 %	67%	↘
Primary opiates administration mode							
<i>Iv</i>	56%	55%	45%	62%	59%	58%	
<i>Non-iv</i>	44%	45%	55%	38%	41%	42%	
Infectious disease							
<i>HIV</i>	4.3%	4%	4%	5%	6%	4%	
<i>HCV</i>	40%	58%	65%	51%	52%	61%	↗

The male/female ratio of the PDU population is stable at 4:1. During the last ten years the proportion of indexed non-native PDU has shown strong variations but a clearly increasing tendency since 2003. The population of non-native drug users largely consists of Portuguese nationals, whose proportion is for the first time in recent years not consistently higher than the one observed in general population. The remarkable and continuous increase of PDU of French origin over the last 8 years has been interrupted in 2009, but continues in 2010 and 2011.

The mean age of indexed PDU evolved from 28 years and 4 months in 1995 to 32 years and 8 months in 2011. Mean age of male PDU has been increasing faster than for females. In general, the proportion of PDU aged more than 40 years has increased and the rate of users less than 30 years has been decreasing. In reference to years 2004 to 2011 a discontinuous decrease of minors in the overall PDU population has been observed in police data.

The mean age of native and non-native problem drug users tends to balance. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to “new” PDU.

Worth mentioning is also the overall, yet discontinuous increase of the average age of overdose victims during the last eleven years. PDU tend to contact drug treatment facilities at an earlier stage, which may be due to a more diversified offer currently available.

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDU. The proportion of **poly drug use** 67% has reached stabilisation after a record level in 2004 (93%) and is even decreasing in 2011. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2011. The ratio of intravenous opiates consume to the inhalation mode is 2:1 in 2011. Provision of ‘blowing paraphernalia’ (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns. The prevalence of the use of cocaine as primary drug shows an increasing trend since 2000, but tends to stabilise in 2009 and 2010. In 2011, however, the increasing trend of cocaine as primary drug is continued anew. Ecstasy-like substances and ATS use appears to be stable which however does not inform on prevalence in general population as RELIS data refer to PDU and not to the overall population of recreational drug users.

All indicators on cannabis use (problematic and recreational) have been showing a discontinuous decrease for several years. The number of persons in contact with the national specialised network for (preferential) cannabis use shows, however, a sensitive increase in 2011 (13%).

PDU show fairly stable infection rates of HIV (4%) between 2000 and 2011, whereas the HCV prevalence rate (61%) is high, and on the increase again after two years of decrease.

The **residential status** of indexed respondents has improved over the last years. In 1995, 31% of the users reported stable accommodation; currently the same proportion situates 70%. This improvement is partly due to various accommodation and housing offers for addicted people set up in the framework of the drug action plan.

The **unemployment rate** (67%) tends to plateau. However, the proportion of professionally active respondents reporting a stable job situation (e.g. long term contract) has sensibly decreased over the 4 last years, which should also be put in the context of the current economic crisis.

- DATA ON PDU 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 PDU from treatment settings knowing that the national drug monitoring system indexes both sources.

The ratio of male and female PDU is almost identical to PDU from treatment sources (82.7% male, 17.3% female offenders). Their mean age is 32 years, women being slightly younger than men (32.7 years for male and 28.7 years for female offenders).

40% of the offenders are natives. Likewise 2010, most non-natives were Portuguese citizens (32%) followed by French native offenders (24%).

73% (83.8%) are recidivists (had more than one drug-related police record during their lifetime). 27.3% were arrested for dealing drugs, 29.1% are charged with illegal drug possession and 43.6% for other crimes related to drugs. Drug-law offenders (who are also problematic drug users) are mostly arrested for heroin and cocaine. A vast majority are reported polydrug users.

5. Drug-related treatment: treatment demand and treatment availability

Introduction

Drug treatment is the 'use of specific medical and/or psychosocial techniques with the goal of reducing or abstaining from illegal drug use and thereby improving the general health of the client'.³¹

Specialised drug treatment infrastructures are relying on state financing and on ministerial control and quality assurance 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:

³¹ SOURCE: Classification of drug treatment in EU member states and Norway, Expert meeting, 8-9 February 2002

- **Outpatient treatment:** the patient receives drug treatment without staying overnight, pharmaceutically assisted or not³²;
- **Inpatient treatment:** the patient is staying overnight, pharmaceutically assisted or not (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;

Drug treatment is monitored and quality assurance occurs via a series of mechanisms that are described under the treatment system section. The external evaluation of the 2005-2009 national drugs action plan recommends to draw an inventory of current quality assurance mechanisms regarding drug treatment. Outcomes of this inventory, will allow to further harmonise existing routines.

- DRUG TREATMENT STRATEGIES AND POLICY

In the mid-seventies the cooperation between State and NGOs working in the social field has progressively gained structure. The first (financing) convention between the Ministry of Family and a series of NGOs, signed in 1975, was the starting point of what is known today as the “Conventionned sector”. Over the years the collaboration schemes between State and NGOs evolved and were extended to the Public Health sector. In 1998 the so-called ASFT law³³ entered in force, regulating the relationship between State and private organisations working in the social, family and therapeutic fields.

Treatment needs’ assessment as well as quality control largely rely on the ASFT legal framework and the existing network of conventionned service providers who have to meet a series of quality standards and be granted a special accreditation from the Ministry of Health. The elaboration of the demand reduction section of the national drugs strategies and action plans builds upon the expertise and involvement of the referred network. A detailed description of collaboration and control mechanisms in place is provided below.

The first specialised drug agency (JDH) was created in 1986 and addressed both drug addiction and Youth. Originally services developed bottom-up and were seeking financial support of the State. Preliminary work done in the framework of the first drug action plan 1999-2004 allowed to better assess national needs and to initiate and develop interagency coordination mechanisms. To date, treatment agencies are specialised whether in polydrug use including illegal drugs, in alcohol abuse, or gambling, etc. As far as illegal drugs are concerned, drug care providers address the whole range of substances meaning that no specialised offers exist according to given type of substance or problems related to it. Currently there are signs that the national drug treatment strategies are evolving towards a more holistic concept of addiction treatment (including illegal substances related addictions and others).

As far as national expenditures for drug treatment provision are concerned please refer to chapter 1.

³² ‘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’.

³³ Loi du 8 septembre 1998 réglant les relations entre l'Etat et les organismes œuvrant dans les domaines social, familial et thérapeutique (entry in force: 24/09/1998)

TREATMENT SYSTEMS

ORGANISATION AND QUALITY ASSURANCE

All specialised drug treatment services are relying on governmental support and control. Specialised agencies need an accreditation to sign a **convention** with the ministry of Health that guarantees their annual funding. Outpatient drug treatment is provided free of charge by specialised agencies. Inpatient treatment and detoxification is covered by health insurance schemes. As far as substitution treatment is concerned, health insurance takes in charge medical interventions and counselling and State covers pharmaceutical costs and pharmacy fees.

NGOs involved in drug treatment fall under the obligation of the above referred to 'ASFT' law (8/09/98) and the subsequent grand ducal decree of 10 December 1998³⁴, 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 'coordination 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 coordination platform. All referred institutions work in close collaboration and have to be viewed as an interdependent therapeutic chain. A series of formal collaboration agreements have been signed in 2008 and 2009 between various agencies in order to insure rational use of resources and through-care. The 2010-2014 national drugs action plan foresees to further develop this synergy by creating a national network of unique reference persons for each drug treatment demander entering the specialised care system.

The **governmental quality standard certification**, as foreseen by the law 'ASFT' of 8 October 1998, represents the main instrument of a standardised quality control of drug treatment offers. General guidelines on setting requirements and human resources/clients keys are set by a grand-ducal decree of 10 December 1998 regarding the accreditation of services from the medical, social and therapeutic field. Funding is, however, not a direct function of mandatory evaluation or outputs requirements. The quality standard certification commits respective NGOs to undertake necessary evaluation measures of their activities by means, however, they deem adequate. Drug treatment agencies have developed proper **evaluation strategies** mostly in collaboration with external evaluators. Recent examples are the evaluation of current offers in the field of socio-professional integration, which future development has been promoted by the national drugs action plan, the implementation of a computer based evaluation procedure by the national substitution programme and prevention interventions in schools by CePT. The external evaluation of the drugs action plan also significantly contributes to assess the functioning and the gaps of the national treatment network.

An external assessment of quality management mechanisms run by specialised NGOs has been foreseen by the national drug action plan and has become available in 2011. Outcomes have shown that current quality assurance routines implemented within involved drug agencies are highly diversified and differ in terms of coverage and complexity ranging from internal activity assessment procedures to EFQM certifications for instance. These outcomes are highly valuable for future improvement of quality assurance and documentation routines of drug related care services.

³⁴ 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)

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 and external evaluation of the national drug action plan 2005-2009, 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 2011. **Intra-institutional multiple counts** are excluded meaning that all treatment demanders indexed by a given agency are 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 provided in respective sub-chapters.

AVAILABILITY AND DIVERSIFICATION OF TREATMENT

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 July 2005, the first 'consumption room' has been opened in Luxembourg City. It has been integrated in the 'TOX-IN centre' providing day care, night shelter and low threshold services to drug addicts.

It should be stressed that no national drug treatment services exclusively targets a given type of substance use and its correlates. Currently national services provide care for persons presenting problems related to heroin, cocaine, amphetamine, cannabis, etc. and polydrug use.

Map 5.1: Geographical coverage of specialised drug agencies in the Grand Duchy of Luxembourg (status 2011)

- JDH : Counselling, substitution, low threshold and after care
- TOX-IN (CND5) : Low threshold
- TOX-IN (CND5): Night shelter, Injection room
- ⊕ SOLIDARITE JEUNES : Youth counselling
- ⊗ Quai 57 (Arcus asbl) : Counselling and referral
- CHNP : Treatment and referral
- ⦶ CTM : Residential therapy, reintegration measures
- ⦶ CTM : Aftercare, supervised housing
- General hospitals providing detoxification



The following treatment typology is applied:

Outpatient: services and offers for adults

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. Quai57 (Arcus asbl) 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: services and offers for minors

Specialised drug care agencies for minors exist in the centre and since 2007 in the north of the country. Although drug counselling agencies accept underage treatment demanders, part of the latter are referred to a specialised service established in the centre of the country (Solidarité Jeunes – Jongenheem asbl).

Outpatient: substitution treatment

Substitution treatment is currently defined as a medical assisted treatment with opioids' agonists and with antagonists (and antagonistic agonists). The objectives of substitution and maintenance treatment are manifold. They range from no-digressive dose, outpatient 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 2002³⁵ 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

³⁵ The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>

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 and multidisciplinary substitution treatment programme** (JDH - mainly liquid oral methadone provided by specialised agencies) 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 found on the national black market. Given that the centralised substitution treatment register did not yet reach full prescriber coverage, multiple prescriptions (a given patient visits more than one prescriber) may not be fully avoided. In that respect, a **central substitution register** is about to be implemented jointly by the 'Surveillance Commission on Substitution Treatment'³⁶, the national drug coordinator and involved specialised treatment centres. At the moment of writing, a test phase is running in order to find the best way to make the implementation of the substitution register and other surveillance mechanisms compatible with daily medical practice. The substitution treatment surveillance commission has been reformed by the Minister of Health and since August 2010 it is chaired by the National Drug Coordinator.

Outpatient: low threshold 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. The further development of harm reduction services in the North is part of the national drug action plan. In this context a needs assessment on low threshold offers has been assessed, state budgetary means increased and adapted responses are currently being implemented.

³⁶ 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.

Inpatient: detoxification 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 'Centre Hospitalier 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, detoxified patients are referred to more psychotherapeutic oriented institutions.

Detoxification treatment is provided by psychiatric units within five general hospitals:

Centre Hospitalier du Nord – Ettelbrück (North)

Centre Hospitalier Emile Mayrisch – HVEA (South)

Centre Hospitalier de Luxembourg – CHL (Centre)

Hôpital Ste. Thérèse (Centre)

Centre Hospitalier du Kirchberg (Centre)

Inpatient: services and offers for adults

The national drug action plan foresees the set-up of an in-patient stabilisation unit. This unit is meant for detoxified patients in transition to more psychotherapeutic care. A working group on drug treatment offers concluded that patients admitted for drug detoxification often stay longer than necessary in hospitals providing this type of treatment. The stabilisation unit should contribute to discharge hospitals and liberate capacities for detoxification demanders, who currently might have to enrol on waiting lists. By the end of 2009 a pilot phase has been started in the CHNP in order to gather first experience.

The national residential therapeutic 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 also offers 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 2000-2004** 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 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 detoxified 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.

The 2010 – 2014 national drugs action plan foresees the creation of a Stabilisation Unit (SU) within the CHNP. The SU should have a capacity of 12 beds and a limited duration of stay (e.g. 3 weeks). The objective is to take in charge drug users, detoxified in hospital settings to further stabilise their health and mental state as well as to prepare their release and re-integration process. The referred unit has become operational in the first semester of 2012.

Inpatient: services and offers for minors

A specialised residential centre for problematic youngsters 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 in its planning phase. The referred case management programme will contribute to fill current gaps in the care system for minors.

- CHARACTERISTICS OF TREATED CLIENTS AND TRENDS OF CLIENTS IN TREATMENT

Table 5.1 summarises drug related institutional contacts of PDU. 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 PDU but they allow following up the increase or the decrease of the latter.

Table 5.1: Drug related institutional contacts (Inter-institutional multiple counting included)

Source: RELIS 2012 / CNS

DEMAND REDUCTION: SPECIALISED DRUG TREATMENT													
SETTING	NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)												
	2000	2002	2004	2006	2008	2009	2010	2011	2011	2011	2010	2009	2011
OUTPATIENT - Drug Free	636	828	916	928	1,162	1,020	980	1,175					
- Substitution	1,002	1,040	1,065	1,044	1,050	1,212	1,248	1,228					
	NUMBER OF EPISODES (Specialised and hospital)												
	NUMBER OF CONTACTS (Low threshold)												
	2000	2002	2004	2006	2008	2009	2010	2011	2011	2011	2010	2009	2011
INPATIENT - Specialised	43	57	53	44	129	156	130	159					153
- Hospital care	/	/	617	637	656	615	527	483					250
LOW THRESHOLD AGENCIES	13,083	29,536	39,526	55,808	78,415	110,674	140,093	123,465					
SUB TOTAL A: Number of drug treatment demanders (Multiple counts not excluded) (Multiple counts excluded)													
	2,112 637	2,450 n.a.	2,639 n.a.	2,639 n.a.	2,733 n.a.	2,675 n.a.	2,653 n.a.	2,806 n.a.					
SUPPLY REDUCTION: LAW ENFORCEMENT INSTITUTIONS													
National prisons	161	101	92	243	332	224	232	193					
Police - Judicial Police – Customs	1,758	2,217	1,808	1,573	1,487	1,963	2,530	2,210					
SUB TOTAL B: Number of drug law offenders (Multiple counts not excluded)	1,919	2,318	1,900	1,816	1,819	2,187	2,762	2,403					
TOTAL NUMBER OF PERSONS SHOWING DRUG RELATED INSTITUTIONAL CONTACTS (Multiple counts not excluded)	4,031	4,768	4,539	4,455	4,542	4,862	5,415	5,209					

The present section is divided in a general description of the drug treatment population and a more in-depth analysis of clients' characteristics and observed trends. Both parts are based on RELIS data and on in-house statistics of specialised drug treatment agencies at the national level.

Overall the number of persons showing drug related contacts with national DR or SR agencies has reached 5,209 in 2011. Until 2004 a sensible increase in drug treatment demands has been observed followed by an overall stabilisation confirmed by 2010 data, whereas contacts with law enforcement agencies have been increasing till 2010 (slight decrease in 2011). The number of substitution treatment demands begun to plateau around 2002 and showed a tangible increase in 2009 to stabilise anew between 2010 and 2011. The number of adult out- and inpatient clients is highest since reported. The most remarkable increases between 2008 and 2010 have been observed in substitution treatment demanders and in the number of contacts in low threshold facilities (2010: 140,093 contacts). In 2011, however, the number OST treatment demanders has showed a stable trend and low threshold contacts even declined. 7.5% (4.7%) of respondents are first treatment demanders, all treatment centres included. As far as **first treatment** demanders are concerned, 22.2 % are female for 77.8% of males.

Of clients in drug treatment (all treatments and all types of unit), 80.4 (78.3%) are male for 19.6 (21.7%) females. The mean age of treatment demanders has significantly increased during the last ten years (1997: 28 years/ 2011: 32.4 years) and this mainly because of an observed increase in average male age (1997: 28Y2M/ 2011: 32Y6M). The mean age of the female clients is slightly lower (2010: 31Y5M). Respectively 63.3 (58.3) % of clients in treatment are natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French, Belgian and German, Italian citizens.

Regarding the educational level of the clients in treatment, 75% have completed primary or complementary school, 22% have completed secondary school and 3% obtained a higher degree. 24.6% of respondents reported stable employment (important decrease - 1997: 65%) against 67% who are inactive or unemployed. Furthermore, 2.9% are students or engaged in a training contract. 41.2% (27.8%) of indexed treatment demanders had experienced one or more overdoses. As far as the exchange of syringes is concerned, 32.9% (25.2%) reported that they never shared syringes during their lifetime (51.7% (39.1%) during the last month. IDU combined to polydrug use is the most observed consume pattern in drug treatment demanders.

Below is presented a more detailed analysis of treatment demands and trends according to type of treatment:

Outpatient: services and offers for adults

RELEVANT TREND: Increase of male treatment demanders (74.5% male, 25.5% female). Stabilisation of the proportion of clients aged 30 and more (2011: 63% / 2008: 61%). A current trend is also to be seen in the increasing number of young mothers or couples with their child/children seeking out- and inpatient treatment.

After several years of stability, national outpatient drug counselling centres have been showing decreasing admission rates from 2008 onwards and decreasing first treatment rates intra and inter-agency wide. 2011 has showed first signs of increase, to be confirmed by 2012 data. Gender distribution showed an overall increase of male clients over the last 10 years. Age distributions are varying according to the geographical situation of treatment centres. All in all, however, the proportion of treatment demanders aged 30 years and more has sensibly increased during recent years (2011: 63% / 2006: 57%). Treatment demands from underage clients tend to decrease until 2007 and stabilised since then, 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 (2011:60% / 2009:61% / 2008: 53% / 2007: 57% / 2006: 51% / 1997: 72%). Cannabis-related demands have shown a clear upward trend since 2009. The prevalence of cocaine use-related treatment demands is stable, however, bearing in mind that the exact prevalence is difficult to assess as in most PDU concomitant use of heroine is observed.

Outpatient: services and offers for minors

RELEVANT TREND: Stabilisation of the number of episodes partly due to the development of new treatment capacities for underage users and/or offenders.

An increasing majority (74.5%) of clients are male. Cannabis use is the main reason of treatment demands (74%) witnessing a currently stable trend. However, the use/abuse of licit drugs and polydrug use is increasingly reported as reason of treatment. An increasing proportion of youngsters presenting psychiatric symptoms and/or socially deviant behaviour in addition to drug abuse are reported by specialised field agencies.

Outpatient: substitution treatment

RELEVANT TRENDS: Between 2005 and 2009 decrease of number of patients in structured JDH substitution programme and increase in substitution treatment prescribed by licensed MDs - stabilisation of gender ratio (3 males/ 1 female) - Increase of substitution treatment demanders being aged between 30 and 34 years.

The number of patients admitted to the national multidisciplinary substitution programme (JDH) has been sensibly decreasing from 2005 to 2009, 83 patients in 2011, which is supposedly due to the increasing access and admissions to lower threshold substitution treatment provided by independent yet specially licensed MDs. 29% (35%) of clients started substitution treatment in 2011. The proportion of female substitution treatment demanders (+/- 30% stable) is higher than the proportion of female PDU in the overall drug treatment population. 22% (18%) of the clients in substitution treatment are aged under 30, 41% (48%) are between 30 and 39, while 37% (34%) are over 40 years old. The **mean age** of clients has significantly increased over the last 10 years (35.7 years), which is consistent to the overall aging trend of PDU. The proportion of **native substitution treatment demanders has increased 50% (43%)**. Polydrug use is the most observed consume pattern in substitution treatment demanders.

The number of patients who did receive substitution treatment by prescription from independent and licensed practitioners has known a steep increase between 2008 and 2009 [(1,246 patients in 2010 and 1,212 patients in 2009 multiple counts excluded (2008: 961)] In 2011 a stabilisation in the number of OST demanders seems to emerge (1,145).

The National Health Found (CNS) annually provides the number of patients receiving referred substitution drugs on prescription as well as the number of prescribing MDs. One observes a sound increase of substitution demands addressed to accredited liberal MDs and an overall decrease of the number of patients choosing the multidisciplinary JDH programme, more demanding in terms of treatment constraints. Over 95% of prescriptions delivered in the framework of substitution treatment refer to methadone followed by buprenorphine.

Table 5.2: Outpatient prescription of substitution drugs by the national network of licensed MDs /(1999-2011)

YEAR	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of indexed patients (double counting controlled)	745	844	849	820	913	/	970	939	979	961	1,212	1,246	1,145
Number of prescribing GPs (double counting controlled)	125	145	147	157	154	158	163	121	122	126	173	188	175

Source : CNS 2012

Table 5.3: Age distribution (%) of patients substituted by the national network of licensed MDs (2008-2011)

AGE CATEGORIES	2008	2009	2010	2011
15-19 years	2	1	0.5	0.1
20-24 years	9	9	7	7
25-29 years	17	16	15	13
30-34 years	19	20	20	19.3
35-39 years	19	18	20	20.4
40-44 years	18	18	17	17
45-49 years	9	11	12	14.7
50-54 years	5	5	6	6.4
55-59 years	1	1	1.5	2
60-64 years	1	1	1	0.1

Source: CNS 2011 – data reformatted by NFP

The proportion of patients aged less than 30 years has been decreasing and the proportion of patients aged 45 and more increasing between 2008 and 2011.

Outpatient: low threshold services and offers

RELEVANT TRENDS: The number of contacts indexed by low threshold agencies has increased dramatically between 2006 and 2010 (2010: 140,093 / 2005: 47,739), and showed first signs of decrease in 2011. 250,000 to 300,000 sterile syringes are distributed and recollected yearly by the same agencies. The proportion of new clients within low threshold settings is on the decrease. Approximately 47% of clients are aged between 25 and 34 years, 31% of clients between 35 and 44, and 15% between 18 and 24.

Inpatient: hospital care (detoxification treatment)

RELEVANT TRENDS: Drug detoxification units throughout the country have been showing a continuous increase regarding number of patients until 2006 (484) and a constant decrease to 250 patients in 2011. The number of treatment episodes, having remained fairly stable between 2004 (617) and 2009 (615), witnessed also an obvious decrease to 483 episodes in 2011. Gender distribution has remained fairly unchanged between 2002 and 2011. Multiple drug use, including heroin, is the main reason for detoxification demands.

Inpatient: services and offers for adults

RELEVANT TRENDS: The number of inpatient treatment demanders (detoxification treatments excluded) has been showing a fairly stable trend over the last 10 years. The proportion of first treatment demands sets around 7%.

Heroin as preferential substance is reported by 66% (76%) (60% (38%) i.v./ 40% (62%) non-i.v.) of drug treatment (all treatment) demanders monitored by the national drug surveillance system RELIS whereas cocaine is only reported by 19.5% (14%) (rising trend) as first substance of use 44% (18%) i.v./ 56% (45%) non-i.v.) The average age at the first use of the preferred drug figures around 18.7 (20.6), whereas the mean age of the first i.v. consumption is 21.3 (19.9). 74% (72%) of the clients consume drugs more than once a day.

In 2009, a weak decrease in preference for intravenous heroin use (1997: 60%, 2009: 49%) was observed compared to 2008 (52%). This trend has been confirmed in 2010 (38%) but shows a slight increase in 2011 (40%). The heroin inhalation mode (2011: 20% 2010: 62%, 2009: 20%) has becoming more prevalent compared to 2008 (14%). Polydrug use is the most observed consume pattern (76%). The i.v. heroin sub-population shows the highest mean age (31.5) of all treatment groups. 8% (5%) of the latter are first treatment demanders compared to 9% (8%) 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 (2011: 19.5% 2010: 14%). Mean age of preferential cocaine using treatment demanders in 2011 was 29.8 (2010 was 31.82). 22% (20% in 2010, 21% in

2009) of first treatment demanders are primary cocaine users. Cocaine prevalence as secondary drug has decreased from 43% in 2004 to 34% in 2009. In 2010 however, a slight increase is observed: 40% of inpatient clients reported Cocaine as secondary drug, in 2011, still 34% report Cocaine as secondary drug (most reported secondary drug). Crack has been reported only once as secondary or occasional drug.

The percentage of treatment demands related to cannabis use are rising 12.5% in 2011 (5% in 2010) following a peak in 2009 (11%). 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.

6. Health correlates and consequences

Introduction

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 MDs. 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 6.6.

Even though DRD based data is provided to the EMCDDA, national figures on drug induced deaths published in the national annual drugs report are, for reasons explained above, based on the RSPJ whose case definition is compatible with the EMCDDA definition: [...] *deaths that are caused directly by the consumption of drugs of abuse. These deaths occur generally shortly after the consumption of the substance(s).* (EMCDDA)

Infectious diseases, including HIV and viral hepatitis have to be reported (notification procedure) when diagnosed to the Directorate of Health (Ministry of Health) that compiles data and is in charge of nation-wide epidemiological follow up. These data do however not allow to breakdown

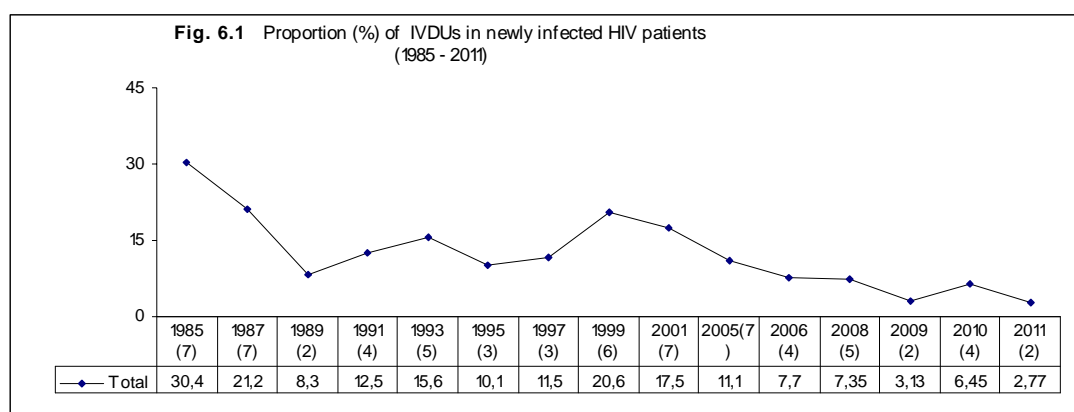
infection prevalence according to PDU status. The national drug monitoring system RELIS therefore allows to gather self-reported data on infectious diseases in PDU. Furthermore specific diagnosed based studies provide complementary information. The report includes data from the latest study on infectious diseases in PDU (Origer & Removille, 2007) based on serological test results to assess current prevalence rates and apply vaccination schemes when medically indicated.

- 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 2011, 1,083 HIV infected persons have been registered at the national level; 123 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 11.36% 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 2011 (2.77%). The lowest proportion of IDU transmission mode ever recorded was observed in 2011.



Source : Laboratoire de Retrovirologie – CRP-Santé. 2011 (data formatted by NFP)

The Origer and Removille study (2007)³⁷ assessed the national HIV, HCV, HAV and HBV in the population of problematic users of illicitly acquired drugs prevalence via serological test results. 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. (Reported in ST 9)

Main results are the following:

³⁷ Downloadable at: <http://www.relis.lu>

Table 6.1: 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 PDU 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)

* Two respondents with valid blood test serology were HBsAg positive only

† Number 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 PDU were not protected against hepatitis A.

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2011, (N=218) 87% of RELIS indexed PDU reported a HIV test during the last 12 months. The testing rates of female PDU were slightly lower than those of male PDU.

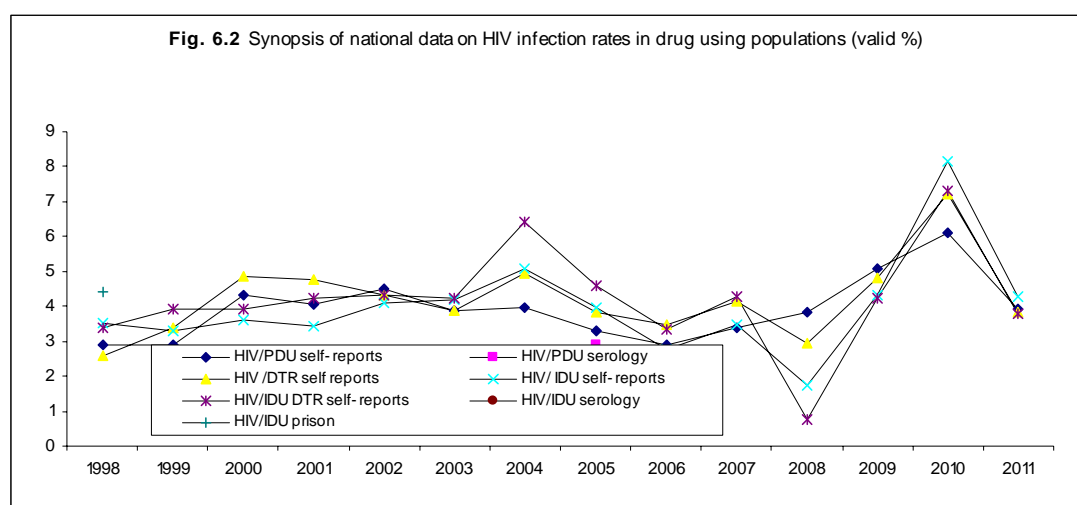


Table 6.2: Synopsis of national data on **HIV** infection rate in drug using populations (valid %)

YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
HIV rate in problem drug users (RELIS self-report)	2.9	2.9	4.3	4.07	4.49	3.88	3.98	3.31	2.9	3.39	3.82	5.08	6.09	3.94
HIV rate in problem drug users (serology-based) (Origer & Removille, 2007)								2.90	/	/	/	/	/	/
HIV rate in drug treatment demanders (RELIS self-report)	2.6	3.4	4.87	4.78	4.32	3.88	4.93	3.84	3.49	4.13	2.96	4.83	7.22	3.85
HIV rate in current IDU (RELIS self-rep.)	3.5	3.3	3.6	3.41	4.08	4.17	5.10	3.96	2.76	3.48	1.75	4.32	8.14	4.26
HIV rate in current IDU treatment demanders (RELIS self-report)	3.4	3.9	3.9	4.24	4.32	4.24	6.41	4.59	3.33	4.27	0.76	4.24	7.29	3.77
HIV rate in life-time IDU (serology-based) (Origer & Removille, 2007)								2.50	/	/	/	/	/	/
HIV rate in current IDU prisoners (Schlink 1998)	4.4	/	/	/	/	/	/	/	/	/	/	/	/	/

Source: RELIS 2011**Table 6.3:** Synopsis of national data on **AIDS** rate in drug using populations (valid %)

YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
AIDS rate in problem drug users (RELIS)	2.5	1.25	1.35	2.03	1.72	1.71	2.13	1.81	1.19	1.86	0.87	1.33	3.05	1.95
AIDS rate in drug treatment demanders	/	1.66	1.76	2.43	1.60	2.04	2.69	2.37	1.65	2.64	0.92	1.96	3.96	2.05

Source: RELIS 2011

HIV rates in current PDU have been varying over the last ten years although in quite narrow margins figuring 3 to 5%. In 2010, however, based on self-reported data from RELIS, the HIV rate increased for all categories figuring 6 to 8%. In 2011 however, HIV rates stabilised again around 3 to 5%.

During the last five years, the HCV infection rate decreased for all PDU and for drug treatment demanders, but the same rate shows variations for IDUs and even increased in 2010 for this category. In 2011, HCV infection rates show an important increase for all categories.

Table 6.4: Synopsis of national data on **HCV** infection rate in drug using populations (valid %)

YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Self-reported HCV rate in drug users (RELIS)	25	32	46	50	49	59.92	64.55	64.94	64.95	64.06	63.39	50.55	49.61	61.45
HCV rate in PDU (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	61.11	53.79	50.47	62.31
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	65.48	58.94	62.63	74.81
HBV rate in ever-injectors (Origer & Removille)							81							

Source: RELIS 2011 (Origer & Removille 2007)

Summarily, HCV prevalence in PDU appears to have reached a plateau at a high level in 2006-07, showing, however a sensible decrease in 2009 and 2010, to increase again in 2011. HIV infection rates show an important decrease for all the categories referred to 2010 data.

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 PDU (see Origer, Removille, 2007).

The DIMPS project (Mobile intervention facility for sexual health) described under chapter 7 aims to access difficult to reach sub-populations and provide prevention counselling and infectious disease testing on site to various populations. Based on experience gathered through the new *DIMPS* project, discussions are currently held whether to extend the *DIMPS* offer to free HBV/HAV vaccination (where appropriate) for clients of specialised drug agencies. This enlarged approach could also allow to collect serological based data on infectious diseases in PDU in a routine and cost effective way.

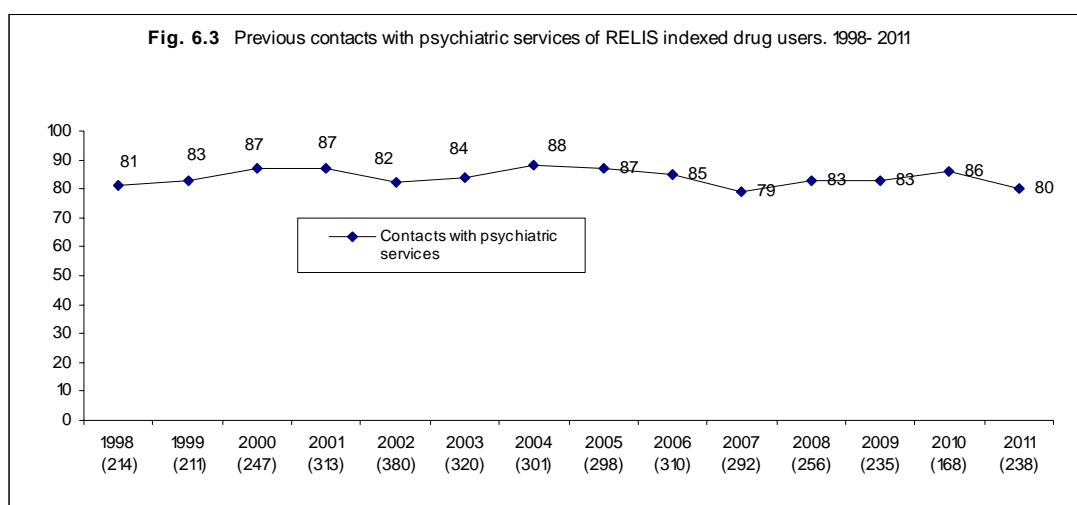
- OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

Psychiatric co-morbidity (Dual diagnosis)

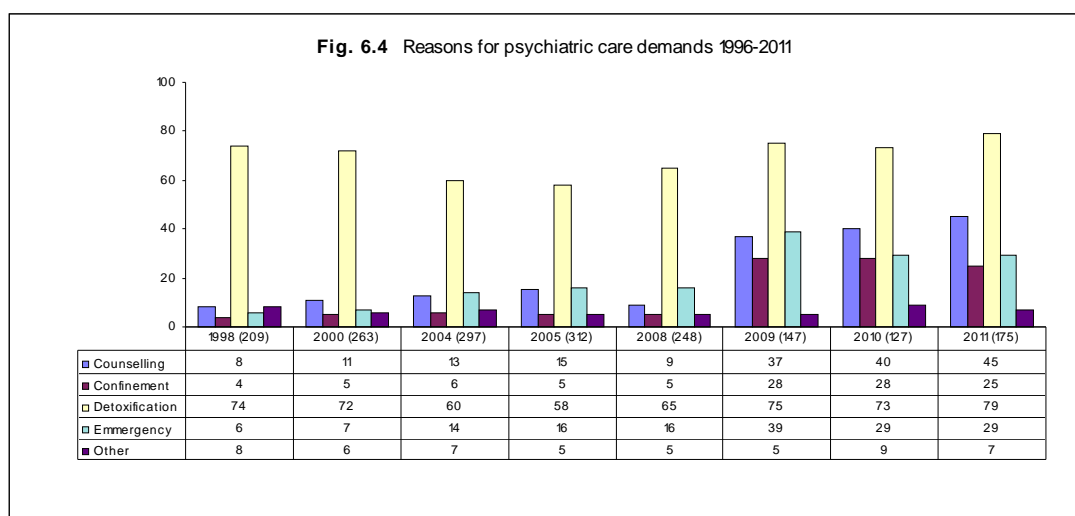
To date any genuine study on co-morbidity patterns in PDU has been performed at the national level. Data presented in the present chapter have been provided by specialised drug agencies and the RELIS drug monitoring system and thus reflect experiences and trends as observed during recent years.

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 borderline behavioural aspects as for instance rapidly changing mood and auto-destructive tendencies.

According to annual data provided by the national drug monitoring system RELIS the following picture can be drawn:



SOURCE: RELIS 2011



SOURCE: RELIS 2011

At the national level, most of detoxification treatments are provided by psychiatric departments of general hospitals.

Data from 1996 to 2011 reveal a fluctuating but a fairly stable long term proportion of PDU showing a psychiatric history.

There seems to be no significant differences of psychiatric profiles in clients according to the type of institutional settings. Multiple drug use is observed in almost all DD patients.

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. 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. To date, no care facilities specialised in drug addiction co-morbidity exist 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. Agreements between the latter administration and a series of specialised care agencies abroad have been made. If the referral demand is approved, related costs are reimbursed by Social Security.

As far as treatment of DD patients in prison is 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.

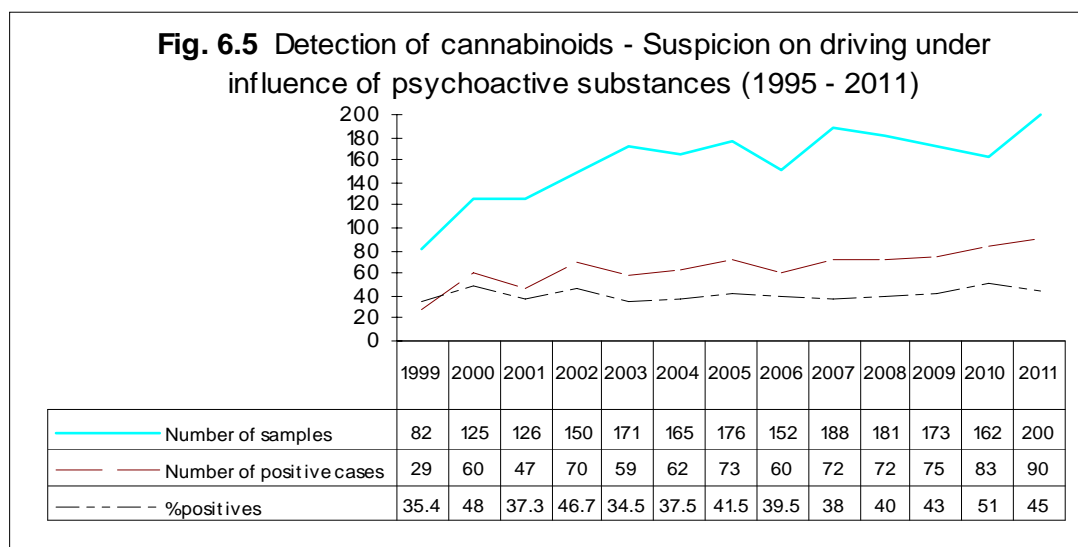
In line with the recommendations of the previously referred to expert group 'Therapeutic chain' discussions held in the framework of the new drugs action plan 2010-2014 currently address the idea to create small supervised housing facilities where care is provided to DD patients on a case management basis.

Somatic co-morbidity

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDU except for HCV prevalence. In 2011, 80 (81) per cent of problem drug users reported a self-perceived satisfying general health condition against 53% in 1997. 58% (56%) report no non-fatal overdose(s) during lifetime which represents a small increase compared with the previous year.

Drugs and driving

Figure 6.4 provides data on cannabis exposure of persons suspected to drive under influence of psychoactive substances from 1995 to 2011. Around 45% of referred persons were tested positive on cannabinoids.



Pregnancies and children born to drug users

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

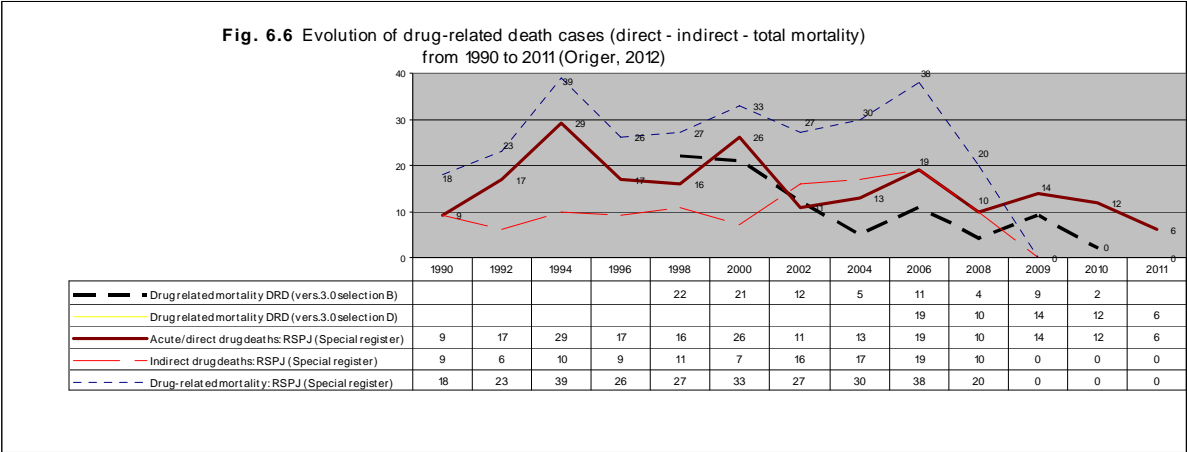
- DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS

Direct Overdoses and indirect drug related deaths (see ST5 and 6)

Methodological information and Drug-related Deaths (DRD) data collection and processing routines can be found in the introduction of the present chapter and in annex I under 'Databases and information systems'.

As can be seen in figure 6.6 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. Cases not filtered by selection B mainly include combined X49 codes, followed by Y34 and T65.9 codes. A very high to perfect agreement is observed between the RSPJ register and selection D (DRD v.3.0).

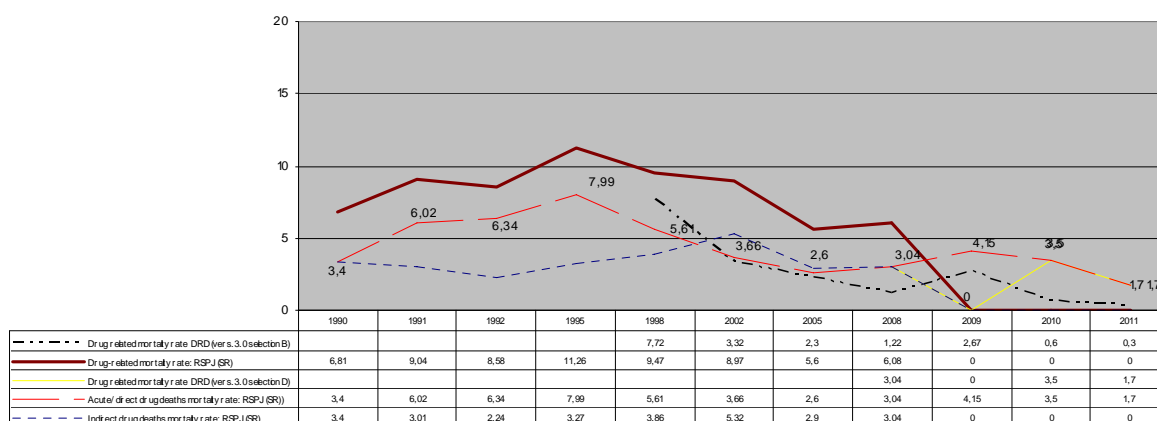
The number of **fatal acute overdoses** indexed at the national level has shown an overall discontinuous decrease since the beginning of the 21st century. In 2000, 26 acute drug deaths were registered whereas 6 cases were reported in 2011. Indirect drug-related deaths have known broad variations in number during the same period (2009, 2010 and 2011 data not available).



Confronted to most recent national prevalence figures on problem drug users referring to data of 2007 ($N = 2.470$), (Origer, 2012), **overdose rate in PDU** situates at 0.29 % cases / PDU (1.1 % in 2000). The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants³⁸ in 2000. In 2011 overdose rates of 1.17 and 1.66 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed. International comparison should be considered with caution since methodologies used to determining prevalence of DRD deaths are not necessary comparable throughout EU as shows for instance the structural underestimation of the number of acute drug death based on the EMCDDA DRD v.3 standard.

³⁸ All age groups

Fig. 6.7 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2011 (Origer 2012)



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 1,000 overdose victims could be assisted and reanimated in this same facility, the life-saving effectiveness of such an offer is proven.

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

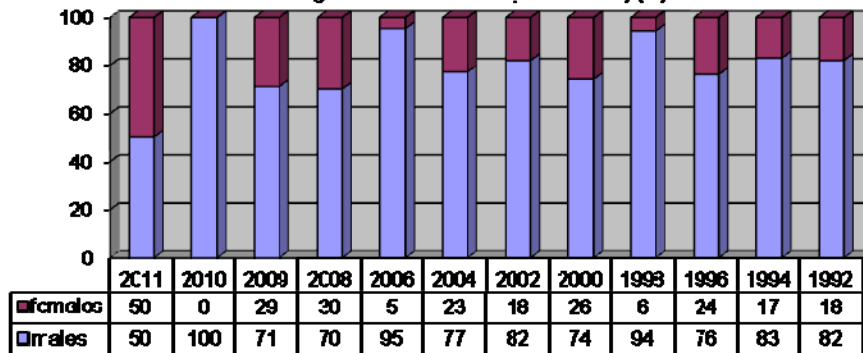
Forensic data by the department of National Toxicology Laboratory on Health³⁹ show that the most frequently involved substance in overdose cases is heroin, followed by methadone and cocaine. To stress that since 2000, methadone presence in blood samples of overdose victims has been increasing.

50% of the victims are male and their mean age at the moment of death shows an increase over the past 20 years (in 1992: 28.4 years and in 2011: 31.5 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 the referred observation period (1 case in 2011).

Also worth mentioning is that a majority of acute drug death victims are known by law enforcement agencies (+/- 80%) for their drug user 'career'. As far as the place of death is concerned, since 2004 approximately 50-65% occurred at the victims' home, followed by public place.

³⁹ Département de Toxicologie du Laboratoire National de Santé

Fig. 6.8 Gender distribution of direct drug-related death cases (1992 - 2011) (%)



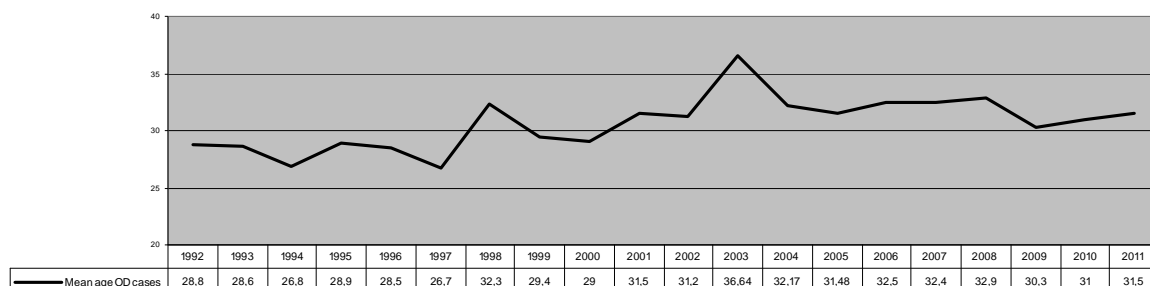
Source: RELIS 2011

Table 6.5: Age distribution of direct drug death cases indexed from 1992 to 2011

	2011	2010	2009	2008	2006	2004	2002	2000	1998	1996	1994	1992	Total
< 20	1	1	2		1			1		1	3		20
20-24	0	4	2	2	4	1	4	8	2	5	6	6	66
25-29	3	2	3	2	4	4	1	6	5	5	13	6	91
30-34	0	2	2	1	2	3	3	6	2	4	6	3	62
35-39	0		2	3	5	2	1	4	4	1	1		43
40-44	1	2	2	2	2	2		1	3			1	27
45-49	1	1	1			1	2	1				1	12
≥ 50	0				1					1			4
Mean Age	31.5	31	30.3	33.16	32.5	32.17	31.18	29	32.3	28.5	26.8	28.4	325
Male	33.6	31	32Y5M	32Y8M									
Female	29.3		25	33Y8M									

In 2011, the mean age of male overdose victims is sensibly lower than in 2008. In 2011, the youngest victim was aged 17 years and the oldest was 45 years. One female underage victim was reported in 2011. Considering the nationality of overdose victims, the majority (83%) were natives. Recently, one could observe a rather stable number of victims from the frontier zone (BE, DE, F) and a decreasing number of victims of Portuguese origin. In 2011, no Portuguese citizen has been reported.

Fig. 6.9 Mean age of acute drug overdose victims (1992-2011) (RELIS 2012)



For more detailed data on 2011 drug related deaths please refer to standard tables 5 and 6.

Mortality and causes of deaths among drug users

The above mentioned study (Origer & Dellucci, 2002)⁴⁰, has revealed that, as far as the Grand-Duchy of Luxembourg is concerned, the mere application of the DRD standard does not allow for a valid computation of drug related death cases. Therefore, the authors did compute the total number of drug-related deaths by adding cases of the SR that were not indexed by the application of the DRD standard to the GMR. The figures resulting from corrected DRD v.3.0. data are referred to as '**national selection**' and provide the annual total number of controlled drug-related fatalities at the national level (6 direct/acute death cases in 2011).

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**.

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.

7. Responses to health correlates and consequences

Introduction

Responses to health correlates and consequences of drug use aim at minimising the resulting damage for the drug users and their environment, and at increasing individual/collective resources. The concept of risk and harm reduction is directly linked to health consequences of drug use, 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. Major efforts have been undertaken in recent years to improve data on drug treatment demands from general healthcare providers by including psychiatric departments of general hospitals in the RELIS data collection network and the pilot implementation of a national substitution treatment register. In addition to the national drug surveillance system RELIS, these new data sources and tools will allow to draw a more accurate picture of intervention outcomes.

In September 2011 a new national HIV/AIDS action plan (Ministry of Health, 2011) covering the period 2011 to 2015 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 builds upon the external evaluation results of the 2006-2010 national HIV/AIDS plan and complements or enhances infectious diseases' reduction measures included in the national drugs action plan 2010-2014. The document can be downloaded under <http://www.ms.etat.lu>.

⁴⁰ A full text version of the study can be downloaded under: <http://www.relis.lu>

As far as availability of service is concerned, 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 a supervised injection facility (currently only in Luxembourg City). The governmental programme 2010-2014 foresees the decentralisation of respective offers by implementing new integrated low threshold centres for drug addicts in the South of the country and by further developing harm reduction measures in the North. In this context the Ministry of Health has commissioned a specialised agency to perform a needs assessment of harm reduction measures in the northern region. Outcomes of the latter will be addressed below.

- PREVENTION OF DRUG-RELATED EMERGENCIES AND REDUCTION OF DRUG RELATED DEATHS

Research and recommendations

In the framework of the first national drugs action plan 1999-2004 foundations have been laid for a comprehensive nation-wide strategy for the reduction of health consequences of drug use. A specific study (Origer & Dellucci, 2002) has been addressing the issue of the reduction of drug-related mortality. The following recommendations have been retained:

- 1. Opening of supervised injection rooms according to the national drugs action plan.
- 2. Heroin assisted treatment (foreseen by the national drugs action plan).
- 3. First aid training courses provided to users and their relatives and partners.
- 4. Gender and ethnic specific interventions.
- 5. Creation of 'transition centres' for ex or current PDU leaving institutional settings.
- 6. Development of reintegration programmes for prisoners in the framework of the recent 'Global care programme for drug addicts in prison'.

Drug injection room and low threshold shelters

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.

The implementation of a first drug injection room in 2005 has to be seen as a part of a broader harm and nuisance reduction oriented strategy. The national drug action plan refers to the creation of low threshold emergency shelter facilities for drug addicts to be implemented regionally.

A low threshold emergency centre for drug addicts (TOXIN) was inaugurated in December 2003 and initially provided day care and night shelter. In July 2005, the first supervised injection room at national level has become operational and has been integrated in the TOXIN centre which from then on has been providing the whole range of harm reduction services, counselling facilities, accommodation, washing and laundering facilities. It should be added that the night accommodation is not to be seen as a permanent housing facility; there is a daily admission procedure. The target population for the consumption room are primarily IDUs. The main objective of the project is the reduction of drug-related harm and nuisances. More precisely it aims at reducing the risks of overdoses, infectious diseases, public nuisance in the neighbourhood, facilitating 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 the Public Prosecutor's Office and law enforcement agencies.

The national drugs coordinator's office elaborated the operational concept of the injection room based on available international experience and evaluations. In terms of management, all

involved parties meet regularly (called 'the Monday round') to assess the current situation and emerging problems related to the functioning of the consumption room. Incidents, nuisance reports, trends, quality assurance, workload, technical improvements and safety issues are addressed by the 'Monday round' in order to promote rapid solution finding and continuous adaptation to fast changing clients' profile and consume patterns.

Table 7.1 provides an insight in clients' and occupation statistics of the TOXIN services since their opening and for 2009, 2010 and 2011 respectively:

Table 7.1: Clients statistics of TOXIN centre services 2005 - 2011

Injection Room	June 2005 - December 2011	2009	2010	2011
Number of user contracts signed	994	94	108	98
Number of users episodes	141,407	36,558	33,017	26,929
Number of injections	168,347	43,871	39,960	31,588
Number of non-fatal overdoses	1073	198	327	283
<i>With loss of consciousness</i>	182	54	42	33
<i>Without loss of consciousness</i>	891	144	285	250
Number of fatal overdoses	0	0	0	0
Medical emergency interventions	152	46	33	31
Day care	December 2003 – December 2011	2009	2010	2011
Number of clients	350,645	77,333	65,307	62,925
Night shelter	December 2003 – December 2011			
Number of different residents	2,146			

Opening hours have been modified in course of 2011 due to an internal reorganisation. Currently the night shelter is open 7 days a week with a capacity of 42 beds. The TOXIN day centre, and injection room (7 injection tables) is open 6 days a week and is temporarily closed on Saturday. TOXIN facilities are mostly used by men (84%); the most commonly used drugs were heroin (87%), cocaine (8%) or both of them (5%). Cocaine use has obviously decreased in 2011. Age category 25-34 is mostly represented (45%).

No fatal overdose has occurred thus far but more than 1000 overdoses have occurred since the opening of the injection room and due to the immediate intervention of ad hoc staff all victims could be assisted, reanimated and their live saved. The drug scene of Luxembourg-City adheres to a great extend to the TOXIN concept with the positive effect that public nuisance has significantly decreased. The increasing number of users attracted by the TOXIN services poses however a problem of clients' management given the fact that the container structure was meant to be of provisional use and is currently reaching the limits of its service capacity. Therefore, a new centre will replace the previous one and should become operational in the beginning of 2012. Its implementation site is the immediate vicinity of the current centre. Architectural planning of the replacement structure has built upon past experience and also foresees the inclusion of a supervised drug inhalation facility, currently not available in the present centre. The concept of the drug injection room has been revised accordingly.

As most relevant drug scenes concentrate in the City of Luxembourg and in the main city in the South of the country, the governmental programme has foreseen the creation of an integrated low threshold offer (including a supervised injection room) also in the city of Esch-sur-Alzette. The search of an appropriate site for the injection room is currently undertaken.

As far as the northern region of the country is concerned, it has been said that a needs assessment was commissioned by the Ministry of Health. The main objective of the latter was to determine the specificity of drug use patterns in this region and the gaps in existing harm reduction offers. During a 6 months prospection phase data have been collected via drug users, residents, shop owners, social actors and local municipal authorities. First results of the assessment (JDH, 2011) clearly emphasis the need of a tailor made low-threshold offer in the region. However, the type of offer needed appears to differ from those currently existing in bigger cities such as Luxembourg and Esch/Alzette. The drug user population living in the

northern region is not locally concentrated and non-intravenous use is reported to be far more prevalent than IDU. Large scale syringes exchange programmes are not a first priority and may even be counterproductive in a sense. This said, the phenomena of stigmatisation, isolation and marginalisation of drug users is far more concerning. Also, the development of region wide outreach work in addition to community offers appears to be a promising strategy for the northern region.

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 and from fines in certain circumstances. In general, witnesses meeting these conditions are not prosecuted. As an accompanying measure an information flyer has been elaborated jointly with field agencies and the Ministry of Health and broadly distributed. The flyer contains useful information on safer injection and advice in case of overdose events.

Heroin assisted treatment (HAT)

The future implementation of a heroin assisted treatment programme, as foreseen by the national drugs action plan 2010-2014, should further contribute to reduce drug-related health damage. In 2008 a feasibility study and an operational framework concept (Origer, 2008), partly inspired by the Swiss guidelines on Heroin Assisted Treatment (Bundesamt für Gesundheit, 2006) has been submitted to the Minister of Health. The main conclusions of these reports can be found in the 2009 edition of the present report. It should be underlined that the HAT is not conceptualized as a low threshold measure. It is intended to be implemented in the broader framework of the national drug substitution treatment strategy with clearly defined medical and psycho-social components.

A drug scene survey was performed in 2008 (JDH, 2009) in order to investigate perceptions and opinions regarding the implementation of HAT. 174 drug users in contact with drug care institutions were interviewed by using a standardised questionnaire. 85% of respondents consider HAT to be a useful complementary offer for the following reasons (in order of importance): reduction of criminality and petty crime, clean quality controlled heroin, reduction of drug-related mortality, social stabilisation and reduction of harm and health damage. 62% of interviewees declared themselves to be personally interested to enter HAT if available.

By the time of writing the general HAT concept was approved, a provisional budget has been set and agreement was reached with a specialised agency in terms of future management of the programmes. First resources have been allocated in 2010 and study visits to several countries running HAT facilities have been undertaken. National experts are currently fine-tuning the existing concept in order to operationalise this new treatment alternative. Also the necessary steps have been taken to determine the import, management, stocking and preparation procedures of diacetylmorphine.

New specialised care structures foreseen in the framework of the 2010-14 action plan

The lack of national detoxification capacities has become a growing problem in the drug care network in recent years. According to international standards the number of detoxification slots in general hospitals revealed to be sufficient, however, waiting lists of new treatment demanders became consistently longer partly due to long duration stays. To further improve peri-hospitalisation procedures, two new projects have been retained in the new drug action plan.

The first refers to the set-up of a so called diagnostic, referral and follow-up mechanism (DDOS). The main idea is to attribute a single (freely chosen by the treatment demander) reference person (social worker, etc.) to each treatment demander. This reference person organises jointly with the patient and care institutions treatment interventions, follows up

progression and guarantees access after-care offers. The reference person also represents a single contact person for involved care institutions. A small scale pilot phase involving a series of specialised actors has been launched in order to gather experience until the necessary resources will be allocated to implement a referent system nation-wide.

Furthermore, in order to allow hospitals and psychiatric departments to concentrate their efforts to interventions for which they are competent, mainly medical care and withdrawal, to reduce relapses and after release overdoses, a stabilisation unit will be operational in 2012 with a capacity of 12 beds and a maximum stay of 3 weeks. The referred unit aims at stabilising recently detoxified persons by providing them with necessary medical care and by offering them a safe environment to start or continue their re-integration process. Negotiations between the Ministry of Health and the CHNP have allowed finding adequate solutions to implement the referred unit in existing infrastructures and accept first clients in the beginning of 2012.

A mobile medical care unit, providing primary medical care to clients of all specialised low threshold agencies will be operational by the end of 2012. Its objective is to increase access to medical care and further referral of hard to reach drug using population.

- PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

Prevention

Interventions aiming at the prevention of drug-related infectious diseases as for instance needle exchange and substitution programmes have been initiated and developed prior to the set-up of a specific legal framework. The drug law amendment of 2001 did not only allow maintaining and to further developing existing harm reduction offers but also set the foundation for the implementation of new services such as supervised drug injection rooms 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. Both IDUs and non IDUs are target groups of HR interventions. The planned inclusion of a drug inhalation facility in the new TOXIN centre is a sound example of the national approach. Furthermore infectious diseases prevention does not focus specifically on IDUs as shows a recent action-research project on HIV and hepatitis infection among PDU (Origer A and Schmit JC, 2010).

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 7.2 shows that the number of distributed syringes stabilised in 2005 and has been significantly decreasing from 2006 onwards, although the return rate continued to increase. From 2008 onwards quantities of syringes distributed through NEP have been increasing anew.

According to RELIS data, one third of IDUs procure their syringes primarily in pharmacies. This proportion has remained fairly stable over recent years and does not directly impact on trend figures from specialised needle exchange points.

As can be seen in table 7.2, the number of re-collected used syringes exceeded in 2009 the number of distributed syringes via the national NEP, (vending machines excluded), which suggests that users also bring along syringes bought in pharmacies or originating from vending

machines, which is considered to be a highly positive evolution. In 2010 and 2011, the number of collected syringes has decreased but is still very high, ranging between 90-97%

Table 7.2: National needle exchange programme (NEP) 1996-2011 including specialised agencies, vending machines and supervised injection room

	Distributed syringes	Collected used syringes
1996	76,259	28,646 (38%)
1998	109,743	58,886 (46%)
2000	189,413	112,625 (59%)
2002	254,596	211,621 (83%)
2004	435,078	376,491 (87%)
2006	332,347	282,909 (93%)
2008	259,607	249,400 (96%)
2009	289,555 of which 45,529 via injection room and 13,353 via vending machines	301,895 (104%)
2010	308,350 of which 44,830 via injection room and 8,109 via vending machines	297,400 (96,5%)
2011	246,858 of which 35,761 via injection room and 5,169 via vending machines	221,975 (90%)

Source: RELIS 2012

A syringe and needle exchange programme has started in the national prison (CPL) in August 2005. Demanding inmates are seen by medical staff and if indicated, an initial injection kit containing sterile injection paraphernalia is handed out. Sterile replacement syringes are delivered on presentation of the used ones and the initial kit. The program is placed under medical secret.

Table 7.3: Needle exchange programme (NEP) in prison (CPL) 2005-2011

	Distributed injection kits	Distributed syringes
08/2005 – 12/2006	64	300
2007	24	77
2008	36	178
2009	33	261
2010	34	328
2011	30	440

Source: CPL 2012

Quality assurance and follow-up of new injection paraphernalia on the market is ensured by a special expert group chaired by the national Drugs Coordinator. Although no mandatory guidelines have been submitted to specialised SEPs the latter do generally agree on common standards within the referred expert group.

Moreover, outreach interventions targeted at (drug using) sex workers aiming at establishing 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 performed an action-research with the objective to estimate HCV and HIV prevalence in PDU and IDUs based on medical diagnosis data (blood testing) and to implement required health care measures. The development of new measures to reduce drug-related infectious diseases (e.g. rapid testing, DIMPS, inhalation rooms) largely built and still build upon the recommendations of the referred report published in September 2007 (Origer & Removille, 2007). The final report may be downloaded at <http://www.relis.lu>. Several related publications in peer-reviewed journals have been accepted in 2010 and 2011.

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. The 2011-2015 HIV/AIDS action plan foresees 2 new free testing sites in the North and the South of the country thus regionalising free testing opportunities.

Under the previous national HIV/AIDS action plan 2006-2010 a mobile intervention facility for sexual health (DIMPS) has been set up. DIMPS may be described as an outreach offer for specific target populations and vulnerable groups aiming to access difficult to reach sub-populations and provide prevention counselling and infectious disease testing on site to various populations. The project, started in May 2009, provides free rapid testing of HIV, hepatitis and outreach counselling targeting among others drug users' scenes, sex workers and asylum seekers. In the course of 2011, 146 counselling episodes have been reported by the *DIMPS team* involving a total of 109 clients. 79 HIV, 31 HBV and 42 HCV rapid tests have been performed during 2011 in the framework of *DIMPS*.

Finally it should be stressed that HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison by intra muros medical staff.

Infectious diseases treatment

The National Service for Infectious diseases, implemented within the CHL provides specialised treatment in collaboration with the counselling staff of the AIDSBERODUNG/Red Cross. In case the patient has no or no valid health insurance, treatment costs may be covered by state.

Since 2009 a specialised medical department for transmittable diseases (COMATEP) is operational within the CPL. Given the fact that according to 2008 data 20.97% of inmates carry a transmittable disease and that yearly more than a third of new admissions in national prisons are drug law offenders, the project is considered to be pertinent and important also by the national drug coordination office.

Interventions related to psychiatric co-morbidity

The number of confirmed DD patients is estimated at 40-50 people (adults) nation-wide. These patients show explicit psychiatric disorders, are often socially disintegrated and need individual follow up although they tend not to be attracted by existing care offers. 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. The 'Therapeutic Chain' expert group has recommended in this context to fine-tune the concept of supervised / accompanied housing in order to move towards a case management approach in a private and individualised environment, knowing that DD patients often have difficulties to adapt to community oriented settings and offers.

- RESPONSES TO OTHER HEALTH CORRELATES AMONG DRUG USERS

Somatic co-morbidity and general health related treatment

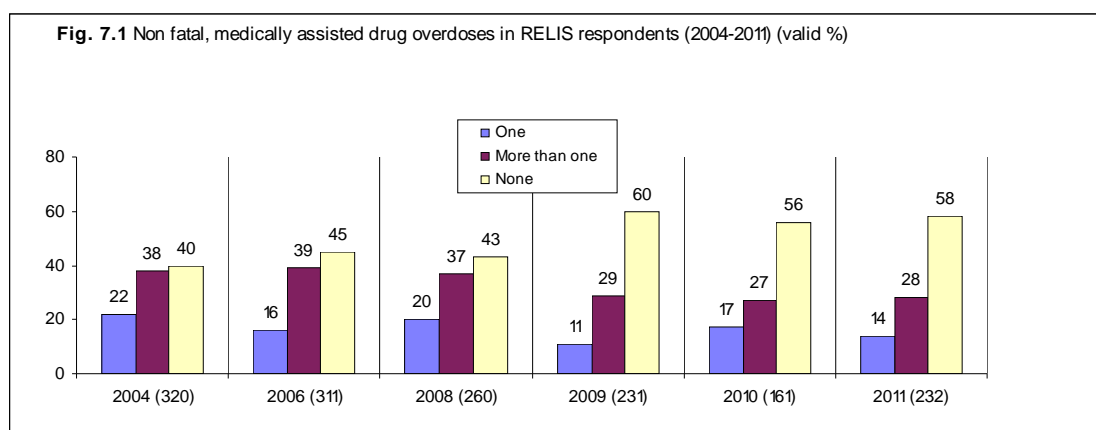
According to longitudinal RELIS data, the general state of health of drug users appears to have improved during the last decade, which could be partly due to the significant development of harm reduction and treatment referral offers.

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.

In the framework of the new drugs action plan 2010–2014, a mobile medical service providing free and on site medical care to drug users independently of the institutional setting they are in (except hospitals) is about to be implemented.

Non-fatal drug-related emergencies

No specific data on drug-related emergencies are currently available at the national level. Figure 7.1 refers to RELIS data on previous non-fatal and medically assisted drug overdose self-reported by PDU. The proportion of indexed drug users reporting at least one overdose (as defined) appears to be decreasing 2008 onwards. These figures have to be seen in the light of the significant number of overdose incidents that have occurred in the national supervised drug injection room without fatal consequences, due to immediate assistance (more than 800).



Source: RELIS 2011

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 tests should be regulated by a grand-ducal decree in the course of 2011. For more details on the new legislation please refer to chapter 1 (laws).

Interventions concerning pregnancies and children born to drug users

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.

Due to the improvement of, and the better access to drug-related treatment and especially the spread of substitution treatment, the birth rate in drug users has increased over recent years. According to data from the national drug surveillance system, the proportion of drug users

having children has progressively increased over the last 10 years (RELIS 2010). This evolution has been leading to the first parental project launched by JDH in 2003 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. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

8. Social correlates and social reintegration

Introduction

Social correlates of drug use typically involve Justice, Health and Educational competences. The Ministry of Health and the Ministry of Family and of Integration both intervene by financing measures to reduce social consequences ranging from early detection of drug use to social-professional rehabilitation interventions. 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 reintegration aiming at reducing daily expenses and depths of drug addicts and thus the prevalence of acquisition crimes.

- **SOCIAL EXCLUSION AND DRUG USE**

Social exclusion among drug users

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 issues between ministries. Obviously a vast majority of homeless and socially excluded people also present to various extends licit and/or illicit substance abuse. Also, economic parameters tend to have a tangible impact on drug use prevalence and patterns as well as on the level of acceptance and perception of drug addicts by the general population.

A sound example of how social rejection and drug abuse are dynamically linked might be seen in the national results of the 4th wave of the European Values Study⁴¹. 55% of national respondents (N: 1,610) described drug addicts as most unwanted neighbours. In 1999 drug addicts still occupied the second position (43%).

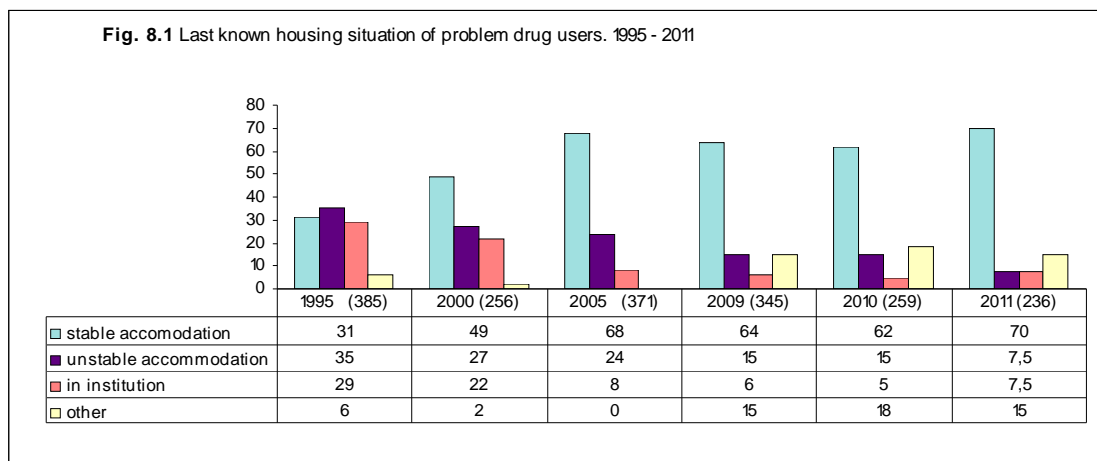
Also, providing medical and psychological care to drug dependent persons is not enough as the social situation of these people needs to be improved before sustained outputs in drug treatment is expectable. This said, the national strategy of care for socially excluded people is based on the principle of progressive reintegration through capacity building and the improvement of the social abilities and environment. Associations as 'Stëmm vun der Strooss' (Street voice) and ARCUS asbl, financed by the Ministry of Health, try to involve 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 below.

⁴¹ EVS Foundation/Tilburg University: European Values Study 2008, 4th wave, Integrated Dataset. GESIS Cologne, Germany, ZA4800 Data File Version 1.0.0 (2010-06-30) DOI:10.4232/1.10059.

Homelessness

According to latest estimations around 700 persons are currently homeless in the Grand Duchy of Luxembourg⁴². 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 over the last years, even though 2009 and 2010 data witnesses a first decrease, but an increase can be noticed again in 2011. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Currently 70 percent (62%) of PDU report a stable housing situation (RELIS 2011). 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. Recent figures also tend to confirm that although specialised accommodation offers have been further developed, the current economic situation has created an even higher demand for this type of housing.



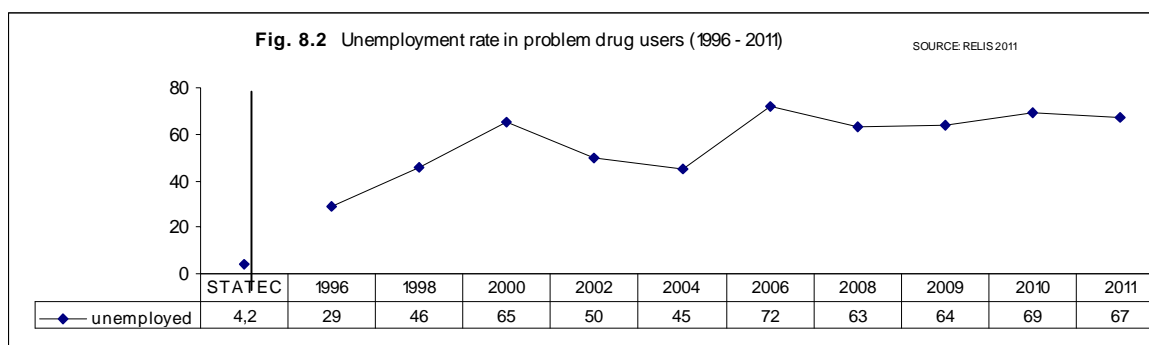
Source: RELIS 2011

Youngsters aged less than 25 and living in the street are referred to as a quite new phenomenon. Societal changes as the increase of mono parental families, an increased number of divorces, increasing youth jobless rates 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, education and perspectives.

Unemployment

The **unemployment rate** (67%) shows a small decrease for 2011. However, an in-depth analysis shows that the proportion of active respondents reporting a stable job situation (e.g. long term contract) (13%) has sensibly decreased over the 4 last years, which might be partly due to the ongoing economic crisis.

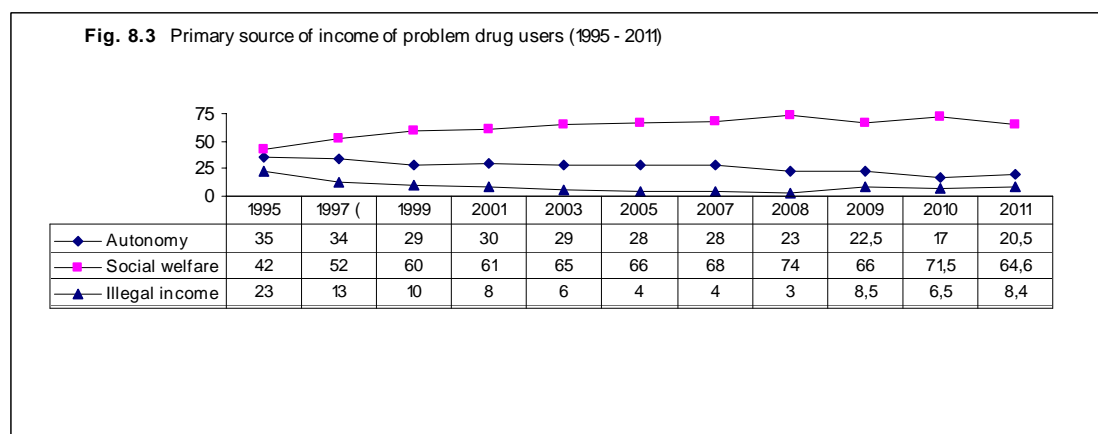
⁴² Centre d'Etudes de Populations, de Pauvreté et de Politiques Socio-Economiques (2007). L'exclusion liée au logement des personnes prises en charge par les centres de jour, les foyers de nuit, les centres d'accueil et les logements encadrés. Luxembourg



Source: RELIS 2011 **Remark:** STATEC: Statistical Department of State – Unemployment rate in active general population.

Data on revenues confirm observed trends in occupational status:

- decrease of social dependence associated to a stable **financial autonomy**. The Guaranteed Minimum Income constitutes the primary source of revenue of PDU.
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 1995, although they have gained in importance in 2009 and 2011, after a small decrease in 2010.

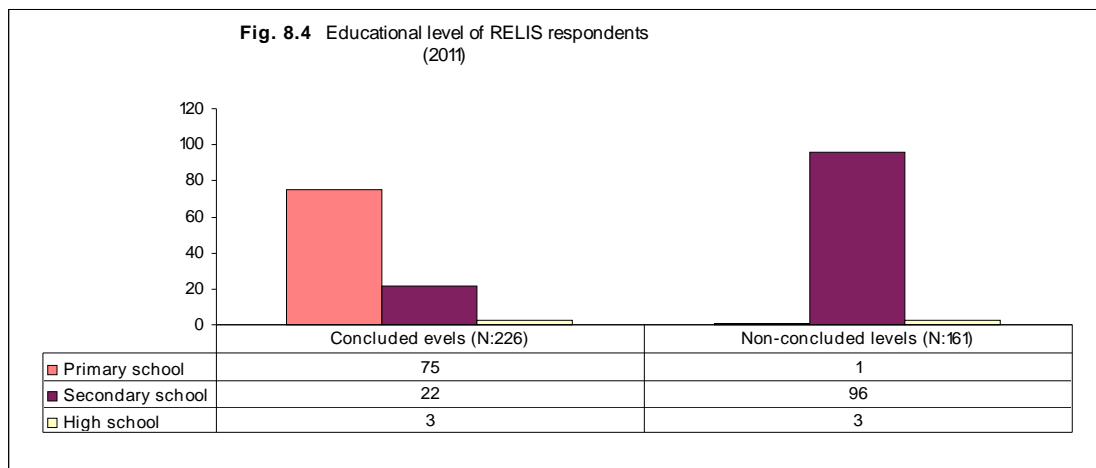


Source: RELIS 2011

School drop out

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 in 2006) 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



Source: RELIS 2011

Regarding PDU, the **educational level** of the latter, low and mostly incomplete, has been showing a creeping deterioration since 1999 according to baseline data from RELIS. 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 at 17.6 years. Lower levels are particularly observed as regards acquired secondary and high school diploma.

Financial problems

The RMG (Guaranteed Minimum Income) (33%) and the proper salary (18%) represent the main income sources of PDU. Between 1997 and 2011, strong variations were observed in relation with these two revenues. RMG as a primary source of revenue has known a remarkable increase from 1997 onwards in contrast to the proper salary, which decreased during the last years (annual fluctuation in 2011 to be further observed). Money provided by parents as first source of income has also decreased (18% in 1997 to 4% in 2011).

Concerning secondary income sources, 47% referred to 'illegal activities'⁴⁴ and 19% were provided money by parents.

In contrast with previous years, the degree of social dependence shows a decreasing tendency (64.6% in 2011 – 71.5% in 2010 – 66% in 2009 – 42% in 1995) which correlates with an inverse trend as far as financial autonomy is concerned.

• **SOCIAL REINTEGRATION**

Housing

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 has foreseen the expansion of existing projects and the implementation of new decentralised reintegration measures based on the previously described principle of progressive reintegration through capacity building and the improvement of the social abilities and environment.

⁴⁴ Mainly selling of drugs

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 Ministry of Health, National Fund against drug trafficking, and the City of Luxembourg (VDL). The vast majority of real estates are rented by the JDH from private proprietors; the remaining ones belong to the national housing Fund (Fonds de logement) or to municipalities.

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. 25 persons benefit from the referred offer that builds upon apartments and houses situated in 6 different municipalities.

In both programmes, apartments are subcontracted by the JDH foundation or CTM to clients and the former are liable to the actual proprietors. This avoids immediate conflict situations in case a client has transitional problems to pay the monthly rent. Rents are also typically lower than general real estate market prices. In the framework of these programmes, beneficiaries are also offered the possibility of financial management and follow-up in case of debts for instance. In the medium and long term, residents may be able to sign a proper rental contract or move to an autonomous housing. The supervised housing projects have allowed thus far to stabilise most of beneficiaries, to avoid relapse and to create the necessary conditions for a socio-professional (re)-integration.

Education, training

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 providing them with low threshold facilities and offering social and professional reintegration activities such as literacy courses (provided by volunteers) and workshops (in journalism and radio broadcasting) held by professionals. 'The voice' ('d'Stëmm') monthly broadcasts a one and a half-hour programme on a local radio. Providing clients with the opportunity to widen their knowledge and introducing them to different or less common professions has led to a fair success in terms of interest of participants and retention rates.

Employment

Another reintegration project run by the referred association is the therapeutic redaction board, where homeless people are given the opportunity to **editing, printing, publishing and distributing an in house magazine**. This activity is supervised by professionals (one educator and one pedagogue). 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 (therapeutic aim). Another aim is sensitizing a wider public and helping homeless people familiarize with new technologies. PDU constitute a significant fraction of their clients.

Additionally clients are offered task and job opportunities in the laundry service called '*Schweessdrëps*' (*Drop of sweat*) which covers the south of the country and is specialised in washing sports teams' uniforms. For the last years, 1 social worker, 3 educators and 30 clients have been working on average for 234 sports teams, washing, drying etc. 3,500 to 4,000 uniforms weekly. Besides these two main work-opportunities, the service also offers a therapeutic workshop called '*Dressed for success*'. The service has been managed by 2 clients (offering them a job opportunity and responsibility). Their main task was to organise (collect, wash, store, etc) clothes offered by donors.

A new occupational project foreseen for 2013 and run by the 'Street voice' ('*Stëmm vun der Strooss*') association should further close the gap in occupational offers for drug addicts at the national level. The residential centre will be offering temporary accommodation and day jobs for homeless and dependant people in a rural setting.

Co-financed by the Ministry of Labour and Employment and the European Social Fund, the Centre Emmanuel association launched the project '**START**' in 2007, targeting progressive re-integration of drug users into the first job market (G. Lambrette, 2009)⁴⁵. The applied methodology combined case oriented follow-up and job coaching and aimed at helping beneficiaries to find a work or professional training place (e.g. establishing contact with companies, preparing job interviews, editing of resumes, etc.) and to assist them in their daily work routine (definition of tasks, conflict management, mediation between employee and employer, motivational follow-up, etc.). Intermediate feedback and final evaluation contributed to improve autonomy of clients and are ideally leading to a permanent work contract. As one of the main impediments regarding access to jobs by vulnerable groups, is the initially or even permanently reduced work performances. The main objective of a job coaching project is the mobilisation of individual resources and capacities of the beneficiary in tune with the need of the company he or she is given the opportunity to work for.

In 2002 Arcus asbl candidated for the EU programme "**Job Alliance**" an initiative of the European Social Fund. Priorities of the referred project are:

1. Improve access to employment and sustained inclusion in the job market
2. Activate the category of persons most distant from the job market.

Decision on acceptance of the national project was still pending at the time of writing.

The referent system

The 2010-2014 national drug action plan foresees the creation of a national 'referent system' for drug addicted persons in need of care. The rationale of this project is straightforward and stems from the observation that drug related care and rehabilitation offers are diverse and a given person enters in contact with several national and transborder care providers and law enforcement authorities in the course of their treatment and (re)-integration history. Often the link between these different stages and institutions could be improved if a designated referent could follow-up patients individually and centralise information on the patient and his/her treatment history. Sound examples of the utility of this system are the preparation of release from prison (e.g. continuation of substitution treatment or housing finding), referral to a national care provider for patients in residential treatment abroad or preparation of admission to therapy following a detoxification treatment in hospital. Provided the necessary financial means are made available, the referent system will be operational by 2013.

⁴⁵ LAMBRETTE, G. (2009), *Projet "START!" – Constats et réflexions autour d'un projet de réinsertion professionnelle pour personnes toxicomanes au Grand-Duché de Luxembourg*, Luxembourg.

9. Drug related crime, prevention of drug related crime and prison

Introduction

The main source of Information of this part of the report is the Judicial Police Service (SPJ) in Luxembourg.

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).

- 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.

Drug law offences

As can be seen in tables 9.1, the total number of arrests (181) 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.

Table 9.1: Arrests broken down by type of reporting institution (1995-2011)

	ARRESTS												
Year	1995	1997	1999	2001	2003	2004	2005	2006	2007	2008	2009	2010	2011
S.P.J.	27	25	27	7	25	38	26	39	49	32	20	15	33
Gendarmerie	8	15	15	45	82	103	94	124	79	102	92	166	97
Police	32	32	32										
Customs	61	82	34	40	28	37	35	62	41	54	33	48	51
Total	128	154	108	92	135	178	155	225	226	188	145	229	181

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. In 2009 and 2010, however, the number of referred police records increased anew (2010: 2,546 records). However in 2011, a decrease, concerning the number of police records, has to be notified (2,225).

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 to 2008 (1,487), one observes a significant decrease in drug law offenders, but obviously a new increase in 2009 (1,963) and 2010 (2,530). The number of arrests on the same charge has decreased from 154 in 1997 to 135 in 2003 to increase and reach its peak in 2010 with 229 arrests. In 2011 a decrease is observed for the number of drug law offenders (2210) as well as for the number of arrests (181).

Table 9.2 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 2011.

Table 9.2: Number of national law enforcement interventions (1995-2011)

	DRUG LAW ENFORCEMENT RECORDS										
Year	95	97	99	2001	2003	2006	2007	2008	2009	2010	2011
S.P.J.	123	137	343	216	239	190	177	110	121	134	165
Gendarmerie	198	255	782	1.126	1.326	824	998	881	1465	1969	1643
Police ⁴⁶	199	177	189								
Customs ⁴⁷	244	236	173	113	95	186	197	228	328	443	477
Total	764	805	1487	1455	1660	1200	1286	1219	1914	2546	2225
	OFFENDERS										
Year	95	97	99	2001	2003	2006	2007	2008	2009	2010	2011
S.P.J.	152	182	434	321	369	248	203	128	121	131	164
Gendarmerie	319	335	916	1.272	1.753	1.007	1.160	1.009	1.459	1960	1632
Police ⁴⁸	371	280	283								
Customs ⁴⁹	421	408	306	182	148	320	324	350	325	439	407
Total	1263	1205	1939	1776	2270	1575	1687	1487	1963	2530	2210

Source: Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 86% **males**; a proportion that has been varying between 79% and 89% during the past decade. Since 1997, **non-natives** (55% in 2011) have been representing the majority of drug law offenders (52-68%). The spectacular increase

⁴⁶ 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

⁴⁷ 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

⁴⁸ 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

⁴⁹ 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

in 2002-2003 of the proportion of **first drug law offenders** is confirmed and even exceeded by 2010 and 2011 data reporting an increase from 828 in 2002 to 913 in 2011 (949 in 2010). Also the **percentage of minors** (< 18 years) among drug law offenders having increased between 1994 (4.9%) and 2000 (8.7%) shows a clear decrease in 2004 (5.7%) and tended to stabilize from there on. However in 2010, the percentage of minors among drug law offenders increases again (9.2%). In 2011, a small decrease is observed, concerning the percentage of minors among drug law offenders (6.4%). Heroin and cocaine are the main drugs involved in first drug offences.

Table 9.3 : Socio demographic data on drug law offenders ('prévenus') (1990-2011)

YEAR	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
AGE																		
0-14	7	6	1	3	7	27	21	11	15	41	24	9	8	11	8	7	26	19
15-19	179	320	169	270	249	415	413	399	647	602	334	436	279	318	282	323	484	494
20-24	383	527	403	447	321	519	497	566	650	557	510	617	415	480	436	594	677	602
25-29	278	371	309	304	220	448	354	299	388	375	278	345	323	321	274	421	551	419
30-34	124	159	186	191	187	269	208	194	219	254	250	230	188	216	205	257	318	301
35-39	27	52	65	80	76	131	113	139	177	162	190	174	136	162	134	157	233	175
≥40	43	46	21	42	78	84	108	113	82	174	126	153	181	165	129	189	209	197
unknown	30	50	20	31	32	46	44	55	40	106	95	70	43	14	19	15	32	3
TOTAL	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	1,487	1,963	2,530	2,210
Male	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	1,263	1,645	2,144	1,900
Female	220	256	209	173	193	248	241	215	292	288	181	237	218	190	206	283	367	301
gender unknown	0	27	27	57	19	33	44	15	21	48	49	46	38	13	18	35	19	9

Source: Specialised Drug Department of the Judicial Police 2011.

Table 9.4: Distribution of drug law offenders ('prévenus') according to first offence and underage status (1992-2011)

	1992	1994	1996	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011
First offenders	697	382	508	422	608	828	585	657	471	533	546	667	949	913
Offenders underage	96	57	102	79	154	145	103	86	72	80	83	86	178	141
TOTAL ('Prévenus')	1,531	1,174	1,368	1,170	1,758	2,218	1,808	2,034	1,575	1,687	1,487	1,963	2,530	2,210

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2011.

Table 9.5: Distribution of first drug law offenders (use and use/traffic) according to substance involved ad minima (1992-2011)

	1992	1994	1996	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011
High risk substance involved ad minima														
Heroin	162	154	121	109	133	114	103	110	84	83	88	70	109	60
Cocaine	64	39	34	30	37	64	125	86	52	37	48	35	62	38
Amphetamines	5	15	11	18	9	12	2	3	3	1	8	5	4	8
Type 'Ecstasy'	1	9	20	26	11	34	8	17	4	4	9	3	4	4
Illicitly acquired medicaments	1	3	0	1	7	0	1	1	4	1	1	1	3	4
Substitution substances	0	1	0	0	0	1	0	1	1	0	0	0	0	1
TOTAL (substances HRC)	233	221	186	184	197	225	239	218	148	126	154	114	182	115

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2011

Other drug-related crime

The routine data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results summarise the situation observed in 2011:

- 82% of drug users indexed⁵⁰ by specialised health care institutions have already been in **conflict with law enforcement agencies** during lifetime.
- 64% of the total PDU population show multiple law enforcement contacts (increase).
- The proportion of 'interpellations' for other reasons than presumed offences against the drug law (e.g. **petty crime** such as criminality linked to drug supply or fights) has been decreasing since 1997 (38%) and has been fairly stable in recent years, except for 2010, where data on 'interpellations' for other reasons reported an important increase (2006: 34%, 2009: 35%, 2010: 65% and 2011: 36%).
- 73% (76%) of indexed PDU have already served at least one **prison sentence** during lifetime. The proportion of PDU having served more than one prison sentence at the time of reporting (42% slight increase) has stabilised during the last years.

- PREVENTION OF DRUG-RELATED CRIME

In recent years, involvement of major cities in the management of drug-related problems and nuisances has developed. So-called municipal 'prevention committees' that include local authorities, police forces and specialised NGOs are in place. The setup of the first national drug injection room in Luxembourg City obviously enhanced the involvement of municipal authorities. The Ministry of Health created 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 safety and order, urban nuisance and hygiene problems related to drugs to guarantee the necessary decentralisation of DR offers and SR interventions. As far as preventive measures targeting youngsters are concerned, a mechanism has been put in place in 1996 aiming at underage and juvenile drug use offenders and in order to prevent recidivism. 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. The available 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.

⁵⁰ Persons who have been indexed by the RELIS network during a reporting year.

Table 9.6: Clients core statistics SOLIDARITE-JEUNES 1997 – 2011													
		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of episodes		132	195	208	231	267	249	322	352	357	432	461	416
Referral from the criminal Justice system		41.4%	44.1%	44.2%	37.2%			46.2%	44.4%	43.4%	44.1%	50.8%	49.7%
Gender distribution	Female	34.1%	32.3%	34.1%	31.6%	31.9%	31.3%	30.1%	24.4%	30.5%	24.3%	29.4%	29.8%
	Male	65.9%	67.7%	65.9%	68.4%	68.1%	68.7%	69.9%	75.6%	69.5%	75.7%	70.6%	70.2%
Age distribution	< 14				9.5%	4.9%	2.0%	4.7%	4.6%	5.9%	4.6%	4.6%	5.3%
	14-15				38.1%	30.0%	27.9%	27.9%	25.6%	24.9%	25.8%	29.8%	30.1%
	16-17				39.8%	46.4%	43.4%	46.9%	46.6%	50.4%	52.4%	47.5%	46.4%
	> 17				12.6%	18.7%	20.5%	16.5%	18.5%	15.9%	17.2%	18.1%	18.2%
	Unknown						11.2%	4.0%	4.7%	2.9%	0%	0%	
Main substance involved	Cannabis				83.1%	72.3%	71.5%	73.3%	67.7%	69.4%	72.8%	74.2%	73.8%
	Heroin				3.5%	4.5%	5.6%	3.7%	2.5 %	1.7%	1.6%	1.1%	0.3%
	XTC/ Cocaine				1.3%	2.2%	0.4%	1.6%	1.1%	0.6%	0.9%	0.8%	1.0%
	Legal drugs				2.6%	3.0%	2.4%	3.1%	5.1%	7.8%	6.2%	5.4%	8.2%
	Polydrug				d.m.	1.9%	3.2%	3.7%	5.4%	4.5%	5.8%	5.1%	5.3%
	Other				1.3%	3.3%	2.0%	2.5%	2.5%	2.5%	1.7%	1.1%	1.2%
	None				8.2%	10.6%	10.4%	10.2%	9.6%	8.7%	6.1%	9.7%	7.3%
	Unknown				0.0%	2.2%	3.7%	2.5%	6.1%	4.8%	4.9%	2.6%	2.9%

Source: Solidarité Jeunes (Jongenheem). 2011

- INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Alternatives to prison

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.

The CPG, may be considered as an alternative to a strict penitentiary regime as it is defined as a semi-open prison established in a fairly rural setting. During daytime, inmates follow a professional activity or participate in one of the centre's workshops (agriculture, animal breeding, kitchen, horticulture, woodworking, locksmith's and duties). After work they return to their individual cells for the night. Every block has its own living room, kitchen, bathroom and laundry allowing inmates to live in more or less autonomy.

Part of inmates participates in the '*DEFI*' programme (see below under 'Reintegration of drug users after release from prison') working outside for a minimum loan (RMG - Guaranteed Minimum Income). Others live under a semi-liberty regime (they live at CPG but have an individual and external work contract).

The '*injonction thérapeutique*' is another alternative to prison (only possible in case of offences for *personal possession* or *use* of illicit substances): the offender is proposed to undergo treatment instead of a prison sentence. In other cases, community services ('TIG: travaux d'intérêts généraux') may also be an alternative (depending on the gravity of the offence and the sentence). The sentence may be suspended if the '*prévenu*' agrees to undergo treatment ('*sursis probatoire*'). This said, these two alternatives are applicable in case of drug possession or use only (not for cases of production, dealing or trafficking of illicit substances), as in the Grand-Duchy of Luxembourg a drug addict is not considered a criminal but a person in need of psycho-social and medical help.

A further, still experimental, alternative to prison available in Luxembourg is the electronic tag. In November 2006, the Minister of Justice presented the introduction of the electronic tag as an alternative to incarceration.

In an experimental phase, this system was exclusively meant for prisoners:

- whose sentence was less than one year
- who did not represent a danger
- socially integrated and residing in Luxembourg
- who were working or undergoing training

- DRUG USE AND PROBLEM DRUG USE IN PRISONS

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

MAIN RESULTS:

Drug use in prison

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

Risk behaviour

- 58% of current IDU prisoners report life-time needle sharing in prison;
- 8% of current IDU prisoners report last month needle sharing in prison;
- 70% of IDU prisoners only use water to clean up syringes, 22% do not clean syringes at all;
- 90% of prisoners reporting sexual intercourse in prison did not use condoms.

Miscellaneous

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

Source: Schlink, 1999

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. 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.

- RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS

Table 9.7 provides the number of general admissions and the number of admissions according to drug-related convictions (DELIT 'STUP') in both national prisons from 1989 to 2011.

Table 9.7: General and DELIT 'STUP' admissions in both national prisons (1989 – 2011)																
YEAR	1989	90	92	94	96	98	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011
New entries (Total)					685	796	767	794	1.078	1.341	1.043	1.030	990	892	927	856
New "STUP" entries	163	244	157	288	292 42.6%	167 21%	161 21%	101 12.7%	92 8.5%	247 18.8%	243 23.3%	212 20.6%	332 33.5%	224 25.1%	232 25%	193 22.55%

Source: Greffe CPL, CPG. 2011

Drug treatment in prison

Following the law of 27 July 1997 concerning the modification of the penitentiary organisation⁵¹, 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

⁵¹ 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.

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 programme (previously TOX project) takes care of the drug dependant inmates in the two state prisons of Schrassig (CPL) and Givenich (CPG). This service is run by a multidisciplinary staff. The basic principles of the TOX programme in the CPG are the voluntary participation, the cooperation, the transparency, the quality of service, the determination of realisable objectives and the empowerment of participants. Additionally, the programme TOX also prepares inmates to enter a second treatment option available in prison: a “drug-free” programme called “Charly”. The programme provides a “drug-free” zone, where inmates can serve their sentence, or part of it, under certain conditions. Staying drug free and accepting to participate in psycho-social interventions are part of the admissions criteria.

A special programme targeting exclusively women exists and becomes operational when a minimum number of women enrol. Otherwise, individual offers are available for the female population.

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. An example of good practice in this respect is the inclusion of clearly time on content defined service providing of external specialised drug agencies contractually foreseen by state conventions (in the framework of the global drug care programme). This mechanism also applies to external agents in the field of HIV and other infectious diseases. One should also stress the role of the Central Probation Service (SCAS), which motivates inmates to undergo treatment and enables contacts with external therapeutic agencies. Although the psychosocial care strategy is similar in both national prisons, the CPG currently disposes of a more structured intervention programme.

Substitution treatment is also provided in prison but not by the services mentioned above. The nursery and MDs are in charge of methadone prescription within prison. More detailed figures on this type of treatment can be found in respective sections and STs. 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 extent buprenorphine (SUBUTEX®) and codeine. Prescription of benzodiazepines is widespread.

Official figures show that 24% of the inmates (of full age) who entered CPL in 2011 received drug substitution treatment, representing a total of 220 persons.

Table 9.8: Number of prisoners receiving opioid substitution treatment (2011)	
Year	2011
Methadone	164
Subutex ®	17 (SUBUTEX + METHADONE) / 39 (SUBUTEX only)
Total (persons)	220

Source : Comité de Surveillance SIDA: Activity report 2011

The average dose of distributed methadone was 23 mg per day (minimal dose 2.5mg and maximal dose 60mg). The average period of treatment was 132 days.

Of clients in treatment units in prison, 93% (93%) are male against 7% (7%) of females. The mean age of treatment demanders is 31.25 (27 years and 11 months), whereas the average male age is 31.40 (28Y5M) and the mean age of the female clients is consistently lower (2011: 29Y, 2010: 21Y). Respectively 31% (55%) of clients in treatment are natives against 69% (45%) of non-natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French citizens.

Regarding educational level of the clients in treatment, 78% (52%) have completed primary school, 17% (41%) have completed secondary school. 30% (21%) of clients in treatment units in prison experienced one or more overdoses. As far as the sharing of used syringes is concerned, 44% (39%) reported that they never shared syringes during their lifetime (71% during the last month, 2010: 83%). IDU combined to polydrug use (24%, 2010: 27%) is together with polydrug use without IDU (24%, 2010: 21%) the most observed consume pattern in drug treatment demanders.

Prevention and reduction of drug-related harm

In 2011, the activities of the previously referred to TOX-programme in prison were centred on three pillars:

- **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 programme without drugs to prepare post-release ambulatory therapy and/or individual preparation for release.
- **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 programme 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 months with an optional prolongation).
- follow-up of the drug free section together with the “Program Charly” started in May 2007, as preparation for multidisciplinary and intensive therapy.

As far as the CPL is concerned, in 2011, 132 demanders were provided with an individual psychosocial follow-up. In 2011, 32% of male and 23% of females convicted inmates have been convicted primarily for offences against the drug legislation. 350 clients have benefited from 75 health prevention groups in 2011. A total of 24 clients participated in the "Programme Charly".

For 2011, the CPG reports a total of 42 groups (withdrawal prevention, tobacco prevention, HIV/AIDS prevention etc.) with a total of 331 participants. 63 clients were provided with an individual psychosocial follow-up and 695 individual counselling sessions were held.

In 2007, the external evaluation report⁵² of the TOX project has been published and recommended the continuation of the action.

The programme is currently part of the RELIS routine data reporting network and first data on treatment demand became available in 2010.

- PREVENTION, TREATMENT AND CARE OF INFECTIOUS DISEASES

New inmates are seen by medical staff in the framework of the admission procedure of both national prisons. A HIV screening test is suggested during the medical counselling. If the inmate accepts, a simultaneous screening of other infectious diseases like syphilis and hepatitis A, B and C is undertaken.

In 2011, approximately 766 HIV tests have been carried out. 12 tests were positive (10 men and 2 women), 4 co-infections (HIV/HCV) were diagnosed (3 of those were known drug users). To prevent further contamination, vaccination against hepatitis B and A is recommended to those who present a negative serology.

A structured syringes distribution programme has officially been launched in 2005 in the framework of the global drug care programme in prison. In order to enrol, inmates have to send a written request to the prison's doctor. After counselling, the inmate is handed a kit containing 2 syringes which may be exchanged at the nursery. As the consumption and possession of drugs is illegal, those inmates in possession with a syringe in its kit, are exempted from sanctions for detention of injection paraphernalia. In 2011, 30 kits have been distributed and 440 syringes exchanged. The programme is under medical secrecy and is operational although a series of changes are currently being discussed to increase the coverage and impact of the programme.

Ascorbic acid, filters, sterile physiological water, antiseptic wipes and small plasters are available at the two nurseries. Condoms are also available at different discrete spots of the prison (at the two nurseries, TOX-programme and at the psychiatric ward).

In order to meet specific needs in terms of infectious diseases in prison settings, the creation of a specialised transmittable disease counselling offer (COMATEP) involving prison administration and CHL has become operational in 2011.

Prevention of overdose-risk upon prison release

Overdose incidents following prison release is a documented reality that has also been addressed by national research. For instance, the Origer & Dellucci study in 2002 recommended the following measures to prevent overdose risk following an in-depth longitudinal analysis of drug-related death nationwide:

⁵² TREPOS, J.-Y. (2007) Evaluation du projet global de prise en charge des personnes toxicodépendantes en milieu pénitentiaire au Grand-Duché de Luxembourg, Université Paul-Verlaine, Metz.

- 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 PDU leaving institutional settings (6)
- development of reintegration programmes for prisoners in the framework of the recent 'Global care programme for drug addicts in prison' (7)

Besides, 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. A new flyer addressing measures to be undertaken by witnesses of a drug-related overdose and the genuine legal situation was elaborated and was broadly distributed among PDU in various settings in 2009.

For persons (with drug careers) leaving prison, a series of measures such as; information and peer education, banning multiple prescriptions of substitution drugs, considering interaction of substitution treatment and concomitant/persistent street drug use and ensuring through-care after prison release need to be further developed.

- REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

The CPL runs a proper psychosocial and educational department (SPSE). Jointly with the SCAS and the prison guards' association, it has set up a project called '**DEFI**' (Challenge) that aims at the development of therapeutic means, training facilities, socio-professional reinsertion measures and indebtedness management, during prison journey and after the prison release phase.

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

The Arcus asbl (see above chapter on social reintegration) also contributes in various ways to (re)insert drug users as far as (re)integration is possible. The future referent system will also contribute to improve the re-integration process of drug-addicted inmates upon release.

10. Drug Markets

Introduction

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 (e.g. dealers approach potential clients and not vice-versa, the dealers insist on selling). 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 to 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 Coast. 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 2004, purity of heroin remains fairly stable while the purity of cocaine has decreased (2004: 61.78% / 2011: 46.7%). 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 40%) in herbal cannabis samples seized in Luxembourg in 2009. However in 2010 and 2011, the concentration of THC (34.2%/ 27.5%) is not as high as in 2000. **Prices** show broad ranges for heroin and cocaine. Cannabis and derivatives however have known certain stability during the last 7 years as far as street prices are concerned.

In terms of **seized** quantities, important variations are observed for heroin since 2000. As far as heroin and mainly cocaine are concerned, increasing quantities have been reported in 2011. The number of seizures also has been showing great variations during the same period, especially for cannabis.

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

- AVAILABILITY AND SUPPLY

Perceived availability of drugs

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.

Table 10.1: Ease of acquisition of drugs in Luxembourg (2002/2004)

QUESTION a: It is easy to get illicit 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%

In 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?”:

Table 10.1 bis Ease of acquisition of drugs in Luxembourg (2008)

	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)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	37	30	22	9	3
EU27	35	26	22	11	5
	Ease of access to ecstasy (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	34	31	25	9	2
EU27	31	25	26	12	5
	Ease of access to cannabis (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	17	11	30	41	1
EU27	19	15	31	32	4
	Ease of access to tobacco (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU		1	10	88	
EU27	1	2	15	81	
	Ease of access to alcohol (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
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 a majority of 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.

In May 2011, the Eurobarometer study "Youth attitudes on drugs" (N°330) provided results summarised in table 10.1 ter. Although answer categories are slightly different, results clearly show that acquisition of illicit drugs is perceived to be more difficult in 2011 if compared to 2008.

Table 10.1 ter: Ease of acquisition of drugs in Luxembourg (2011)

2011	Ease of access to heroin (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
Luxembourg	30	35	24	8	2	1
EU27	24	36	22	8	5	5
LU	Ease of access to cocaine (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	22	33	32	9	2	2
EU27	19	28	26	14	8	5
LU	Ease of access to ecstasy (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	21	33	31	9	2	4
EU27	20	28	25	14	8	4
LU	Ease of access to cannabis (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	12	10	23	27	25	3
EU27	11	13	15	28	29	4
LU	Ease of access to tobacco (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU		2	2	14	82	
EU27		2	2	14	81	1
LU	Ease of access to alcohol (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU		3	3	15	79	
EU27		1	2	14	82	1

Origins of drugs

The national production of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2010 no clandestine drug-manufacturing laboratory has been dismantled at the national level. Law enforcement sources⁵³ 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.

Drug trafficking patterns

The **expansion of more structured distribution networks** by organised criminal associations has been reported earlier. 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 since then, although non-native drug traffickers represent 75% (63% in 2010). 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.

⁵³ Non published information from the Specialised Drug Unit of the judicial Police

Little, however, is known on the provision sources of the referred distribution networks. 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.

- SEIZURES

In terms of **seized** quantities, important variations are observed for heroin and cocaine since 2000. As far as heroin and mainly cocaine are concerned, increasing quantities have been reported in 2011. The number of seizures also has been showing great variations during the same period, especially for cannabis.

Quantities and numbers of drug seizures

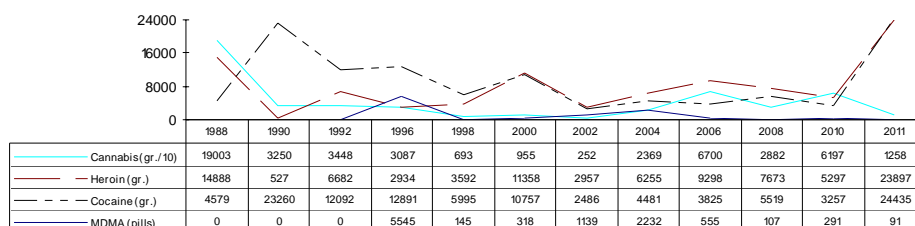
Striking variations have been observed as to the quantity of illicit substances seized since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002⁵⁴. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. However, this trend is not observed in 2009 and 2010 for heroin. In 2011, an important increase in the quantity of seizures is observed for heroin. Cocaine seizures (quantity) are highly variable since the beginning of the nineties. Compared to 2010 data, the quantity of seizures of heroin and cocaine went up strongly in 2011.

Notwithstanding the quantities of heroin and cocaine seized, increasing importantly between 2010 and 2011, the **number of seizures** has grown discontinuously since 1990 (small decrease in 2011). This means that more seizures of bigger quantities have been reported. Since 2000 the number of cannabis seizures has clearly increased, small decrease in 2011, while the number of heroin and cocaine seizures tends to stabilise. Markedly, the number of cannabis seizures has risen from 167 to 897 between 1994 and 2011. The total **number of persons** involved in traffic has followed a constant upward trend until 2002 and showed up- and downturns since then (2011: 2210, 2010: 2530, 2009: 1963 persons). In 2011, the data show an decreasing trend concerning the total number of persons involved in traffic, compared to 2010. A confirmed majority of offenders 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. After years of rather modest XTC type pill seizures, 2009 data reveals consistently higher amounts of seizures. In 2011, however, the MDMA seizures show again an important decrease.

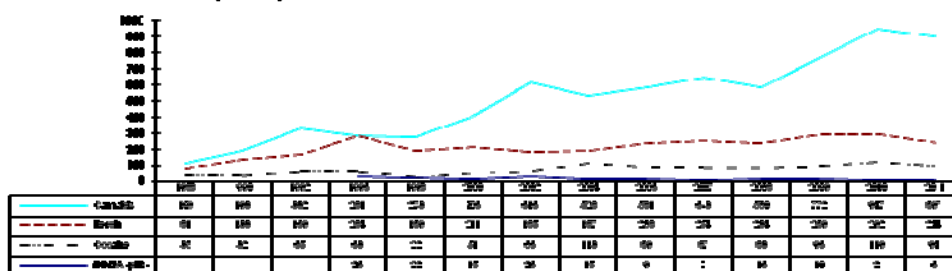
⁵⁴ Non-transit drugs destined to the national market

Fig. 10.1 Total quantites of national yearly seizures: heroin, cocaine, ecstasy type
(1988 - 2011)



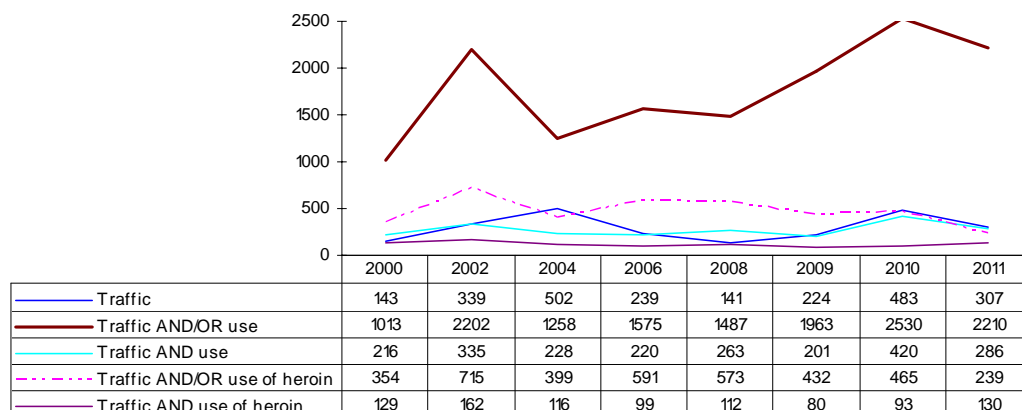
Source: Specialised Drug Department of the Judicial Police 2011

Fig. 10.2 Total number of national yearly seizures: Cannabis, Heroin, Cocaine, MDMA
(1988 - 2011)



Source: Specialised Drug Department of the Judicial Police 2011

Fig. 10.3 Number of offenders involved in seizures according to type of offence
(1988-2011)



Source: Specialised Drug Department of the Judicial Police 2011

Quantities and numbers of precursor chemicals

No information available.

Number of illicit laboratories and other production sites dismantled

The last time the dismantling of a synthetic drug manufacturing laboratory was reported by law enforcement dates back to 2003. Since then, no further laboratory seizure on the national territory was reported.

According to police records, single cannabis growing fields are found on a fairly irregular basis. Local cultures of cannabis remain rather insignificant in terms of quantity and national production is limited to small indoor cannabis cultivations (mostly for personal use and not primarily meant to procure economic profit).

- **PRICE/PURITY**

Price of drugs at retail level

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen from 1998 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 derivatives however have known a fair stability during the last 8 years, but is increasing in 2011. Typical street retail cannabis is sold for 5-35. – EUR per gram (2010: 4-25. – EUR).

Table 10.2: Price per unit evolution at the street level (1994-2011)

	1994	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011
Cannabis Hashish 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	8-10 5-10	5-16	4-10 7-25	10-35 5-30
Cocaine	100-150	120 -170	90	50	20-120	20 – 110	30-100	30-100	70-100	50-200	50-250	14-166
Heroin (brown)	65-150	90 -150	74.4	50	82	80	50-90	50-90	60-80	33-100	20-250	21-125
STA		25-30	n.a.	25	n.a.	n.a.	5	5	20	n.a.	20	20-35
Ecstasy		9 - 13	10.7	7	10	10	5	5	5-15	n.a.	5-12	5-25
LSD	11-13	11 -13	n.a.	n.a.	10	10	n.a.	n.a.	5-15	n.a.	12	15-25

Source: Specialised Drug Department of the Judicial Police (1994-2007), Tox-In (2008-2011)

Price: expressed in EURO at street level.

For cannabis, cocaine & heroin (since 2009) and amphetamines, price per gram is indicated.

For heroin and cocaine, minimum prices refer to traffic units (until 2008) Maximum and average prices refer to street retail quantities.
For ecstasy and LSD, price per pill or unit are indicated.

Purity/potency of illicit drugs

Compared to the situation in 2004, purity of heroin tends to stabilise while the purity of cocaine decreased (2004: 61.78% / 2011: 46.7%). However, a slight decrease can be observed in 2011, compared to the data of 2010. 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 40%) in herbal cannabis samples seized in Luxembourg in 2009. However, in 2010 and 2011, the maximum concentration of THC has decreased again (34.2%/ 27.5%). Prices show broad ranges for heroin and cocaine. Cannabis and derivatives however have known certain stability during the last 8 years as far as street prices are concerned.

Attention has to be paid to the striking differences in maximum and minimum purities of all substances. For instance heroin and cocaine show very high maximum purity rates. These values should however be considered carefully, the sampling may contain intermediary seizures, not ready for street consumption and to which cutting agents were supposed to be added. Historically high maximum concentration of THC in cannabis samples seized in Luxembourg has been observed in 2009. Herbal cannabis showed highest maximum levels of THC concentrations, which are still high but have however decreased since the maximum concentration in 2009 (27.5% in 2011, 34.2% in 2010, 40.78% in 2009, 25% in 2008). In 2010 and 2011 average THC concentration in herbal cannabis was higher than in resin cannabis. For more detailed information please refer to standard table 14.

Table 10.3: Purity of drugs at street level (1994-2011)

	1996	1998	2000	2002	2004	2006	2007	2008	2009	2010	2011		
	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)		
	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	MIN.	MAX.	AVRG.
Cannabis (THC)			8.03	7.96	6.94	7.36	9.61	9.82	11.25	11.32	<0,05	27,55	10,99
<i>Marihuana Hashish</i>							10.21 8.52	9.75 10.3	11.18 12.39	11.84 7.30	<0,05 0,35	27,55 25,20	11,28 9,54
Cocaine	60-90	60-90	60.25	62.99	62.37	58.80	51.00	52.00	43.20	46.92	0,10	95,45	46,74
Heroin (brown)	15-23	20-25	17.59	9.97	17.07	15.80	16.60	16.10	18.50	24.02	0,24	45,55	10,08
STA				15.09	9.44	7.1	13.81	18.2	15.38	10.43	4,50	29,45	15,58
Ecstasy⁵⁵ (MDMA) (MDEA) (MDA)			35.5 6.8	71.11	29.77 6.25	26.44	20.52 1.25	23.52 23.57	17.32	53.14	44,40 nd nd	89,90 nd nd	77,88 nd nd
Psilocybine			0.41			/	/	/	/	0.05	nd	nd	nd

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2011

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.

In 2011 S. Schneider and F. Meys⁵⁶ published a paper on analysis results of illicit cocaine and heroin samples seized in Luxembourg from 2005 to 2010. Abstract: This article discusses drug purity, frequency of appearance and concentration ranges of adulterants of 471 illicit cocaine and 962 illicit heroin samples seized in Luxembourg from January 2005 to December 2010. For cocaine samples the mean concentration was lowest in 2009 (43.2%) and highest in 2005 (54.7%) but no clear trend could be observed during the last 6 years. 14 different adulterants have been detected in cocaine samples, from which phenacetin has been the most abundant in terms of frequency of appearance and concentration until 2009. In 2010 the veterinary antihelminthic drug levamisole has become the most abundant adulterant detected in cocaine samples, its concentrations however remained low (1.5-4.1%). The mean heroin concentration was 26.6% in 2005, a decline has been observed in 2006 and the concentrations have been relatively stable since then (15.8-17.4%). Paracetamol and caffeine were by far the most abundant adulterants detected in heroin samples.

Composition of illicit drug tablets

Information for this section was provided by the National Laboratory of Health (LNS) and formatted by the NFP. 15 pills were analysed during year 2011. 33.3% of analysed pills contained MDMA as main active substance and 0% contained other substances, as caffeine, paracetamol or ibuprofene.

Most common cutting agents found in MDMA, amphetamine or mCPP containing products were sugar and caffeine.

For detailed information please refer to standard table 15.

⁵⁵ Ecstasy : dose in mg/pill

⁵⁶ S. Schneider, F. Meys, Analysis of illicit cocaine and heroin samples seized in Luxembourg from 2005-2010, Forensic Sci. Int. (2011), doi:10.1016/j.forsciint.2011.06.027

Part B: Selected Issues

11. Residential treatment for drug users in Europe

1. History and policy frameworks

1.1. History of residential treatment

The “Central Hospice” was the first institution providing residential care to persons living on the edge of society from 1855 onwards in the Grand Duchy of Luxembourg. In 1901 it turned into the “Maison de Santé” and admitted persons with psychiatric disorders. Since 1974 the “Maison de Santé” was renamed into “Neuro-psychiatric Hospital of Ettelbrück (HNP)”.

In 1978, the first, and so far, the only national residential treatment centre for alcohol dependant persons, an annexe of the HNP, called the Centre of Useldange (CTU), was opened. At the same time, an increasing demand for drug treatment (not only detoxification) did emerge. In 1980, the Residential Treatment Centre of Manternach for drug addicts (CTM) opened its doors with a capacity of 18 beds. At that time, the CTM was a department of the HNP.

Simultaneously, in the beginning of 1980, a youth club of Hesperange (City near Luxembourg) took care of marginal groups and drug addicts. Thanks to a financial convention with the Ministry of Family, the youth club established a non profit association called “Kollektiv Spackelter” and implemented a residential treatment centre. This treatment centre was closed in 1984. In April 1984 a new NGO was created and conventioned by the Ministry of Health, called “centre d'action anti-drogue” Jean Baptiste de la Salle. The therapy centre was called “Schléckenhaus” with a capacity of 18 beds. Both treatment centres (CTM and “Schléckenhaus”) offered individual and group psychotherapy as well as occupational therapy. In 1985, the CTM got a new directorate and a new multidisciplinary team and the concept was revised. A mix of psychotherapy with occupational therapy was offered, and the therapeutic program was adapted to the daily routine of life (e.g. therapy after work).

In 1986, the capacity of both residential treatment centres was not fully used and the need for two residential treatment centres was questioned. The “Schléckenhaus” treatment centre closed its doors and its patients were referred to the CTM.

In 1986 the first outpatient treatment centre called “Jugend-an Drogenhëllef” (JDH) opened in Luxembourg-City. The JDH also implemented the national methadone programme a few years later (in 1989).

In 1989 the CTM opened an outreach centre near the drug scene in Luxembourg City. A decade later (in 1998) the first methadone patients have been accepted in the CTM and its offer was expanded to systemic family therapy.

In 1998 the HNP became a public establishment of private law⁵⁷ and increasingly specialised in care provision for persons with psychiatric disorders, older persons with geronto-psychiatric disorders and persons with mental handicaps. The “Neuro-psychiatric Hospital of Ettelbrück (HNP)” was renamed to “Centre Hospitalier Neuro-Psychiatrique” (CHNP). Currently, 3 main services with different offers exist: the “Rehaklinik – Un der Uelzecht” (psychiatric rehabilitation

⁵⁷ Loi du 17 avril 1998 portant création d'un établissement public dénommé « centre hospitalier neuropsychiatrique »

of psychosis, dependence, alcoholism and psychogeriatrics), the “Centre Pontalize” (elderly people health care) and “de Park” (socio-pedagogic accompaniment of mentally handicapped persons).

In 2003 the CTM launched an aftercare supervised accommodation offer. Until 2012, 30 housing units were created. In 2003, an outreach and guidance centre in Luxembourg City called “Alternativ Beröndungsstell” and managed by the CTM also opened. In 2006, an annexe was built on the CTM site with single rooms, mainly for clients with children.

Meanwhile, in 1989, a reform of institutional psychiatric offers was launched. The “Haefner report”⁵⁸ of 1993 recommended a decentralisation of psychiatric care based on, evidence-based interventions. The report also put forward the crucial role of social reinsertion offers helping patients to return to real life environment or to supervised extra-hospital structures (treatment, accommodation, job and leisure time). The “Rössler report” (2005)⁵⁹ was in line with the previous strategy, which can be summarized as follows: decentralisation, ‘dehospitalisation’, ‘destigmatisation’ and prevention. In this respect, since 2005, opened facilities for mentally ill persons as well as the paediatric and adolescent psychiatry have been implemented in the main hospitals of the 3 hospital regions. Besides, the placement of mentally ill persons has been ensured from then on by acute services of general hospitals. The tradition of 150 years to primordially place mentally ill persons in the CHNP ended at this time. The new mission of the CHNP was thenceforth the psychiatric rehabilitation. A decentralisation of related offers was furthermore developed and is currently still in progress.

The governmental declaration of 1999 defined drug dependant persons as ill persons in need of help in the first place. In 2000, the Ministry of Health was therefore assigned to coordinate the overall activities in the field of demand reduction and a governmental drug coordinator was appointed. Coordination and financial supervision of all state accredited drug services fell under the responsibility of the Ministry of Health.

1.2. Strategy and policy frameworks for residential treatment

The national drug action plan (2010-2014) includes a project of creation of a specialised post-hospital residential and medicalised stabilisation unit for drug dependent persons. The target group consists of drug dependent persons who have undergone previously a detoxification treatment in a regional psychiatric ward. This project originates from the recommendations of an expert working group from the Ministry of Health and has been implemented in the beginning of 2012. It is a short-term accommodation offer with a multidisciplinary care. The objective is a physical and psychological stabilisation of the drug dependent person after an acute phase. The concept foresees 12 to 14 beds for a duration of stay lesser than 1 month. The stabilisation unit offers day care, supervised activities and outings and an accommodation. This stabilisation unit is meant to discharging general hospitals, reducing waiting lists and providing for a better utilisation of resources.

In the framework of the application for “Recognized for Excellence” (EFQM), the CTM has defined a five year plan concerning its mission, its vision and values (in 2009). A Balanced Score Card was developed in order to collect indicators that are relevant for the policy and strategy. Regular meetings with the CHNP addiction sector (*filère toxicomanie*) as well as SWOT analyses allow the CTM to discuss and agree projects.

Strategic aims of the CTM are as follows (source: CTM EFQM qualification file 30/9/2010):

⁵⁸ Gemeindepsychiatrie; Grundlagen und Leitlinien; Planungsstudie Luxemburg 1993; Rössler, Salize, Haefner, VIP-Verlag; ISBN 3-85184-004-6

⁵⁹ Psychiatrie Luxemburg; Planungsstudie 2005, Rössler, Koch ; Auftragsbericht, Ministère de la Santé, Luxembourg

- enlarge the spectrum of services for the rehabilitation of drug-addicted persons,
- develop the aftercare services jointly with other actors,
- develop the collaboration with similar centres in the greater region (neighbouring countries),
- improve the therapeutic network by regular contacts and exchange and specifically with a national reference person system,
- evaluate all the services on a regular basis,
- train and involve employees continuously,
- improve the quality management system in order to assess effectiveness,
- renovate and adapt existing facilities for a modern and sustainable rehabilitation.

The budget of the CTM is managed by the central financing department of the CHNP. CTM-CHNP are depending on the National Health Fund (CNS). As the CTM is a department of the CHNP, which is legally speaking a hospital, its financing depends on the budget of the CHNP. The CNS negotiates each year individually with each hospital an operational budget according to a global or an anticipatory budgeting system. The State, by means of investment subventions, participates up to 80% in the modernisation, the accommodation and the construction of certain hospital infrastructures and heavy equipment. These investments are to be approved by the Minister of Health following a previous decision by the Permanent Commission of the hospital sector.

The authors of the study on the estimation of direct economic costs of policies and interventions in the field of illicit drug use (Origer A., 2002)⁶⁰ have accounted, among other tasks, all costs related to the functioning of the CTM for the year 1999. The total expenditures, including staff costs, travelling and subsistence expenses, and the total operating costs, reached 646,327 Euros in 1999.

The law of 28 August 1998⁶¹ indicates that the Minister of Health is in charge of the coordination and planning of the hospital establishments. Each hospital establishment needs an authorisation for its creation, as well as an authorisation for its operation from the Minister of Health. Among other tasks, the “hospital plan” determines the sanitary regions, and assesses needs in terms of infrastructures, services and hospital beds. The “hospital plan” is based upon a ‘*sanitary card*’ that is revised each 5 to 7 years. The sanitary card is an “annual snapshot” of national hospital services in the light of sanitary needs.

The CTM also depends upon the national PRN (Nursing Research Project), an instrument allowing to calculate staff needs in the health care domain. The PRN score builds upon the documentation of nursing activities.

2. Availability and characteristics

2.1. National (overall) availability and accessibility

To date, the therapeutic centre “Syrdallschlass Manternach” (CTM - CHNP), a decentralised department of the CHNP Rehaklinik “Un der Ulzecht” in Ettelbrück, is the only national residential centre for drug-dependant persons at national level. As cited above, it was founded in 1980. The centre operates on the model of a therapeutic community for drug dependant

⁶⁰ Origer, A. (2002). Le coût économique direct de la politique et des interventions publiques en matière d'usage illicite de drogues au Grand-Duché de Luxembourg. Séries de recherche n°4. Point focal OEDT Luxembourg – CRP-Santé. Luxembourg.

⁶¹ Loi du 28 août 1998 sur les établissements hospitaliers.

persons. CTM admits up to 25 persons, including client on substitution treatment, prior to their admission (since 1998). Parents accompanied by their children are also admitted. The therapeutic offer includes social and professional reinsertion measures.

The CTM:

- offers the clients an appropriate and diversified medico-socio-psychological and ergo therapeutic treatment,
- helps clients to assume accountability for their behaviour as well as to improve capacity building in conflict resolution,
- aims to develop clients emotional, social and intellectual capacities, as well as their individual autonomy,
- encourages the resocialisation, professional and familial reinsertion,
- provides alternatives to the behaviour of drug dependent clients.

Each interested client can be informed about the therapy by contacting the outreach service of the CTM “Alternativ Beröndungstell” or by contacting directly the CTM. Then, an intake interview can be convened either alone, with the partner or with family members. Contact interviews are also organised in hospitals or in prison.

In 2011, the total team was composed of 19.5 FTE corresponding to 25 different collaborators (orientation and aftercare included).

In 2011, 57.9% (62.5% in 2010) of admissions of CTM have been new admissions. A total of 92.1% of clients were unmarried (single) and 38.15% were parent of at least one child. 11.8% of admissions have been transferred from the CHNP to the CTM and 40.8% have been transferred from regional hospitals. 7.9% have been transferred from the CPL (national prison) and 38.2% on demand from the client himself. 1.3% of the admissions came from another therapeutic centre. 73.7% (70.3% in 2010) of clients in therapy at the CTM underwent a methadone substitution treatment with the objective to reduce progressively their daily dose. A total of 23 persons have been present at the CTM on 31 December 2011. 44.8% of clients were over 30 years old, 32.9% were aged 26-30 years, 21% were aged 20-25 years and 1.3% were aged less than 20 years. 76.4% of clients were nationals, 13.2% Portuguese, 2.6% German, 2.6% Italian and 5.2% other nationalities.

Aftercare housing offers are also managed by the CTM. These are supervised housing offers for persons who have undergone treatment at the CTM. The level of the supervising offer can be modulated. These homes predominately situate in the east of the country and are focussing on social interventions.

The CHNP “Rehaklinik”, implemented in February 2012, is a multidisciplinary care for drug dependent patients for a period of 3 to 4 weeks in order to stabilise the psychological and physical state in a medicalised stabilisation unit. Specific objectives are the stabilisation of the substitution treatment, the diagnosis and/or treatment of associated harms, the improvement of health after detoxification and an orientation towards a post-hospitalisation project in close contact to a national referent. The stabilisation unit offers a residential support, individualised activities and supervised outings. The target group consists of drug-dependent persons who have previously undergone a detoxification treatment in a general hospital. The stabilisation unit has a capacity of 15 beds.

Admission criteria are as follows:

- aged more than 18 years,
- negative urine drug test for non-prescribed drugs,

- stable physical and psychological state without signs of pharmacological intoxication, without signs of withdrawal from illicit substances and non prescribed drugs,
- medical certificate attesting that the patients state is sufficiently stable before admission.

2.2. Types and characteristics of residential treatment units

2.2.1. Common approaches;

The offer of the CTM is based upon individual psychotherapeutic sessions and group sessions. After two months, each patient gets a therapeutic planning which defines the duration of the therapy (varying between 6 and 15 months). The therapy plan is individually designed, defines therapeutic aims and regulates therapy agreements (for example personal themes to be dealt with, duration of therapy etc.). Regularly, these aims are re-discussed with the client and, if necessary, newly defined.

The admission criteria are as follows: the patient has to agree on the therapeutic concept and, previously to its admission, has to have undergone a detoxification treatment. He/she has to present a medical certificate attesting his/her general health status. He/she has to undergo a urine analyses and accept that the personal belongings are searched through. The patient has also to subscribe individual third-party insurance.

At the beginning of the therapy, the client is assigned a reference person from the group as referent person from the staff team, and as therapist. The community life is regulated by internal house rules.

The main house rules are:

- no violence
- no threat of violence
- no consumption of illegal drugs
- no consumption of alcohol.

The CTM works according to the principles of a therapeutic community which are based upon mutual help within the group (and by providing professional support). This method enables clients to develop and formulate their own needs, to get more autonomous, to progressively adopt more responsibility and to learn to recognize and respect limits.

Phase 1 is called motivation phase (duration about 8 weeks). The patient has to familiarise with the therapeutic concept, to get accustomed to the house and the group, to conform to rules and to take distance from the drugs environment. Contact to the outside is limited. This phase is meant to create relations to the other group members and the staff team.

The therapeutic offer includes: individual interviews, thematic group sessions, gender specific group sessions, family therapy, ergo therapy, sports therapy, corporal and relaxation therapy, leisure time activities and learning support.

The client has to make an application for the next phase. After agreement of the group and the staff team, an individual therapy plan is established for the next phase.

Phase 2 is called development phase (duration about 4 to 7 months). The patient is invited to intensely participate to the therapeutic sessions (individual, group, as also family and couple sessions). The client has to learn to take responsibility for his own actions but also for his work, the rules and the other members of the community. If possible, she/he will now be responsible for a certain work plan/sector (kitchen, gardening, joinery, keeping of animals, household...). At

the end of this phase the main focus is laid on external referral and the reintegration to social life.

Phase 3 is called detachment phase (duration about 2 to 3 months). It is the switch from a protected community life to a more autonomous life. Objectives are a reintegration to the employment market, organisation of leisure time outside the community and search for accommodation.

2.2.2. Typical mix/integration of services;

The CTM only admits patients who have previously undergone a detoxification treatment in a hospital. The CTM offers continuation of previous OST, individual psychotherapeutic and group sessions, gender-specific sessions, family therapy, ergo therapy (joinery, locksmithery, animal husbandry, gardening, kitchen work, housekeeping, landscape planning), recreational therapy (fitness, music, PC, darts, cultural visits, pedagogical activities), sports therapy (jogging, football, volley-ball, basket-ball, handball and swimming), relaxation and corporal therapy (shiatsu, massage, meditation, aromatic therapy, foot reflexology, autogenic training) vocational training (reading, arithmetic, orthography), life skills training, housing and employment.

2.2.3. Integration of OST in residential care;

The CTM is organised as a therapeutic community and admits patients who follow a methadone substitution treatment. In 2011, 73.7% of patients in therapy were on OST. Clients get their daily dose of methadone in liquid form either once or twice a day by a nurse. Once a month the multidisciplinary team decides on the opportunity to reduce the daily dose of the client and discusses the retained option with the client. The reduction of methadone to zero level is not the primary aim in the therapy concept. Drug screening tests are organised weekly, unheralded or on suspicion.

2.2.4. Typical levels of collaboration and networking;

A formal joint working agreement exists, which means that close cooperation with other units providing treatment, rehabilitation or complementary services is set up and is promoted.

The aftercare homes of the CTM offer 30 places. To be admitted, the client has to have stayed at least 3 months at the CTM. The concept also foresees procedures to get regular employment by and for clients. The client has also to pay a monthly rent (lower than common market prices). 1.5 FTE educators take care of clients.

In the framework of the European Foundation of Quality Management “EFQM”, the CTM closely collaborates with the drug treatment centre “Schaumberger Hof”. In 2010 a benchmarking convention was signed with the “Schaumberger Hof” (Saarland- Germany) and “Hanosiushmühle” (Rhineland-Palatinate- Germany).

3. Quality management

3.1. Availability of guidelines and service standards for residential treatment

The CHNP is a member of the alliance of Luxembourgish hospitals (“Entente des Hôpitaux Luxembourgeois – EHL”), which is the association representing the institutions of health from the acute sector (hospitals and clinics) respectively of the long stay care sector. The implementation of the EFQM model in hospitals, the management model developed by the “European Foundation for Quality Management”, was decided by the EHL and the Union of

Sickness Funds (Union des Caisses de Maladie - UCM) in 2002. This EFQM model was implemented in hospitals during 2004 and 2006. A progressive implementation of common performance indicators, quality indicators and result indicators is pursued since 2005. Also the grand-ducal decree of 13 March 2009 implementing the national hospital plan⁶² sets up in each hospital an evaluation and quality assurance committee as well as a national quality assurance committee. The committee has to elaborate an annual report of good functioning and of the quality of services provided. Each hospital establishment has also to designate a quality coordinator. The committee has to follow the guidelines and recommendations of the national quality assurance coordination committee. The law defines the CHNP as a specialised establishment which has to proceed every 3 years to a widespread evaluation of the medical practices and accorded care as well as to proceed to a comparison with similar structures abroad and best practices.

The CHNP is an active member of the EFQM association and of the Luxembourgish Quality Movement (MLQ which was created on 5 March 2001) and promotes the logic of excellence and of the development of competency centres. The aim is to guarantee excellent services for the patients/clients, quality relations with partners and satisfaction of collaborators. A steering group for quality was implemented inside the CHNP.

In 2006, the CTM has received the Luxembourgish Award of Quality with the mention “on the route of Excellence”. The CTM-CHNP was recognized for excellence in 2010 in the framework of the EFQM. Three assessors of the European Foundation of Quality Management have been evaluating the organization of the management, the human resources, the infrastructure, the processes and the results. On the basis of a quality report, the international team of assessors underlined the high level of organisation of the CTM and its culture highly oriented towards the client.

Since 2004, every two years, an EFQM self-assessment is conducted in the CTM through the CHNP. A quality coordinator from the CHNP is actively implicated in the quality management of the CTM. Each year, the CTM organises a client satisfaction survey. Besides this, employee satisfaction surveys are conducted regularly. In the framework of the EFQM, the following indicators are evaluated since 2007: readmissions, clients on waiting lists, number of clients with ADHS, clients staying more than 6 months, liver function tests, methadone substitution, number of clients from the “Alternativ Beröndungsstell” and number of consultations, employee absence, right to care posts (PRN), hours of training of CTM employees, press articles, visits by external organisations, number of practitioners from nursing school, participation in community activities, suppliers, collaboration with partners, turnover CTM, turnover in apartments (aftercare), operating costs, mean duration of stay of patients and occupancy.

4. Discussion and outlook

4.1. Outlook

The Therapeutic Centre Syrdallschlass (CTM) currently shows high occupation rates. During recent years the offer of group therapy switched to an increasingly individualized psychotherapy offer. Individual needs of clients are increasingly focused on in the drug help system. Experts also notice a tendency towards more social, intellectual and educational deficits from the clients in therapy.

⁶² Règlement grand-ducal du 13 mars 2009 établissant le plan hospitalier national et déterminant les missions et la composition minimales des structures d'évaluation et d'assurance qualité des prestations hospitalières et les modalités de coordination nationale de ces structures.

In 2008, a special working group of the Ministry of Health elaborated recommendations in the field of national needs in offers of treatments for drug dependent persons. The group recommended not to increase the number of beds for the CTM but to continue to diversify offers and modulate the different levels of care.

As the CTM is the only residential treatment centre in the Grand-Duchy of Luxembourg, an average of 120 patients per year undergo a therapy abroad. Related costs are covered by the social security scheme.

Related websites:

www.chnp.lu
www.schaumbergerhof.de
www.fachklinik-hanosiusmuehle.de
www.ehl.lu
www.cns.lu
www.ms.public.lu
www.legilux.public.lu
www.jdh.lu
www.relis.lu

12. Recent trends of drug-related public expenditures and drug services

Introduction

Budget lines covering labelled and non-labelled drug-related public expenditures and drug services have been increasing continuously between 2005 and 2010, and were not subject to state budgetary austerity policies in Luxembourg. Data available and provided in the present chapter correspond to 3rd level quality as defined in the EMCDDA report 2012 guidelines.

In order to present evidence of the lack of impact of the general and recent economical situation, drug-related budget lines of 2005 have been compared (when possible) with 2010 figures in table 12.1. Some budget lines have been added during the referred period and others have merged with more generic budgets, but most figures are comparable between 2005 and 2010 and they show a consistent total increase of 35% during the referred period.

Table 12.2 presents the annual progression of the budget of the Ministry of Health and human resources allocated to drug-related services between 2004 and 2010. Both budgetary indicators witness an increase of approximately 40% between 2005 and 2010.

One should be cautious in the interpretation of figures as year specific expenditures (e.g. acquisition of real estate for services, restoration, major maintenance work of buildings) as well as changes in HIV incidence in PDU/ IDU, changes in the cost of OST or ARV medications and changes in IDU/PDU prevalence, treatment demand (number of detoxification treatment in psychiatric hospitals) and consume patterns (e.g. if there is an increase of inhalation route, number and related cost of distributed sterile syringes will decrease), may result in variations in state budgets that are not indicators of austerity or investment policies in the field of drugs at state level.

However, as far as Luxembourg is concerned, all indicators show an increasing trend in budgetary means allocated to drug-related policies and services. These increases are substantial enough to state that there has been no austerity policy in drug-related budgets in place between 2005 and 2010.

Table 12.1: National estimates of labelled and non-labelled public drug demand reduction expenditures: 2005 – 2010

LABELLED EXPENDITURES			
Ministry of Justice	S7.2/12.370 0.30 TOX PROGRAMME: Care and treatment programme for drug addicts in prison	0.- 820.000.-	<i>Extracted from the national state budget 2005,2011</i>
Ministry of Education [...]	S.10.0 12.223 04.01 Drug prevention in primary and post primary schools	64,997.- 0.-	<i>Extracted from the annual national state budget</i>
	S 11.4 12.301 08.30 Drugs prevention campaigns in schools	3,938.- 2,000.-	
Ministry of Health	S 14.0 12.000.05.00 Fees for National Drug Substitution treatment commission	1,500.- 0.-	<i>Extracted from the annual national state budget</i>
	S 14.1/33.013 05.23 – 33.015 05.23 Staff and operational costs of specialised drug agencies conventioned by state (25/40% non-specialised)	4,555,482.- 7,548,226.-	<i>Idem</i>
	S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	318,151.- 537,000.-	<i>Idem</i>
	S 14.2 12.301 05.20/12.801 05.20 Toxicological surveillance of drug addicts	161,950.- 150,000.-	<i>Idem</i>
	I52.002 05.22 Participation in equipment costs of drug treatment facilities	371,664 300.000.-	<i>Idem</i>
Directorate of Health	S 14.1/33.014 05.23 Staff and operational costs of drug related activities of the National Aids counselling Centre	143,111.- 201,449.-	<i>25% of total budget of the centre: average proportion of PLWHIV/AIDS infected via IDU in clients</i>
Ministry of Social Security	S 17.2 Staff, operational and mission costs for agents in	70,694.- 80,000.-	<i>Estimation by MSS based on analysis of work/mission/career</i>

	charge of drug treatment referral abroad		
Ministry of Public Works	Maintenance work on/in buildings occupied by specialised NGOs (not covered by other budgets)	0.- 25.000.-	<i>Extracted from the annual national state budget</i>
NON LABELLED EXPENDITURES			
<i>Health/Social Insurance</i>			
	<p>B. <u>Substitution treatment</u></p> <p>Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (net patients' contribution excluded)</p> <p>Reimbursement of pharmacies fees generated by substitution medication preparation /delivery</p> <p>Reimbursement of medical counselling costs related to substitution prescriptions</p>	<p>138,517.- 327,451.-</p> <p>25.000.- est 48,835.-</p> <p>184,000.- 234,796.-</p>	<p>Detailed breakdown by the National Health Insurance Funds</p> <p>Detailed breakdown by the National Health Insurance Funds 2010</p> <p>Number of substitution prescriptions X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)</p>
	<p><u>B. Inpatient hospital drug treatment</u></p> <p>Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification)</p> <p>Medical counselling costs associated to hospital treatment episodes</p>	<p>2,320,805.- 3,001,734.-</p> <p>153,645.- 201,855.-</p>	<p>2010 data</p> <p>ICD-10, F11, F12, F14, F15, F16,F18, and F19 hospital episodes X average cost per episode (adjusted CNS data)</p> <p>Number of medical consultations X reimbursed fees according to duration of stay</p>
	<p><u>C. Drug treatment abroad</u></p> <p>Reimbursement of drug treatment costs abroad/ e.g. residential therapy or therapeutic offer unavailable in Luxembourg</p>	<p>1,041,490.- 1,428,800.-</p>	<p>Year-adjusted breakdown provided by CNS</p>

	<u>D. Inpatient therapeutic treatment extra-hospital</u>	600.000.- 797.705.-	Institution specific budget adjusted for salary costs and inflation
	<u>E. Drug treatment costs subsidised by Min. Health</u>	70.000.- 105,755.-	Budgetary section 14.0.34.011: Breakdown of real costs generated by drug treatment not covered by the CNS
	<u>F. Cost of HIV/AIDS treatment provided to patients infected via IDU</u>	1.672,000.- 576.000.-	Number of HIV/AIDS patients infected via IDU x yearly average cost of HIV/AIDS treatment X reimbursable proportion
	G. Estimation of state revenue loss from low renting prices for real estates provided to specialised NGOs	200.000.- est 234,000.-	Yearly sum of differences between paid rent and market value rent.

TOTAL LABELLED DRUG –RELATED EXPENDITURES:

2005: 5,691,487 **2010: 9,663,675**

TOTAL NON LABELLED DRUG-RELATED EXPENDITURES:

2005: 6.405,457 **2010: 6,956,931**

TOTAL DRUG-RELATED EXPENDITURES:

2005: 12,096,944 **2010: 16,620,606**

Table 12.2: Annual progression of the budget of the Ministry of Health and human resources allocated to drug-related activities 2004 - 2012

Budget Year	2004	2006	2009	2011	2012
Budget (EUR)	5,771,000.-	6,584,000.-	7,991,583.-	8,321,620	9,745,925
Annual progression rate	Reference year	6.27%	9.65%	4.13%	17.12%
Annual cumulative progression rate	Reference year	14.09%	38.48%	44.20%	68.88%
Dedicated human resources Full Time Equivalent (FTE)	59.5	69.25	83.75	88.75	90.75
Annual progression rate	Reference year	9.06%	6.70%	1,7%	2.25%
Annual cumulative progression rate	Reference year	16.39%	40.76%	49.16%	52.52%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2006/2010. Volume 1. (Ministère des Finances 2004-2011)

Bibliography

Origer A., Cloos J.-M. (2002) Study on socio-economic costs of drug addiction and the fight against drugs. Séries de recherche N°4, EMCDDA Focal Point – CRP-Santé, Luxembourg

Alphabetic list of relevant internet addresses

www.relis.lu

Part C

Bibliography

Appenzeller, B., Schneider S., Yegles, M., Maul, A., Wennig, R. (2005), *Drugs and chronic alcohol abuse in drivers*, Forensic Science International

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

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

Bundesamt für Gesundheit (2006), *Handbuch Heroingestützte Behandlung, Richtlinien, Empfehlungen, Information*, Bern.

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.

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

Centre de Prévention des Toxicomanies (2012), *Bilan d'activités 2011*. CePT, Luxembourg.

CNDS / TOXIN (2010), *Rapport d'activités 2009*, CNDS, Luxembourg.

Comité de surveillance du Sida, (2012), *Rapport d'activités 2011*, Luxembourg.

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

Dellucci, H. (2006). *Etude descriptive sur les connaissances actuelles et les besoins en matière de prévention du Sida dans la communauté lusophone au Luxembourg*, Luxembourg.

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

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

European Commission (2008), *Young people and drugs among 15-24 years-olds*, Analytical report, Flash Eurobarometer 233 – The Gallup Organization, Brussels.

European Commission (2011), *Youth attitudes on drugs*, Analytical report, Flash Eurobarometer 330 – The Gallup Organization, Brussels.

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

European Monitoring Centre for Drugs and Drug Addiction (2010). *Annual report on the state of the drugs problem in the European Union 2009*, Office for official publications of the European Communities, Luxembourg.

European Monitoring Centre for Drugs and Drug Addiction (2009). *Annual report on the state of the drugs problem in the European Union 2008*, Office for official publications of the European Communities, Luxembourg.

EVS Foundation/Tilburg University: *European Values Study 2008*, 4th wave, Integrated Dataset. GESIS Cologne, Germany, ZA4800 Data File Version 1.0.0 (2010-06-30) DOI:10.4232/1.10059.

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

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

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

Fonds de Lutte contre le Trafic des Stupéfiants (2010), *Rapport d'activités 2009*, Ministère des Finances, Luxembourg.

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

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

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

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

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

Jugend an Drogenhëllef (2010), *Jahresbericht 2009*. JDH, Luxembourg.

Kripler, S. & Kittel, F. (2010). Toxicomanies en milieu professionnel: prévalence de l'usage de substances psychoactives et sa relation avec le poste de sécurité et le stress, *Archives des Maladies Professionnelles et de l'Environnement*, 72, p.181-188.

Lambrette, G. (2009), *Projet « START », constats et réflexions autour du projet de réinsertion professionnelle pour personnes toxicomanes au Grand-duché de Luxembourg*, Centre Emmanuel asbl, Luxembourg.

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

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

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

Ministère de l'Education nationale et de la Formation professionnelle (2006), *Le décrochage scolaire au Luxembourg. Ministère de l'Education nationale et de la Formation professionnelle Luxembourg*.

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

Ministère des Finances (2008), *Projet de loi concernant le budget des recettes et des dépenses de l'Etat*. Ministère des Finances, Luxembourg.

Ministère des Finances (2009), *Projet de loi concernant le budget des recettes et des dépenses de l'Etat*. Ministère des Finances, Luxembourg.

Ministère des Finances (2010), *Projet de loi concernant le budget des recettes et des dépenses de l'Etat*. Ministère des Finances, Luxembourg.

Ministère des Finances (2011), *Projet de loi concernant le budget des recettes et des dépenses de l'Etat*. Ministère des Finances, Luxembourg.

Ministère de la Santé (2012), *Rapport d'activités 2011*, 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.

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

Ministère de la Santé (2005), *Stratégie et plan d'action 2006 – 2010 en matière de lutte contre le HIV/SIDA*, Ministère de la Santé, Luxembourg.

Ministère de la Santé (2010), *Stratégie et plan d'action 2010 – 2014 en matière de lutte contre les drogues et les addictions*. Ministère de la Santé, Luxembourg.

Ministère de la Santé (2011), *Stratégie et plan d'action 2011 – 2015 en matière de lutte contre le HIV/SIDA*, Ministère de la Santé, Luxembourg.

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

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

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

- Origer, A. (1998), Enquête auprès des médecins généralistes et des médecins psychiatres sur la prise en charge des patients toxicomanes, in *Rapport RELIS 1997*. Ministry of Health, NFP, Luxembourg.
- Origer, A. (1998), Local drug prevalence estimate for Luxembourg-City, in Annual report on the state of the drugs problem in the European Union. EMCDDA, Lisbon.
- Origer, A. (1999), Comparative study on the drug population of Portugal and a representative sample of Portuguese drug addicts residents of the Grand Duchy of Luxembourg, Point Focal OEDT Luxembourg - Ministère de la Santé, Luxembourg.
- Origer, A. (2001), Estimation de la prévalence nationale de l'usage problématique de drogues à risque élevé et d'acquisition illicite - Etude comparative multi-méthodes 1997 – 2000, *Séries de recherche n°2*, Point focal OEDT Luxembourg - CRP-Santé, Luxembourg.
- Origer, A. (2002). Le coût économique direct de la politique et des interventions publiques en matière d'usage illicite de drogues au Grand-Duché de Luxembourg. *Séries de recherche n°4*. Point focal OEDT Luxembourg – CRP-Santé. Luxembourg.
- Origer, A. (2008), Rapport sur l'opportunité et la faisabilité d'un projet de distribution de stupéfiants sous contrôle médical au Grand-Duché de Luxembourg – Concept cadre, Ministry of Health, Luxembourg
- Origer, A. & Pauly R. (2000), Mortality rate in problem drug users, Direction de la Santé, NFP, Luxembourg.
- Origer, A. & Dellucci, H. (2002), Etude épidémiologique et méthodologique des cas de décès liés à l'usage illicite de substances psycho-actives Analyse comparative (1992-2000), *Séries de recherche n°3*, Point focal OEDT Luxembourg-CRP Santé, Luxembourg.
- Origer, A. & Cloos, J.-M. Dr. (2003), Study on socio-economic costs of drug addiction and the fight against drugs. *Séries de recherche n°4*. EMCDDA Focal point - CRP-Santé, Luxembourg.
- Origer, A. & Removille, N. (2007), Prévalence et propagation des hépatites virales A, B, C et du HIV au sein de la population d'usagers problématiques de drogues d'acquisition illicite. Dépistage, vaccination HAV et HBV, orientation et réduction des risques et dommages. Point focal OEDT Luxembourg-CRP Santé, Luxembourg.
- Origer, A. (2009), Estimation de la prévalence nationale de l'usage problématique de drogues à risque élevé et d'acquisition illicite - Etude comparative multi-méthodes 1997 – 2007, *Séries de recherche n°6*, Point focal OEDT Luxembourg - CRP-Santé, Luxembourg
- Origer A, Schmit J.-C. Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. *J Epidemiol Community Health* 2012;**66**:64-68.
- Origer A. Prevalence of Problem Drug Use and Injecting Drug Use in Luxembourg: A Longitudinal and Methodological Perspective. *Eur Addict Res*. 2012;**18**:288-296.
- Schlink, J. Dr (1999), Etude épidémiologique des infections à l'HIV et à l'hépatite virale C dans les prisons luxembourgeoises, CPL, Luxembourg.
- Schneider, S. & Meys, F. (2011), Analysis of illicit cocaine and heroin samples seized in Luxembourg from 2005– 2010, Forensic Sci. Int. (2011), doi:10.1016/j.forsciint.2011.06.027
- Service Central de la Statistique et des Etudes Economiques (2010), *Annuaire Statistique du Luxembourg 2009*, STATEC, Luxembourg.
- Service Central de la Statistique et des Etudes Economiques (2006), Les activités illégales liées à la drogue : estimation de leur impact économique au Luxembourg, *Statnews n° 35/2006 et Bulletin du Statec n° 2-2006*, Luxembourg.
- Trépos, J.-Y. (2007), *Evaluation du projet global de prise en charge des personnes toxicodépendantes en milieu pénitentiaire au Grand-Duché de Luxembourg*, Université Paul-Verlaine, Metz.
- Trimbos Instituut (2009). *Evaluation of the national drug action plan (2005-2009)* od Luxembourg, Utrecht.

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Annex II

- Relevant data bases and information systems

- a. RELIS drug monitoring system

Relying on a multi-sectorial data network including specialised in- and outpatient treatment centres and low threshold facilities, general hospitals as well as law enforcement agencies and national prisons, the RELIS drug monitoring system, established in 1995 by the NFP in collaboration with the Ministry of Health enables the assessment of new trends in the problem drug users population in general as well as in drug treatment demanders in particular. The NFP 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 17 core items and over 37 sub-items. The standard protocol has been last modified in 2009 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, (**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 (attributors) 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 an online 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 a login to a restricted website, enabling the access to the online calculator and the production of the code of each patient/client. The reliability in terms of data protection was approved by national data protection authorities, by German partner regions of the Mondorf Group and by the National Commission for Informatics and Liberties (CNIL) of France.

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

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

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

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

b. Register on drug law offenders (SPJ)

The register on drug law offenders is paper-based and maintained by SPJ. Research and queries on drug law offenders are performed manually. Special authorisation has been reached by the NFP to access the referred register and to manually include non-nominative data on offenders into the RELIS database. The NFP thus has developed a standard data collection protocol relying on SPSS ® based data analysis. This procedure 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)

The 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. An integrated software based on the DRD ICD-10 standard allows to extract DRD cases from the GMR according to EMCDDA standards.

d. Special Overdose Register (SR) of SPJ

The SR is a paper-based register on acute drug-related deaths run by the SPJ. Over the past years, NFP relies on computer-based indexing procedure (SPSS ®) of drug-related deaths by means of a comprehensive data form. NFP is maintaining a standardised database on acute drug-related deaths from 1985 to 2010. Anonymous drug-related death data is encoded at the SPJ and transmitted to the NFP according to approved standards.

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 coordination of key data providers' activities. The national coordination unit of EWS is implemented within the NFP. The head of NFP has been appointed national EWS coordinator.

The new mandate of the **Inter-ministerial Group on Drugs** (November 2000), which represents the top decision level in the field of drug policies, expressly 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 level 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 under age 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 to 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 counterpart, 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 on-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 CLDDT 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/>