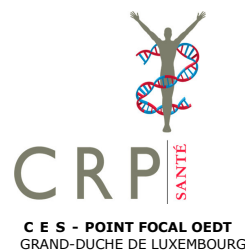




European Monitoring Centre
for Drugs and Drug Addiction



**2006 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point**

“GRAND DUCHY OF LUXEMBOURG”

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

Alain Origer

REITOX

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ABBREVIATIONS

AST	Service d'Action Socio-Thérapeutique
CNDS	Comité National de Défense Sociale
CePT	Centre de Prévention des Toxicomanies
CPOS	Centre de Psychologie et d'Orientation Scolaire
CRP-HT	Centre de Recherche Public - Henri Tudor
CRP-Santé	Centre de Recherche Public - Santé
CTM	Centre Thérapeutique de Manternach
CHNP	Centre Hospitalier Neuro-Psychiatrique
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
GHD	Groupe Horizontal « Drogues »
GID	Groupe Interministériel « Drogues »
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMA	Agence Européenne pour l'Evaluation des Médicaments
EUROPOL	Office Européen de Police
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
JDH	Fondation Jugend- an Drogenhëllef
LNS	Laboratoire National de Santé
MSF	Médecins Sans Frontières
OEDT/EMCDDA	Observatoire Européen des Drogues et des Toxicomanies
OGD	Observatoire Géopolitique des Drogues
PFN	Point Focal National de l'OEDT
PNUCID	Programme des Nations Unies pour le Contrôle des Drogues
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
SEPT	Semaine Européenne de Prévention des Toxicomanies
SNJ	Service National de la Jeunesse
SPJ	Service des Stupéfiants de la Police Judiciaire
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
ZePF	Zentrum für Empirische Pädagogische Forschung – Universität Landau

Foreword

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

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Luxembourg, 28 October 2006

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Summary

Annual National Report on the Drug Situation (Edition 2006)

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

Political, legal and organizational framework

Following the parliamentary elections of June 1999 the government entrusted the Ministry of Health with the overall coordination of drug-related demand and risk reduction actions. This led to the creation of the national drug coordinator's office in 2000.

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

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

The **global budget of the Ministry of Health** granted to drug-related services and programmes went up from 1,270,169 EUR in 1999 to 5,770,643.- EUR in 2004, indicating a **progression rate of 354%** since 1999. The 2005 budget went up to 6,195,518.- EUR representing a supplementary raise of 7.4% in reference to the 2004 budget. In regard to the 2006 budget, 6,583,862. - EUR have been allocated to concerned services representing an increase of 6.3% compared to 2005. Human resources dedicated to specialized state financed drug agencies have known a significant increase from 30.75 full time posts in 2000 to 69.25 in 2006.

Epidemiological indicators

The total number of drug users in the world is estimated at some 200 million people, equivalent to about 5 percent of the global population aged 15-64. Cannabis remains by far the most widely used drug (some 162 million people), followed by amphetamine-type stimulants (\pm 35 million people), which include amphetamines \pm 25 million people) and ecstasy (almost 10 million people). The number of opiate abusers is estimated at 16 million people, of which 11 million are heroin abusers. Around 13 million people are cocaine users.

In the last decade, the most important increase besides cannabis, applies to ATS (including ecstasy) followed by cocaine and opiates. A similar evolution is observed within the **EU** and the micro-geographical level of the **Grand Duchy of Luxembourg**, however accompanied by more or less sustained local variations with regard to prevalence.

National drug prevalence in the general population

Drug prevalence in school population

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

National prevalence of problem drug use (PDU)

Data on institutional contacts and drug treatment demands

The **number of problem PDUs** indexed by national institutions in 2005 figures 4.101 (1994: 2,213) (double counting included). For comparison, 873 users have been indexed by national specialised drug demand reduction agencies and 1,340 persons by supply reduction agencies in **1994**. In 2005 the same agencies have indexed 1,901 and 2,200 persons respectively, which equals to a total **increase rate of 85 %**. **5%** of respondents are **first treatment demanders**, all treatment centres included. More recently one has observed a **stabilisation of treatment demands in outpatient drug agencies** and inpatient therapeutic centres whereas detoxification demands and contacts with low threshold drug agencies are clearly increasing.

The male/female ratio of the PDU population is 3:1. The last ten years the proportion of indexed non-native PDUs has shown strong variations but a clearly increasing tendency since 2003. The **population of non-natives** drug users largely consists of Portuguese nationals, a proportion constantly increasing until 2004 and consistently higher than the one observed in general population. Notably, one observes a remarkable increase of PDUs of French origin (23%). This trend is confirmed by last 5-years data on drug law offenders.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 29 years and 10 months in 2005. **The gap between youngest and oldest PDUs continues to grow**. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to “new” PDUs. Worth mentioning also the significant increase of the **average age of overdose victims** and a **significant but currently decreasing proportion of minors** among drug law offenders STUP. Respectively 85% and 40% of current PDUs have tried cannabis and heroin (i.v.) while being minor of age. In 1995 the same proportions figured 71% and 23%. Most interestingly, evolution of drug use patterns tend to accelerate in terms of shorter time spans separating first non-iv use from first iv-use. This acceleration is also observed as far as first treatment demands are concerned. PDUs tend to contact drug treatment facilities at an earlier stage, which may be due to a more diversified offer currently available.

Problem drug use prevalence and consume trends

The multi-methods prevalence study on PDUs at the national level, published in 2001 (Origer 2001), provides a prevalence rate of 8.42 per thousand inhabitants aged 15-64 (absolute figure 2,450 PDUs). According to indirect follow-up indicators (Origer, 2005), **prevalence figures** applied to the national population aged 15-64 currently situate between 2,500 and 2,800 PDUs.

Intravenous heroin use associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. As already indicated, the switch to **intravenous drug use** occurs earlier. The ratio of **intravenous opiates consume to the inhalation** mode has stabilised at 2:1. The prevalence of the use of cocaine as primary drug continues to increase, which is partly due to increased availability on the national market.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use had known a sensitive increase the last three years but decreased again in 2004 / 2005. **Amphetamine like substances and ecstasy** are only weakly represented, which, however, does

not inform about prevalence in general population as RELIS data refer to PDUs and not to the overall population of **recreational drug users**.

The proportion of **poly drug use** (92%) has reached stabilisation after a record level in 2004. The average ages at **first time consumption of a preferred drug** and **illicit drugs in general**, show a slow but continuous decrease for the last 8 years. In 2005, age of first use of cocaine (iv/non-v) and heroin (non-iv) stabilised, contrarily to average ages of first intravenous heroin use and even more significantly the average age at first cannabis use (almost 1/3 of respondents were not older than 13 at the moment of first cannabis use. In general, the proportion of PDUs aged more than 39 years and of users less than 19 years is increasing continuously as also the gap between these two groups.

Drug-related morbidity and mortality

HBV (hepatitis B) and the HIV/AIDS prevalence among PDUs have not been increasing in recent years while the **infection of HCV (hepatitis C) showed a clear progression**. Data from the Laboratory of Retrovirology of the CRP-Santé suggest a **long term and discontinuous decreasing tendency of average proportion of IVDUs in newly diagnosed HIV cases** until 2004. **HIV infection rates in IVDUs** situates around 4 percent thus witnessing a currently stable trend. Attention has to be paid to the strong increase of the **HIV infection rate in female IVDUs** figuring more than 10% in 2005.

The implementation of the 2000-2004 and 2005 - 2009 action plans has been accompanied by a significant decrease of **overdose cases** in the Grand-Duchy of Luxembourg (2005: 8 cases). Expressed in the number of overdose cases in the general population of the Grand-Duchy of Luxembourg, this proportion figured 1.76 overdose death per 100,000 inhabitants in 2005 (2000: 5.9 cases per 100,000 inhabitants). **Forensic data** of 2005 confirm that nearly every drug-related death involved heroin use associated to multiple substance use. Detected associated drugs in blood samples of overdose victims showed primarily cocaine and methadone as also the involvement in a majority of cases of alcohol and benzodiazepine type medicaments. To date no lethal intoxication related to ecstasy type substances has been reported.

In 2005, 9 **indirect drug death cases** have been indexed. Main causes of indirect deaths between 1996 and 2005 are, in order of importance: suicide, traffic accidents, undefined intoxication, associated cardio-vascular or pulmonary complications pharmaco-dependance, liver failure and immune deficiency diseases.

The overall number of indexed direct and indirect drug death cases informs about **drug-related mortality**. Drug-related mortality prevalence has been showing small variations between 1996 and 2004 figuring roughly 26 to 33 cases per year. 2005 stands for a historic minimum of 17 drug related deaths.

Law enforcement indicators¹

Seizures of illicit substances at the national level

Striking variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002². Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. **Cocaine** seizures (quantity) are highly variable since the beginning of the nineties.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. Since 2000 the number of cannabis and cocaine seizures has clearly increased and the number of heroin seizures tends to stabilise. Markedly, the number of cannabis seizures has risen from 167 to 649 between 1994 and 2005. The total **number of persons** involved in traffic has followed a constant upward trend until 2002 and seems to have stabilised since then. A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

¹ If not specified, data refer to 2005. Figures between brackets refer to 2004 if not specified.

² Non –transit drugs destined to the national market

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

Drug law offenders and prison sentences

The **number of police records** for presumed offences against the modified drug law of 1973 has more than doubled between 1995 (764) and 2005 (1,601). A similar evolution has been observed with regard to the **number of drug law offenders**. In 2005, 155 (178) **arrests** for presumed offences against the modified 1973 drug law have been reported. Generally speaking, the number of police records, the number of drug law offenders and the number of persons arrested on the same charge have stabilised in recent years

88% of drug law offenders are male, a proportion which has been varying between 79% and 90% during the last ten years. Since 1998, the proportion of **non-native drug law offenders** went from 50% to 66% (68%). In 2005, 32% of the registered cases are **first drug law offenders** (lowest level since 1998); the percentage of **minors** in drug law offenders has increased from 5.4% in 1993 to 13.8% in 2003 and decreased again to 7,6% in 2005.

National prison data of 2005 refer to 1,425 (1,033) new admissions of which 166 (11.6%) were related to drug law offences; a proportion having represented 42.6% in 1996.

Profile of the national drug market

According to data provided by the Special Drug Unit of the Judicial Police, likewise 2004, a majority of **illicit drugs consumed in the Grand Duchy of Luxembourg originate** from the Netherlands, followed by Belgium and Morocco. Heroin consumed in Luxembourg originate primarily from Afghanistan, Laos and Myanmar. Cocaine distributed on the national illegal market originates mainly from Brazil and ATS like substances mostly come from the Netherlands followed by Poland and the Czech Republic. The road network is still the main transport and transit route of drugs destined to the national market.

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

Since 2003 no new **clandestine drug laboratory** has been dismantled thus far. Local cultures of cannabis and magic mushrooms are rather insignificant in terms of quantity and quality.

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen from 1996 to 2002/2003 but broader price ranges as well as higher maximum prices for cocaine and heroin have been observed in 2005. Cannabis and derivatives however have known a fair stability during the last 4 years.

As far as **purity** is concerned, samples of suspected substances analysed by the National Laboratory of Health show an increase of THC rate in cannabis derivatives and in heroin purity and a decrease in cocaine quality. In regard to other substances, tendencies are not clear. However, data from 2005 confirm a significant decrease of MDMA concentrations in ecstasy like substances for the last 3 years.

Harm reduction activities

The number of **sterilised syringes** (2005: 435,000/ 1996: 76,259) distributed in the framework of the **national needle exchange programme** has been constantly rising from the start of the latter. The same trend is observed with regard to the number of **used syringes collected** (2005: 381,000 (88%)/ 1996: 28,646 (38%)). An increasing majority of injectors (37%) procure their syringes in specialised agencies followed by pharmacies and automatic dispensers.

The **number of contacts** registered by low threshold structures has increased dramatically over the last 8 years and literally exploded in 2005 (2005: 47,730/ 1996: 6,456). The number of syringes distributed by the same agencies has been following a similar evolution although stabilising for the first time in 2005. The proportion of **new clients** within low threshold settings has also stabilised.

The number of clients of the national **methadone substitution programme** went from 30 in 1993 to 114 in 2005 (decreasing tendency since 1998). In addition to the methadone substitution programme financed by the Ministry of Health, an important number of PDUs address substitution treatment demands to **independent general practitioners**. Data delivered by the Union of Health Insurance Funds refer to 970 different patients who did receive substitution treatment in 2005 (2002: 889 patients) by means of the prescription of methadone or buprenorphine containing medicaments (MEPHENON ®, METHADICT ® and SUBUTEX ®) by 163 prescribing GPs (1999: 125).

Part A: New Developments and Trends

1. National policies and context

Overview

Drug use is defined as behaviour potentially associated to health and social damage. Consequently national drug policies are based on shared political competencies and responsibilities. Furthermore, in terms of intervention strategies, the more holistic concept of addictive behaviour is gaining in importance and influences increasingly policy debates.

National parliamentary elections of June 2004 have resulted in a new coalition government of social democrats (CSV) and socialists (LSAP). Competencies and ministerial attributions in the drugs field have not been modified. The governmental declaration of 2004³, and the subsequent coalition agreements, emphasised the need of further development and diversification of specialised health care, a more pragmatic approach towards law enforcement by means of legislative amendments and the promotion of harm reduction measures, where appropriate.

In June 2005, the Minister of Health presented the new drug strategy and action plan 2005 – 2009, elaborated by the National Drug Coordinator's Office created in 2000. The referred action plan is based on the evaluation outcome of the previous action plan and the assessment of current and future needs. One of the first achievements of the new drugs action plan is the implementation of the first national drug consumption room in Luxembourg City (July 2005). Prior to this achievement Luxembourg hosted a visit of M. Antonia Costa, executive director of UNODC (25 January 2005) to clearly expose the reasons and the rationale behind the implementation of such a facility at the national level.

● LEGAL FRAMEWORK⁴

○ Laws (2000- 2006)

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

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

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

- **law of 11 August 2006**⁸ on the fight against tobacco regulates advertising of tobacco and related products, the prohibition of smoking in certain areas and the prohibition of sale of oral tobacco. Main legal amendments concern an increase of the number of smoke free public areas, a prohibition of smoking in catering establishments, a general prohibition of advertising, the prohibition of tobacco sale to minors under 16 and the prohibition of import and sale of tobacco in

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

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

⁵ Official gazette A 1973, p.319

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

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

⁸ Official gazette A 2006, p.2265, (Adoption : 13/07/2006, Entry in force : 05/09/2006)

forms of candy or toys. The prohibition of smoking in spaces where food is served can be compassed by the implementation of separate smoking rooms, not exceeding 25 % of the total area, with specifically installed smoke extraction systems. Access is denied to youngsters aged less than 16 years. Pubs and bars are only concerned during core hours as far as they serve meals. Hospitals are allowed to install one smoking room exclusively reserved to patients.

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

○ **Grand ducal decrees (2004/2006)**

- The **grand ducal decree of 16 March 2006**⁹ defines maximum prescription periods for methylphenidate, oral morphine, transdermic fentanyl, buprenorphine, hydromorphone and methadone.

- The **grand ducal decree of 18 January 2005**¹⁰ establishes the model of prescription forms of narcotic based pharmaceuticals. The referred prescription form contains 2 separate annexes. The first to be used in case of substitution treatment and the second to be completed in case of other types of medical treatments.

- The **grand ducal decree of 7 October 2004**¹¹ modifies the national list of controlled psychotropic substances.

The following substances complete annex A:

2C-I (2,5-diméthoxy-4-iodophénéthylamine)

2C-T-2 (2,5-diméthoxy-4-éthylthiophénéthylamine)

2C-T-7 (2,5-diméthoxy-4-(n)-prophylthiophénéthylamine)

TMA-2 (2,4,5-triméthoxyamphétamine)»

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

- The **grand ducal decree of 30 January 2004**¹² modifies the substance lists annexed to the grand ducal decree of 2 February 1995. (list cf. footnote)

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

- Grand ducal decree of 4 **March 1974** regarding certain toxic substances
- Grand ducal decree of 20 **March 1974** regarding certain psychotropic substances
- Grand ducal decree of 26 **March 1974** establishing the list of controlled narcotics
- Grand ducal decree of 8 **May 1993** regarding commerce of narcotics and psychotropic substances
- Grand ducal decree of 2 **February 1995** regarding the production and distribution of certain

⁹ Official gazette A 2006, p. 1156 (Adoption : 16/03/2006, Entry in force : 31/03/2006)

¹⁰ Official gazette A 2005, (Adoption: 18/01/2005, Entry in force: 14/02/2005) Règlement grand-ducal du 18 janvier 2005 déterminant le modèle du carnet à souches prévu à l'article 30-1 de la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie.
<http://www.legilux.public.lu/leg/a/archives/2005/0211402/0211402.pdf?SID=cac954462991e49701fd54f107a49282#page=5>

¹¹ Official gazette A 2004, (Adoption: 07/10/2004, Entry in force: 21/10/2004) Règlement grand-ducal du 7 octobre 2004 modifiant le règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ainsi que le règlement grand-ducal modifié du 6 février 1997 relatif aux substances visées aux tableaux III et IV de la Convention sur les substances psychotropes, faite à Vienne, le 21 février 1971.

<http://www.legilux.public.lu/leg/a/search/resultHighlight/index.php?linkId=4&SID=e598ed3498d37aa98708757b0b038d49>

¹² Official gazette A 2004, (Adoption: 30/01/2004, Entry in force: 13/02/2004)

Règlement grand-ducal du 30 janvier 2004 modifiant le règlement grand-ducal modifié du 2 février 1995 relatif à la fabrication et à la mise sur le marché de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes.
<http://www.legilux.public.lu/leg/a/search/resultHighlight/index.php?linkId=1&SID=e0622007c5892b499e6269171b466eaf>

substances used in the illicit production of narcotics and psychotropic substances - Grand ducal decree of 6 February 1997 regarding substances listed in schedules III and IV of the UN Convention on psychotropic substances of 21 February 1971.

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

○ **Projects and propositions of law**

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

Project of law of 16 July 2004 modifying the modified law of 14 February 1955 concerning public traffic regimentation¹³ (Doc.Parl. 5366). The project of law foresees among other measures in the framework of traffic security, the implementation of rapid onsite drug tests. (see selected topics 2006: Drugs and Driving)

Project of law of 31 January 2006 concerning the fight against tobacco (Doc. Parl. 5533).

Project of law of 14 February 2006 prohibiting the sale of alcoholic drinks to minors aged less than 16 years (Doc. Parl. 5543). Prohibition of sale of alcoholic drinks to minors aged less than 16 years is extended to all forms of commerce, as supermarkets and petrol stations. Currently this restriction only concerns pubs, restaurants and bars.

○ **Laws implementation**

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

The **law of 27 April 2001**¹⁴ modifying the basic drug law of 19 February by decriminalising cannabis use, and enhancing the differentiation of penalties according to the type of drug offences and the nature of controlled substances involved and the **grand ducal decree of 30 January 2002**¹⁵ 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.

● INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES

○ **Coordination arrangements (NNIA)**

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

At the national level, the co-ordination among the competent ministries takes place in the *Inter-ministerial Commission on Drugs (ICD)*, chaired by the Ministry of Health (the national drug coordinator is currently vice-chair). It is composed of senior delegates from the main governmental departments and delegates from selected NGO’s and constitutes the top decision level with respect to co-ordination and orientation of actions. Both, the ICD and the Ministry of Health are responsible for the implementation of national drugs strategies and action plans, supervise field

¹³ [Loi modifiée du 14 février 1955 concernant la réglementation de la circulation sur toutes les voies publiques. \(Entry in force: 07/03/1955\)](#)

¹⁴ Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001)

¹⁵ Official gazette A 2002, p.232 (Adoption: 30/01/2002, Entry in force: 12/02/2002)

activities and are bound to guarantee an effective consultation process with other involved ministries (e.g. Justice, Foreign Affairs). The ICD meets regularly to exchange information. There are four permanent agenda items: the implementation of action plans, the early warning system on drugs, emerging trends and legal changes and international affairs.

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

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

A close link between the EMCDDA national focal point and the policy level is ensured by the fact that the head of focal point has been appointed National Drug Co-ordinator. The national Drug coordinator is also the head of the national delegation within the Horizontal Drugs Group and the national permanent correspondent within the Pompidou Group. Furthermore, he is a member of the national substitution treatment surveillance commission and the national AIDS surveillance COMmission.

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

○ National plan and/or strategies (NNIA)

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

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

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

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

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

○ Implementation of policies and strategies (NNIA)

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

output oriented way as follows: ' 1. Description/objective of action – 2. Responsibilities – 3. Budget – 4. Outcome – 5. Deadlines for outcome and evaluation'.

The active involvement of specialised NGOs and civil society from the very start of the conceptualisation work and consensus making prior to the implementation phase have shown to be a major criteria to guarantee an effective implementation process. Indeed 87% of the measures retained by the 2000-2004 national drugs action plan have been materialised within the retained deadlines. The measures not yet implemented (e.g. heroin distribution programme) have been delayed not for technical, budgetary or administrative reasons but for political ones. These actions have been included in the new drugs action plan, and by the time of writing one of the most controversial delayed actions has been implemented: the first national drug consumption room.

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

○ **Impact of policies and strategies (NNIA)**

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

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

● BUDGET AND PUBLIC EXPENDITURE

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

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

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

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

Year	2000	2001	2002	2003	2004	2005	2006
Budget (EUR)	2,066,000.-	3,210,000.-	4,294,000.-	4,862,000.-	5,771,000.-	6,196,000.-	6,584,000.-
Progression rate	Reference year	55%	108%	135%	180%	200%	217%

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

Human resources dedicated to specialized state financed drug agencies have known a significant increase from 30.75 full time posts in 2000 to 69.25 in 2006.

○ Funding arrangements (NNIA)

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

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

● SOCIAL AND CULTURAL CONTEXT

○ Public opinions of drug issues (NNIA)

No large-scale national public opinion survey focusing on drugs and drug addiction has been conducted thus far. Several surveys however have included items on public perceptions on legal and illegal drugs at the local or regional level. Several local or community based surveys on public opinions and attitudes towards drugs and drug use have been conducted in recent years. Results of these surveys have been produced in the 2003 report.

○ Attitudes to drugs and drug users (NNIA)

Within the scope of the Eurobarometer 57.2, a public opinion poll named "Attitudes and opinions of young people in the European Union on drugs¹⁶" was carried out in the 15 Member States between April and June 2002 at the request of the European Commission. This survey included a representative sample of the national population aged 15 to 24. In Luxembourg this public opinion poll was performed by ILRES in 2002 in the framework of EUROBAROMETER wave surveys.

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

¹⁶ EORG (2002). PUBLIC OPINION REGARDING ATTITUDES AND OPINIONS OF YOUNG PEOPLE IN THE EUROPEAN UNION ON DRUGS

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

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

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

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

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

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

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

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

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

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

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

○ Initiatives in Parliament and civil society

The Governmental declaration of 2004 and the subsequent coalition agreements as well as the drugs action plan of the Ministry of Health put emphasis on the need to develop primary prevention measures, therapeutic treatment offers, post-therapeutic structures and socio-professional reinsertion measures.

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

The amendment of the national driving code is foreseen in order to allow police forces to use new drug detection devices. Debates related to tobacco started in civil society after the Minister of Health proclaimed to prohibit smoking in restaurants. Some MPs raised parliamentary questions concerning this topic. It is also discussed to proceed to legal amendments in order to prohibit the selling of cigarettes to minors as also to increase the taxes of the so-called “alcopops”.

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

○ Media representations

A national and international press review on drugs, jointly compiled by the State’s Press Service and the NFP since 1998, allows a close follow-up of the media approach towards the drug phenomenon. Most of national media provide objective information although a few more socially oriented radio stations and newspapers put further emphasis on controversial, yet constructive, analysis of the current situation.

The NFP performed analysis of main daily and weekly Luxembourg newspapers published between January 2005 and July 2006. The screening revealed that nearly 50% of the topics most commonly covered by the national press concerned demand reduction topics. By reason of the recent amendment of the anti-tobacco law, articles addressing tobacco have been most prevalent followed by articles covering themes of driving under influence of alcohol and the danger of designer drinks (alcopops) for youngsters. Articles concerning NGOs mainly referred to annual reports and a special interest was put on the impact of the drug consumption room. Nearly 30% of articles covered themes of supply reduction. They mainly concerned drug traffic, drug seizures, arrests and court decisions and addressed the evolution of the drug scene in the area of the main railway station of Luxembourg City. Some major weekly newspapers focussed on national drug policies and the national drugs action plan.

Several articles informed about the launch of the EMCDDA annual report 2005 as also the launch of the national focal point RELIS 2005 report, including main information about the European and national drug situations.

Concerning international topics, most interest concerned Afghanistan’s drug situation followed by important drug traffic cases and seizures. Citations of international organisations involved in drug issues, EU strategy and action plan have been relatively rare. One may note that, even though the topics were quite varied, press interest focussed predominantly on national topics.

2. Drug Use in the Population (NNIA¹⁷)

Overview

Drugs referred to in the present report include narcotic drugs and psychotropic substances covered by the international drug control conventions (the Single Convention on Narcotic Drugs of 1961, as

¹⁷ No New Information Available. The HBSC study 2005 will provide new data for next years’ report

amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988). Drugs not listed in the latter UN conventions are addressed by the present strategy only in the context of their associated use to listed drugs.

‘Drug use’ is hereinafter defined as the self-administration of a psychoactive substance, that is a substance that, when ingested, affects mental processes. Psychoactive substances may be of licit or illicit production, sale, or use and associated risks may 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 Amphetamine Type Stimulants (ATS). Cannabis use is still increasing and shows the highest prevalence regardless considered age categories, whereas the prevalence of other psychoactive drugs varies according to age and data collection setting factors.

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

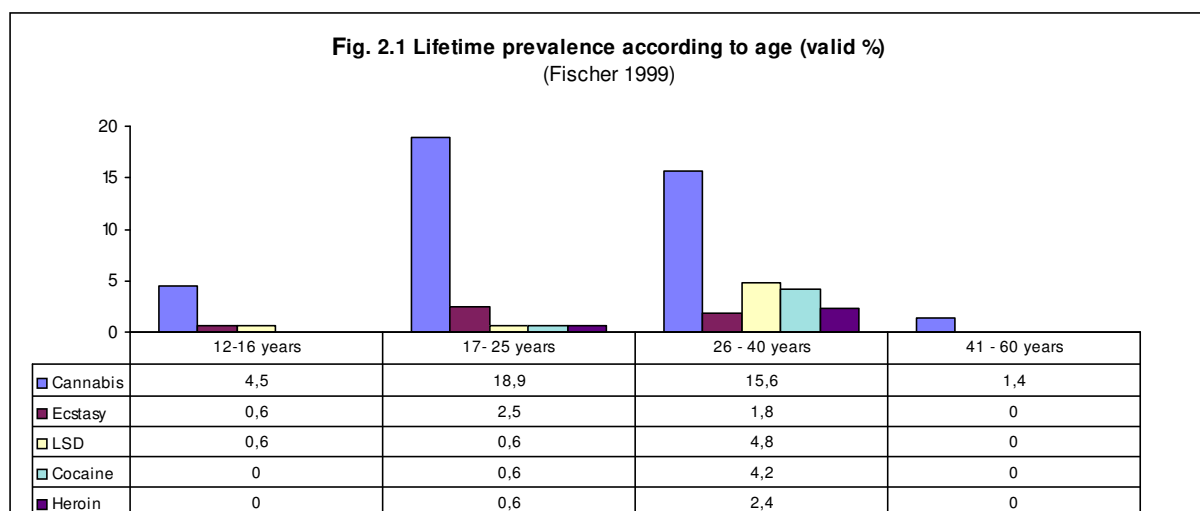
● DRUG USE IN THE GENERAL POPULATION

To date, no national, large-scale (representative) general population survey on drug use has been conducted. Several community or targeted population surveys however allow estimating current prevalence. It should be stressed that a new HBSC study is underway. The section on drug use in youngsters will allow to updating a series of current data.

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

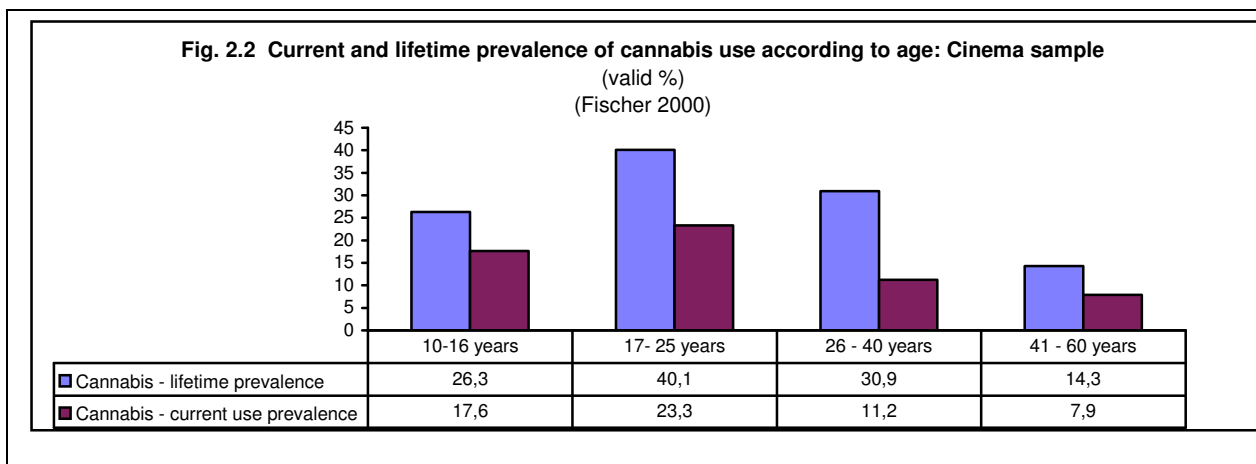
REFERENCE 1.		Fischer U. CH. Et Krieger W. (1999) Suchtprävention an der Gemeng – Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg. EN: Drug prevention at the communal level
Year of data collection	1998	
Single/repeated study	Single study	
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

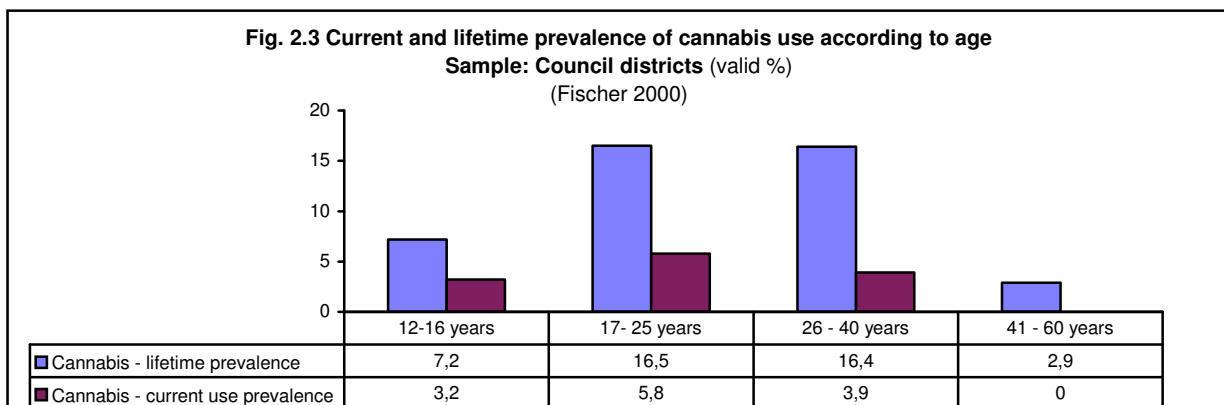


A second survey organized by the CePT was published in 2000 (“Fischer 2000 study”). Even if cannabis consumption was the main subject of the study, several other substances have been taken into account. The samples have been drawn on the one hand from a cinema visitor’s population in Luxembourg city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

REFERENCE 2.1: Fischer U. CH. (2000) Cannabis in Luxembourg – 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	<i>Detailed results of both surveys are provided in EMCDDA standard tables</i>



REFERENCE 2.2: Fischer U. CH. (2000) Cannabis in Luxembourg – 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%



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

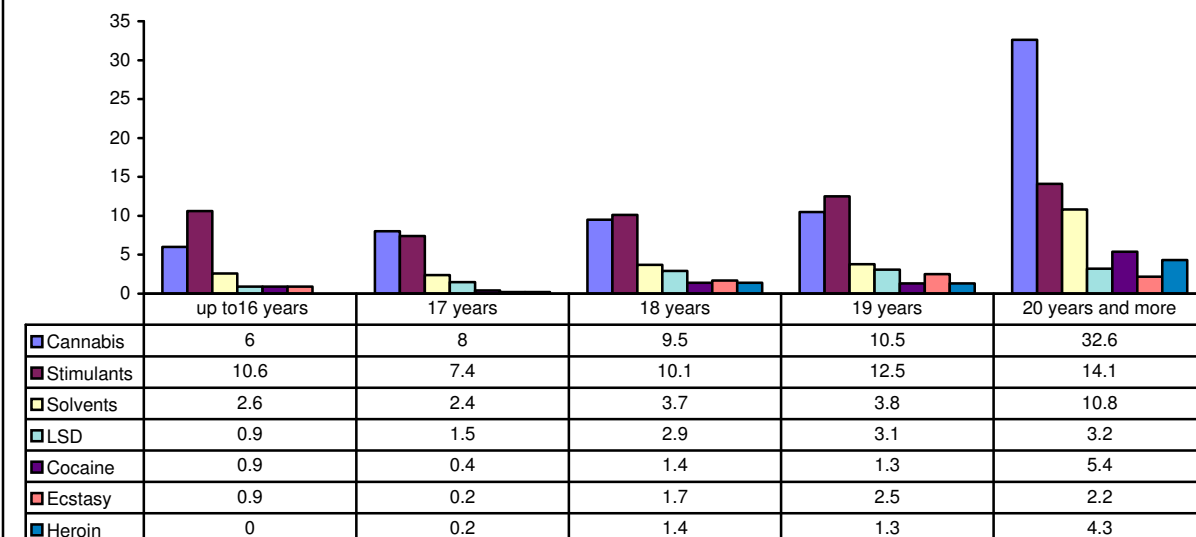
● DRUG USE IN THE SCHOOL AND YOUTH POPULATION

National school surveys may be divided in **two categories**. A first category refers exclusively to drug prevalence surveys in schools; the second refers to cross-sectional surveys combining data collection in school settings and other youth environments. To be stressed that a new HBSC study is underway. The section on drug use in youngsters will allow to updating a series of current data.

Surveys: category 1

REFERENCE 1:	Matheis J. et al. (1995) 'Schüler an Drogen', IEES, Luxembourg. EN.: Students and Drugs
Year of data collection	1992
Single/repeated study	Repeated study 1983 – 92
Context	Public Health
Area covered	Nation wide
Type of school	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
Response rate (M, F, T)	96%
	Matheis and Prussen (1985) have conducted a survey on 1983 data relying on the same methodological criteria than the 1995 survey. The referred study will be addressed in the comparative analysis part.

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



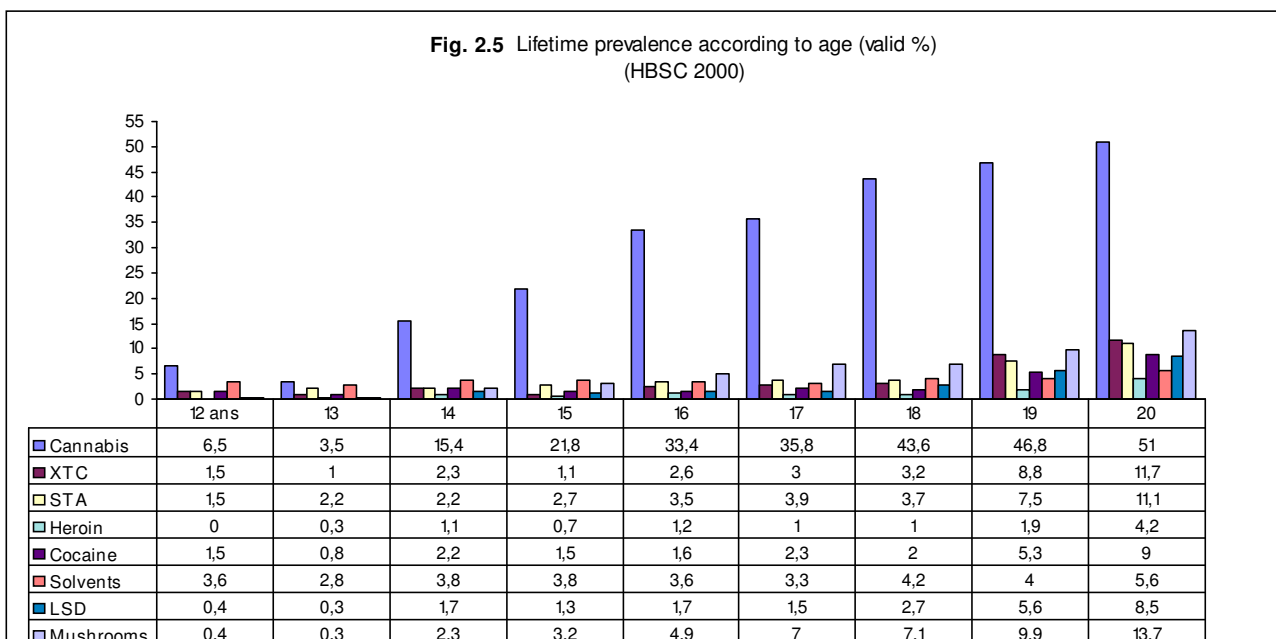
REFERENCE 2:	Dickes P. et al. (1996), La consommation de drogues légales et illégales des élèves des 6 ^{ième} de l'enseignement secondaire et des 8 ^{ième} de l'enseignement secondaire technique, CEPS/INSTEAD. Luxembourg. EN.: The use of licit and illicit drugs by students in 6 th and 8 th classes of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

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

Source : Dicks 1996

REFERENCE 3: Das Wohlbefinden der Jugend – HBSC Studie (in press), Ministère de l'Education Nationale de la Jeunesse et des Sports, Direction de la Santé, Luxembourg.
EN.: Health and Health Behaviour of Young People

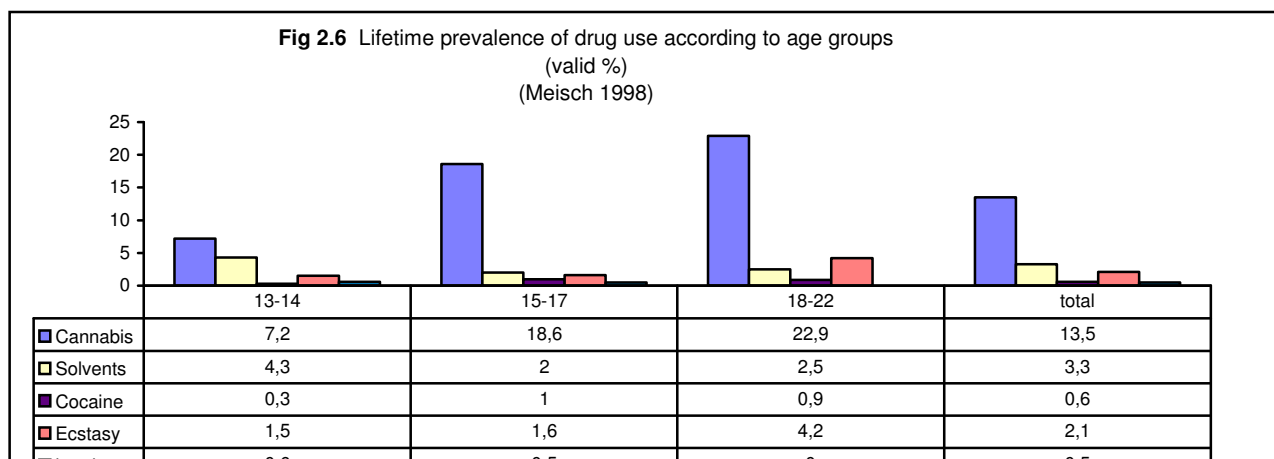
Year of data collection	1999
Single/repeated study	Repeated study (intended each 4 years)
Context	Health and Health Behaviour among Young People – WHO cross-national study
Area covered	Nation wide, representative
Type of school	Secondary schools
Age range	12-21 years
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	7,347
Response rate (M,F,T)	97%



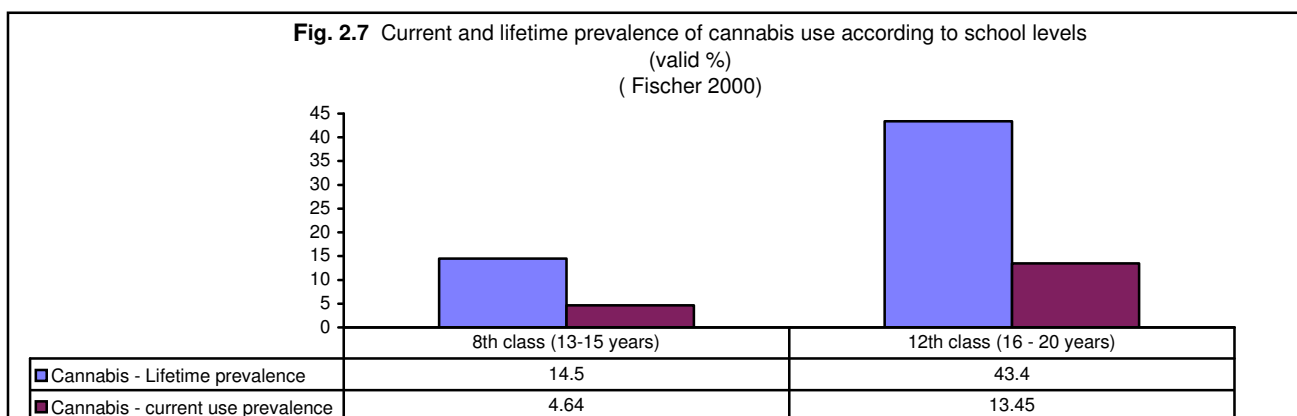
The consumption of illegal drugs has clearly increased the last years. A comparison of the Matheis 1992 study and the most recent HBSC 2000 study reveal that in 1992, 18.1% of secondary school students of 5th class of secondary school (16-20 years) declared having had contact with illegal drugs. In 2000,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

Surveys: category 2

REFERENCE 4 :	Meisch, P. (1998), Les drogues de type ecstasy au Grand-Duché de Luxembourg, CePT, Luxembourg. EN: Ecstasy type drugs in the G. D. of Luxembourg
Year of data collection	1997
Single/repeated study	Single
Context	Public Health – primary drug prevention
Area covered	Nation wide
Type of school	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 5:	Fischer U. CH. (2000), Cannabis – Eine Analyse der aktuellen Situation, CePT, Luxembourg. EN.: Cannabis – Rapid assessment of the current national situation.
Year of data collection	1999
Single/repeated study	Single
Context	Cannabis prevalence
Area covered	Nation wide
Type of school	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%



LIFETIME PREVALENCE: SCHOOL POPULATION:

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

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

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

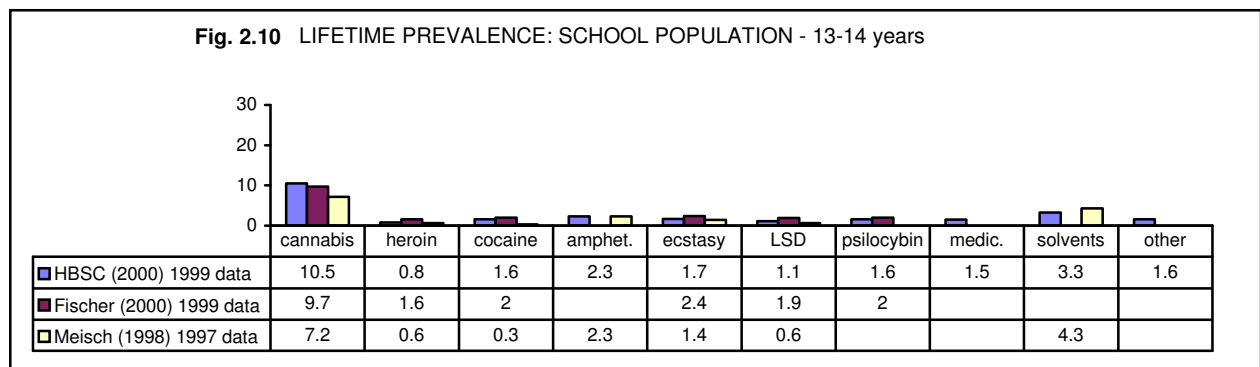
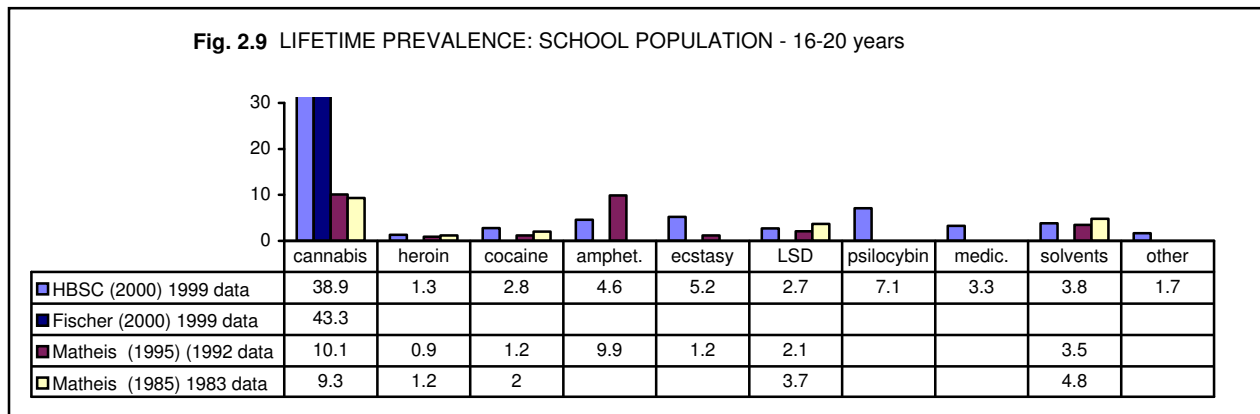
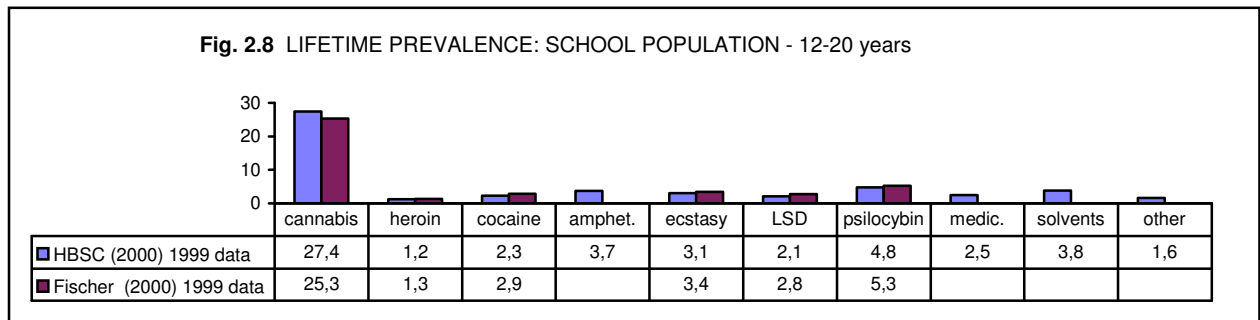
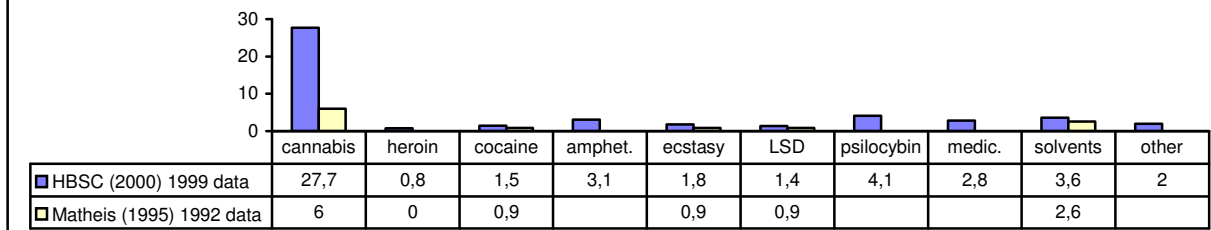


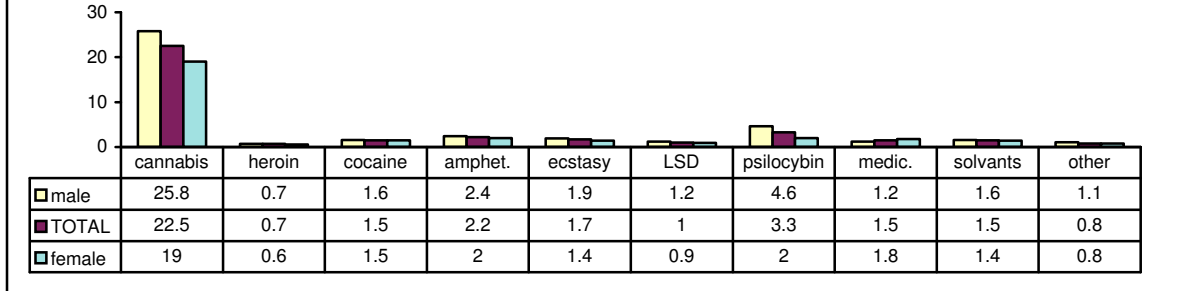
Fig. 2.11 LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years



LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

The HBSC survey (2000) is the only to provide last 12 months national prevalence figures in 12 to 20 years aged schoolchildren. Results mirror respective proportions of lifetime prevalence rates with particular emphasis on high cannabis (22.5%), psilocybin (3.3%) and amphetamines (2.2%) prevalence. Gender differences reflect the results of the lifetime prevalence surveys except for amphetamines use that is proportionally higher in females during the last 12 months. Medicaments use in females during last year is more prevalent than in males. **LAST 30 DAYS PREVALENCE:**

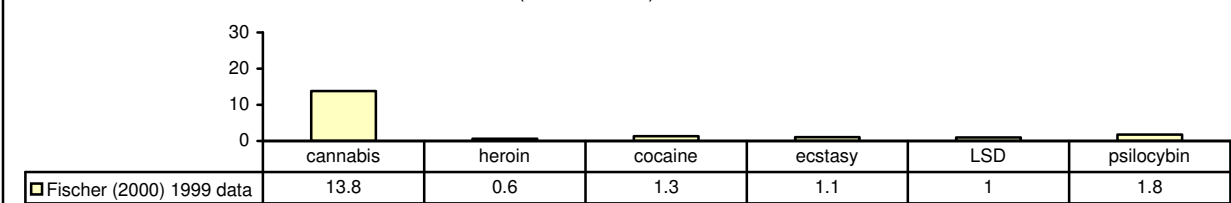
Fig. 2.12 LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION - 12-20 years (HBSC 2000)



SCHOOL POPULATION

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

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



● DRUG USE AMONG SPECIFIC GROUPS:

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

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

MAIN RESULTS:

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

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

● ATTITUDES TO DRUGS AND DRUG USERS

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

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

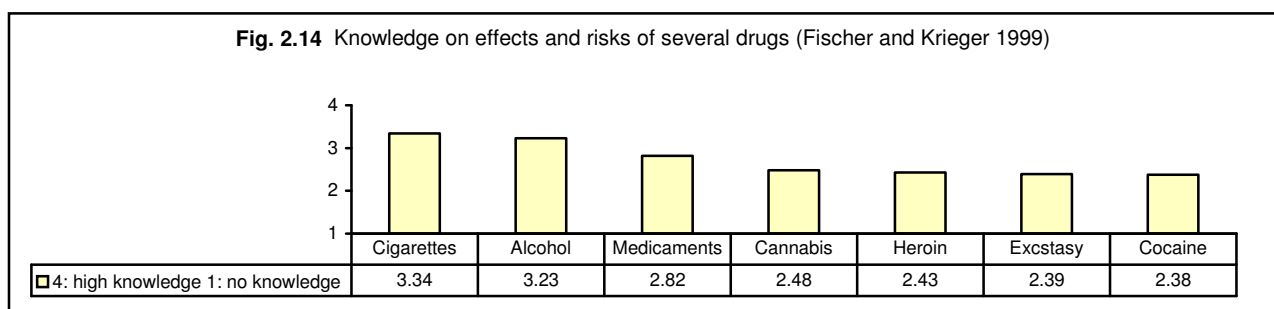
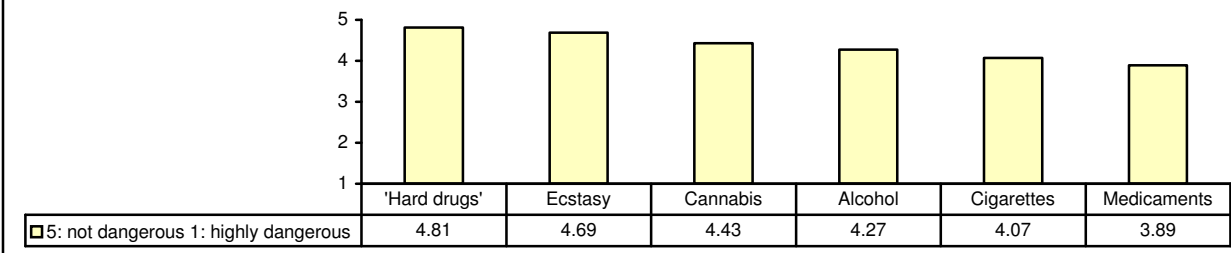
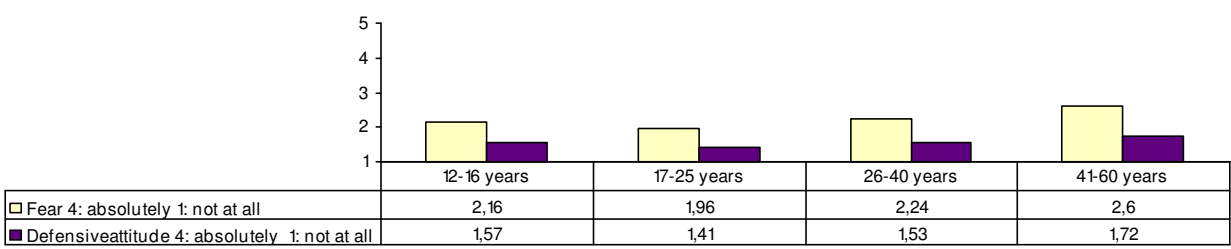


Fig. 2.15 Perceived risks associated to drug use (Fischer and Krieger 1999)



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

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

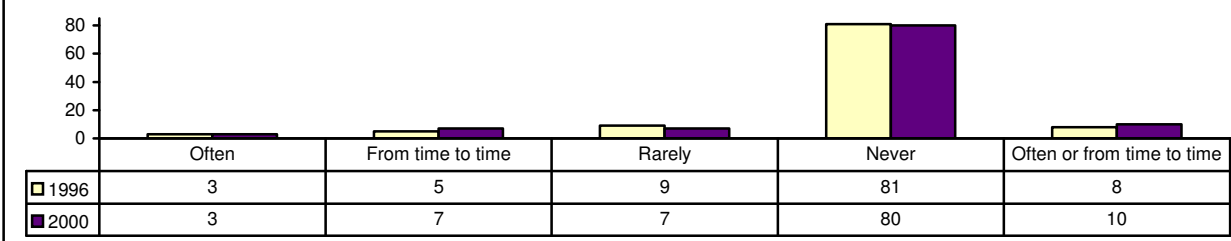


A second group of surveys worth mentioning refers to the serial surveys performed by ILRES in 1996 and 2000 in the framework of EUROBAROMETER wave surveys n°44.3 (1996) and 54.4 (2000) (EC 2001).

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

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

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



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

3. Prevention

Overview

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

The present chapter provides a summary of recent universal and selective prevention measures undertaken at the national level. More detailed information and examples of good practice can be found in the EDDRA database of the EMCDDA under: <http://eddra.emcdda.eu.int/>

The **national drugs action plan 2005-2009 addresses primary prevention as a main intervention area.**

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

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

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

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

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

Direct drug prevention expenditures reached 672,000.- euros in 2000 and 830,000.- euros in 2006. These figures include staff and operating costs of agencies and ministerial department specialised¹⁸ in drug prevention. In coming years the total expenditure will know a significant increase since 4 actions/programmes have been included in the 2005-2009 drugs action plan.

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

Training interventions in drug demand reduction are increasingly developed at the national level. The CePT publishes an annual training directory including training activities ranging from evaluation methodologies to demand reduction action-research strategies targeted at **drug prevention and public health actors, educators, youth animators and teachers**. The

¹⁸ The exact estimation of prevention related costs is hazardous since multiple factors influence the development of a youngster. Education, leisure activities, sport, etc may have a positive impact on resources building; they however cannot be quantified in terms of exclusive input.

'Recherche et Innovation Pédagogiques et Technologiques (SCRIPT) ' department is actively involved in the referred training activities. The Department for Scientific and Applied Research may finance training activities following request. In the framework of its 10th anniversary, the CepT published a manual on the training of multipliers in primary drug prevention available at www.cept.lu. The manual was presented during a workshop on 25 November 2005.

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 (NNIA)**

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

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

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

In 2000, the CePT in collaboration with the SCRIPT started a pilot project called 'd'Schoul op der Sich' (**School on quest**) (see EDDRA and standard table 19) running for two years and having been evaluated in 2003. The aim of this participative project consisted in creating prevention groups among all participating secondary schools in order to initiate a process of reflection on drug related themes. The CePT was providing training, on site interventions and documentation to the prevention groups. A first achievement of the project partners was to set up a drug related theme catalogue (by method of brain storming) and to conduct school internal surveys on drug related issues. Overall, 5,500 students have been contacted in the framework of these inquiries.

Well-being in school was the most relevant theme cited and drug issues were interpreted differently by youngsters and adults. Gradually, the prevention groups organized conferences, project flyers, seminars, information sessions, round-tables, workshops etc. Meanwhile, three basic training sessions were offered to the project partners by the CePT and the judicial police, a two-years training module for teachers was offered by the SCRIPT and a further training of "multipliers in primary prevention" was organised by the CePT. In the course of 2001, two meetings from the project partners of the 6 prevention groups took place in order to share a common concept of primary prevention. In the framework of the second meeting a national prevention week was planned.

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

the pilot project all six partner schools expressed their motivation to continue the process of prevention work inside their respective schools. Two schools left the project however pursued the prevention process.

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

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

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

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

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

○ **Family (NNIA)**

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

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

“prevention boxes” took place in different communities participating in the project of addiction prevention in local communities.

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

○ Community

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

Generally speaking, local and regional communities do rarely dispose of a comprehensive drug prevention strategy. Commonly, a given national agency initiates projects, defines the general intervention framework and seeks active collaboration with community authorities in order to meet local needs. The observed situation is mainly due to geographical parameters of the Grand Duchy. At present only two agencies focus on interventions in recreational settings, namely the CePT (community project¹⁹) and the MSF Solidarity Youth (on site-interventions planned).

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

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

● SELECTIVE/INDICATED PREVENTION

○ Recreational settings

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

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

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

¹⁹ 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

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**”²⁰ do fit in a broader programme named “Adventure pedagogy and primary addiction prevention”. Those activities primarily aim to provide the opportunity to youngsters to experience group dynamics, conflict management, limit and risk assessment as well as the feeling of solidarity within a group of socially and culturally different people. The program further aims at the reduction of risk factors and the enhancement of protection factors, by focussing on youngsters and their environment, rather than on drugs and addiction. Currently regional teams specialised in drug prevention meet in autonomous working and training groups and report activities to the Mondorf Group.

The CePT closely collaborates with the National School for Physical Education and Sports (ENEPS) in the framework of a project called ‘Give strength to children’. Information and training sessions in presence of a top professional sportsman have been organised. A working group has been set up in order to elaborate a concept for future activities. A programme called ‘**Sport and drug prevention**’ started in the course of 2002.

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

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

The **law of 29 June 1989** on taverns (inns)²¹ management regulates the functioning of establishments licensed to serve alcoholic beverages in terms of control measures and security standards to meet (laid down by subsequent grand-ducal decrees). No reference is explicitly made to illegal drug use. The Ministry of Finances controls the application of the law at the national level. As far as nightlife venues are concerned, organisers have to fulfil security and hygiene standards defined and controlled by special departments of the ministry of Labour²² and the ministry of Health.

The governmental declaration of 2004 puts emphasis on the risks of alcoholic mix-drinks (**alcopops**) and the high prevalence among youngsters. A special working group chaired by the Ministry of Health has proposed further measures to reducing the consumption of alcohol and alcopops. Measures yet to be implemented are a significant raise of taxes imposed on alcopops, 16 years minimum age for the purchase of alcoholic beverages and zero tolerance for young drivers. The very same propositions have been put forward by the national Ombuds-Committee for the right of children in 2004²³

²⁰ See EDDRA

²¹ Loi du 29 juin 1989 portant réforme du régime des cabarets. Entry in force 29/06/1989

²² A special department of the ministry of Labour called ITM is in charge of issuing and controlling security standards for workplaces and places with public access. The ITM standard ITM-CL54.1 addresses night and festivity venues. These standards are legally binding. The ITM has to provide a formal authorisation before the opening of a given venue.

²³ Ombuds-Comité fir d’Rechter vum Kand, (2005), Rapport 2004 au gouvernement et à la chambre des députés, Luxembourg

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

○ **At-risk groups / At-risk families**

On January 2006, MDs without frontiers - Youth Solidarity in collaboration with the Public Prosecutor's Department of Youth Protection and the Judicial Police- Drugs Unit launched a new project called **CHOICE**, which is based upon a pilot project of "early intervention of first drug offenders" (FreD) initiated by the Federal ministry of health and social security of Germany. The target group consists of youngsters aged 12 to 17 who entered in conflict with drug law. The overall aim of CHOICE is to offer youngsters an early and short-term intervention in order to prevent further development of drug abuse and drug addiction. An "in-take" interview allows to assess 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 members 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 MDs without frontiers within two weeks and the latter inform the Public Prosecutor on the participation level. A certificate testifies the participation of the youngster. Since January 2006, the beginning of the project, to May 2006, 36 CHOICE sessions have been organized. An external evaluation is foreseen for 2008.

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

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

In this context and due to an increased prevalence of HIV infection cases, AIDS and drug related problems in the Portuguese speaking community of the Grand-Duchy of Luxembourg, the Committee of AIDS Surveillance in collaboration with the Ministry of Health have commissioned an exploratory study on current knowledge and needs of the target group in relation to HIV prevention. (Dellucci, 2006).

By means of anonymous questionnaires and semi-structured interviews, 270 persons, thereof 24 persons interviewed, have answered questions addressing their way of living, perceived importance to HIV prevention, HIV screening, drug dependence, sexual behaviour, needs of information.

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

In general, half of respondents believed themselves sufficiently informed on AIDS. However, 11.1% of respondents asked information concerning the topic "AIDS and Drugs". Most of respondents showed to be sensitized to the dangers of a transmission via intravenous drug use.

Content analysis of the semi-structured interviews showed that references to HIV transmission by infected syringes in the context of drug use came in second place followed by sexual intercourses. Concerning HIV protection, syringe exchange has been rarely mentioned. As far as the assessment of risk groups is concerned, drug users have been perceived as a particularly exposed population to HIV infection. Respondents declared drug users as the major source of newly infected HIV cases in Luxembourg notably in relation to intravenous drug use. Generally, AIDS has been perceived as a disease concerning above all specific risk-groups such as homosexuals, prostitutes, non-natives and intravenous drug users.

Results show respondents not belonging to perceived risk groups underestimated HIV infection risks for themselves and overrated risk associated to more vulnerable groups.

The study identified needs of information concerning risks and protective factors, measures of prevention, AIDS and sexuality, AIDS and drug dependence, screening and socio-medical support.

However a specific HIV prevention programme for the Portuguese speaking community is not deemed to be appropriated since focusing on a specific community could provoke various resistances. The study recommends, among others, a linguistic diversity as far as prevention messages and the composition of counselling teams are concerned.

4. Problem Drug Use

Overview

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

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

According to recent indicators, **prevalence figures** applied to the national population aged 15-64 situate between 2,500 and 2,800 the number of PDUs. **Intravenous heroin use** associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. The recent increase in **low quality cocaine use** in combination with heroin has been confirmed by 2005 data. **Ecstasy-like** substances and **ATS** show an increasing demand even though seizure figures do suggest an inverse and currently stable trend. The use of most 'new synthetic substances'²⁴ recently detected in other EU Member States has not been reported thus far.

All indicators on **cannabis use** (problematic and recreational) have been on the increase for several years. Cannabis showing **high THC concentrations (max:22%, mean:11%)** is increasingly found on the national market.

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

The **mean age of first use of cannabis, ecstasy and i.v. heroin** tends to decrease. Also, the **average age**, applied to the total PDU population and to od victims has markedly increased over the last 6 years. The proportion of **PDUs aged 39 and more and those younger than 19 years** has constantly increased as well as the **standard deviation** of the observed age distribution meaning that the gap between youngest and oldest problem drug users tends to increase. Furthermore, increases have been noted with regard to the proportion of **minors** in the overall PDU population and to the percentage of students in problem drug users until 2003. In reference to years 2004/2005 a stabilisation, and as far as police data is concerned, a downward trend has been observed.

²⁴ Substances such as MBDB, 4-MTA, Ketamin, PMMA 2C-I, 2C-T-2, 2C-T-7, 2C-D, 2C-E, TMA-2, BZP, TFMP, 5-MeO-DIPT, 5-MeO-DMT, AMT, ALEPH 7, DXM, DPT, mCPP.

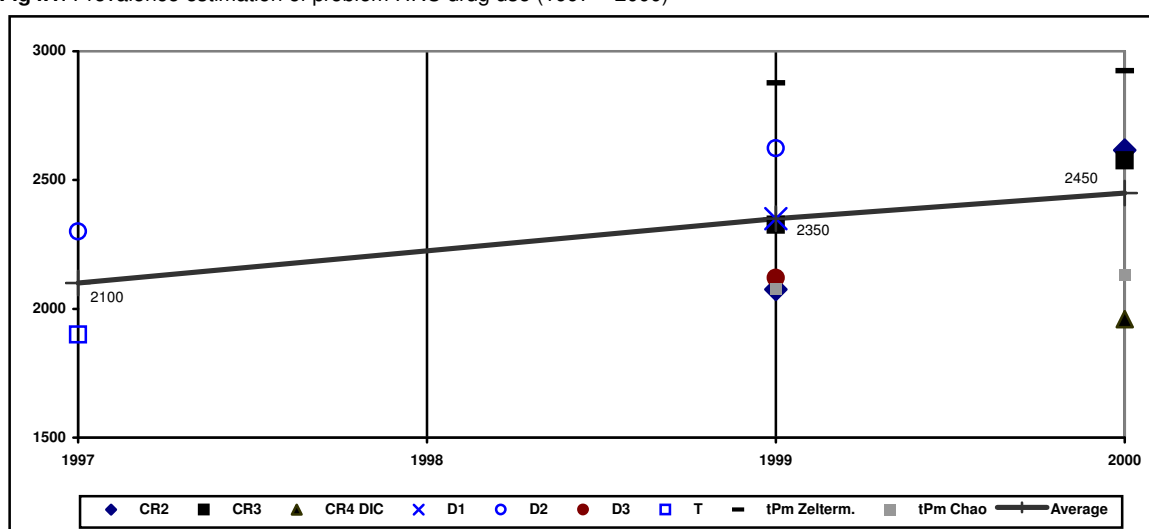
The average ages of native and non-native problem drug users tend to balance. The **average ages** at the moment of **first consume** of the current main drug and illicit drugs in general have shown a slow but constant downward trend for the last 6 years. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2005.

● PREVALENCE AND INCIDENCE ESTIMATES

Data presented in the present chapter have been provided by the latest drug prevalence study on PDUs aged between 15 and 64 years (hereinafter referred to “2001 study”) conducted by the focal point between 1999 and 2001 (Origer 2001)²⁵ and refers to the years 1999 and 2000. Since there have been no national prevalence study since 2000, indirect indicators have been further observed and produced in order to assess the general evolution of PDU prevalence.

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

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



Source:

Origer 2001

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

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

Source: Origer 2001

²⁵ Downloadable at <http://www.relis.lu>

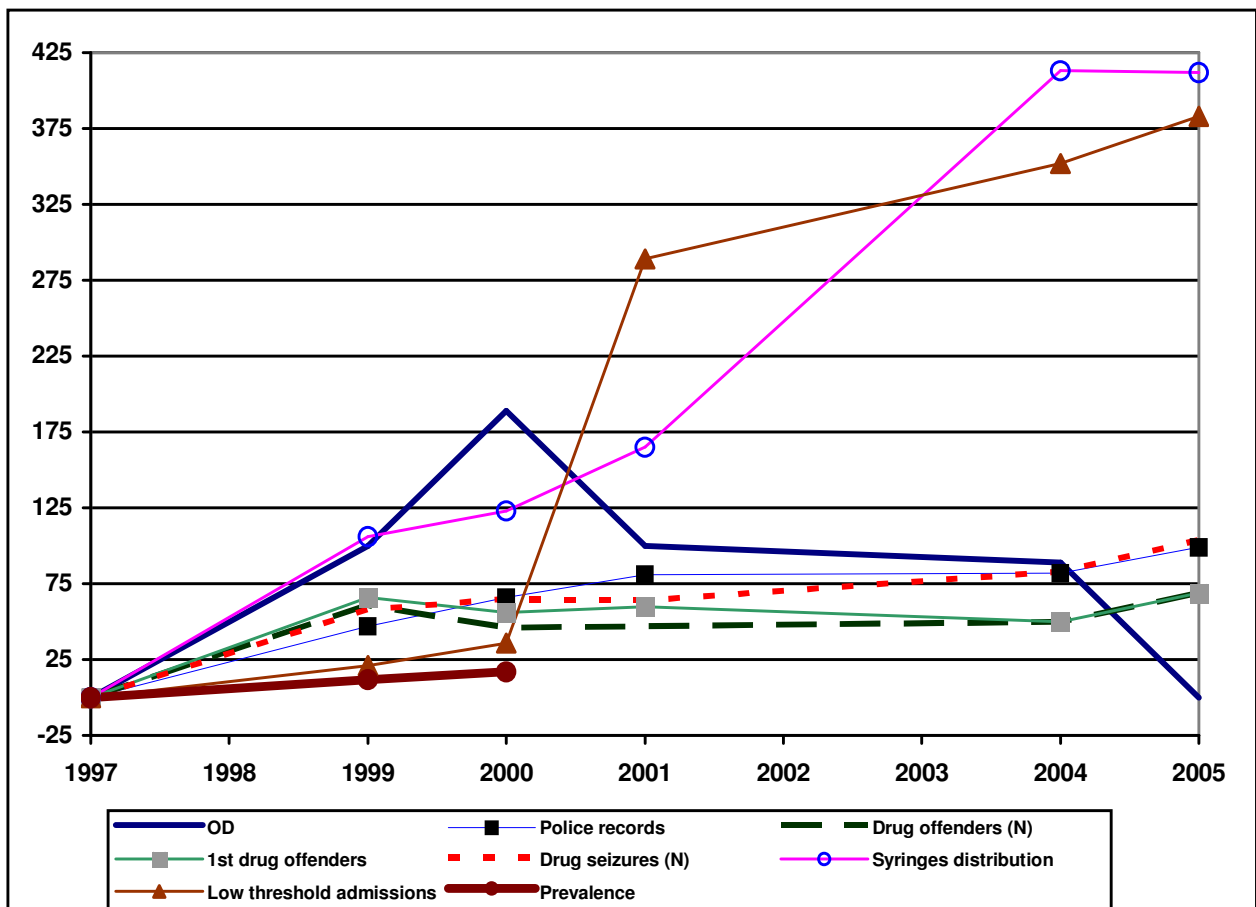
In order to validate estimated prevalence rates, data from different sources had to be considered. As can be seen in chart 4.1. prevalence estimates from 1997 to 2000 indicate a moderate upward trend in compliance with the observed evolution of **indirect drug use indicators** (1997: reference year,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

As can be seen in graph. 4.2 all indirect indicators, except number of acute drug deaths, have been showing stable trends if compared to 2004. The fact that the number of ODs has been decreasing is mainly due to the fact that a supervised injection room has been implemented in Luxembourg City since July 2005, which had an impact of drug related fatalities and does not allow to state that the drug population prevalence has decreased. Number of syringes distributed and admission in low threshold agencies have known significant increases. This increase has to be interpreted cautiously. Indeed during recent years new low threshold services have been implemented which may have attracted an increasing number of clients. As far as the increase of distributed syringes is concerned, one should stress that low quality cocaine has largely complemented heroin on the national drug market during recent years with the consequence that drug addicts have to inject more frequently (more syringes) than in the past, to get the desired effects.

Taking into account the previous comments, one may state that **PDU prevalence tends to stabilise** at the national level. A second national drug prevalence study, which is foreseen for year 2007, will provide more information of the current situation.

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

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



Source: Origer 2006

LOCAL PREVALENCE STUDIES

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

NATIONAL 'DRUG SCENES'

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

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

CHARACTERISTICS OF INDEXED PDUS

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

The number of **problem PDUs** indexed by national institutions in 2005 figures 4.101 (1994: 2,213) (double counting included). For comparison, 873 users have been indexed by national specialised drug demand reduction agencies and 1,340 persons by supply reduction agencies in 1994. In 2005 the same agencies have indexed 1,901 and 2,200 persons respectively, which equals to a total increase rate of **85 %**. **5%** of respondents are first treatment demanders, all treatment centres included.

29% (38%) of PDUs (of which 62 % are non-natives) reported their first institutional contact (intra-institution) in 2005. 5% of PDUs reported **first lifetime drug treatment** in 2005. 79% (72%) of respondents have had at least one **substitution treatment** before being indexed in 2005.

The male/female ratio of the PDU population is 3:1. The last ten years the proportion of indexed non-native PDUs has shown strong variations but a clearly increasing tendency since 2003. The **population of non-natives** drug users largely consists of Portuguese nationals, a proportion constantly increasing until 2004 and consistently higher than the one observed in general population. Notably, one observes a remarkable increase of PDUs of French origin (23%). This trend also shows in last 5-years data on drug law offenders.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 29 years and 10 months in 2005. **The gap between youngest and oldest PDUs continues to grow.** One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to “new” PDUs. Worth mentioning is the significant increase of the **average age of overdose victims** and a **significant but currently decreasing proportion of minors** among drug law offenders STUP. Respectively 85% and 40% of current PDUs have tried cannabis and heroin (i.v.) while being minor of age. In 1995 the same proportions figured 71% and 23%. Most interestingly evolution of drug use patterns tend to accelerated in terms of shorter time spans separating first non-iv use from first iv-use. This acceleration is also observed as far as first treatment demands are concerned. PDUs tend to contact drug treatment facilities at an earlier stage, which may be due to a more diversified offer currently available.

The mean age of native and non-native problem drug users tends to balance. **Average age at first use of illicit HRC drugs** has decreased approximately 3 years from 1995 to 2004 (2004:12Y8M;2005:15Y2M). In 2005 age of first use of cocaine (iv/non-v) and heroine (non-iv) stabilised, contrarily to average ages of first intravenous heroin use and even more significantly the average age at first cannabis use (almost 1/3 of respondents were not older than 13 at the moment of first cannabis use. In general, the proportion of PDUs aged more than 39 years and of users less than 19 years is increasing continuously as also the gap between these two groups.

Intravenous heroin use associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. The proportion of **poly drug use** (92%) has reached stabilisation after a record level in 2004. As already indicated, the switch to **intravenous drug use** occurs earlier. The ratio of **intravenous opiates consume to the inhalation** mode has stabilised at 2:1. The prevalence of the use of cocaine as primary drug continues to increase, which is partly due to increased availability on the national market. **Ecstasy-like** substances and **ATS** show an increasing demand even though seizure figures do suggest an inverse and currently stable trend.

All indicators on **cannabis use** (problematic and recreational) have been on the increase for several years. Cannabis showing **high THC concentrations (max: 22%, mean:11%)** is increasingly found on the national market.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use had known a sensitive increase the last three years but decreased again in 2004 / 2005. **Amphetamine like substances and ecstasy** are only weakly represented, which however does not inform about prevalence in general population as RELIS data refer to PDUs and not to the overall population of **recreational drug users**.

The **residential status** of indexed PDUs has improved over the last years. **The geographical distribution** suggests that the southern region (43,3%) and the centre region (40,1%) are the most representative. The northern region (11,6%), after multi-annual increase show signs of stabilisation (2004:17%).

Recent data suggest that the **employment status** of respondents tend to worsen. Also the **unemployment rate** has increased in 2005 (67%). The decrease of financial autonomy of PDUs is associated to an **increasing social dependency**. Although a continuous decline at the level of revenues of illegal origin and a moderate decrease of the proportion of PDUs presenting **major depths** have to be underlined.

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

○ By substance used

The main substance involved in drug treatment demands is **heroin**. Prevalence rates fluctuate around 70 and 75% (60% iv / 15% non iv). In 2005, a decrease of 4% in preference for intravenous heroin use was noted compared to 2004. The increasing preference for heroin by **inhalation** registered several years ago is not observed anymore. The i.v. heroin sub-population shows the highest mean age (31Y6M) of all treatment groups. 4% of the latter are **first treatment** demanders compared to 5% of non-iv heroin users.

Cocaine use as main reason of treatment demand shows a strongly increased prevalence (20%) that is consistent with current supply indicators. Mean age of preferential cocaine using treatment

demanders is 27 years and 3 months years. With 5% (12%) of first treatment demanders, primary cocaine users show the highest lifetime first treatment rate. Cocaine prevalence as secondary drug has decreased from 43% in 2004 to 38% in 2005. **Crack** is newer reported as main problem drug and very rarely (0%) as secondary or occasional drug.

A recent trend has also to be seen in the increasing number of treatment demands related to **cannabis use**. The percentage of the latter has passed from 4% in 1997 to 11% in 2002 showing no increase in 2004 and a decrease again in 2005. Treatment demands related to **ecstasy use** are rare (1-3%) and have shown a fair stability over the last years. The same comments apply to **ATS use**.

○ By centre types

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

The proportion of **first treatment demanders** observed in 2005 was 5% (1998: 4%). For the sake of a comprehensive presentation of main observed trends, the following typology of treatment settings is applied:

➤ Outpatient, adults

After several years of decrease, national outpatient drug counselling centres show **fairly admission rates and first treatment rates** in 2004. Gender distribution shows a **weak upward trend in female treatment demanders** (2005: 38% / 1997: 34%). **Age distributions** have to be analysed according to the geographical situation of treatment centres. The proportion of treatment demanders aged 30 years and beyond (58%) has sensibly increased, during recent years. The proportion of **underage treatment demanders** has been increasing in recent years but stabilised in 2004 (4.4%) and tends to decrease mainly because specialised agencies for minors have been implemented meanwhile. **Treatment demands for problem i.v. opiate use** associated to multiple-use, is still the main demand pattern although it has clearly decreased during the last years and shows stability for 2 years now (2005: 47% / 1997: 72%). **Cannabis-related demands** have shown a clear upward trend since 2000 (2003: 15% / 1997: 1%) and decreased significantly after 2003 (2005 8%), which may also be due to the development of treatment offers for minors.. The prevalence of **problem cocaine use** significantly increased, especially intravenous cocaine use.

➤ Outpatient, underage

Specialised drug care agencies for minors only exist in the centre of the country. The **rate of new treatment demanders** has constantly increased since the implementation of the referred agencies and stabilised in 2005 for the first time. The number of new treatment demanders has decreased in 2005. Gender distribution in minor treatment demanders his stable (2005: 31%. The **mean age of clients** has been slowly decreasing since 1997. The proportion of clients aged below 15 has raised from 7% in 1997 to 25,7% in 2005. Cannabis use is the main reason of treatment demands (71.5%, stable), followed by heroin and ecstasy.

➤ Inpatient, drug therapy

Likewise the situation observed in outpatient counselling centres, the proportion of **new clients** has markedly increased in inpatient therapy settings in recent years. The proportion of **male treatment demanders** has increased during recent years (81,8%) and the observed mean age still is on the increase (2004: 31Y11M / 1998: 27Y). The referred age distribution reflects an **overall trend** observed in most adult drug treatment demanders, that is, a decrease of patients under 25 and an increase of patients **older than 25 years**. An increase is observed as to the **proportion of natives** within the inpatient treatment demanders. All treatment demands are related to **opiate abuse**, mainly i.v..

➤ Inpatient, detoxification

Drug detoxification units throughout the country show a recent significant increase regarding number of admissions and patients (382 patients in 2004 vs. 568 patients in 2005). **First treatment demands also tend to decrease**. **Gender distribution** has remained fairly unchanged

and the mean age of clients has been on the decrease for the last six years. **Multiple drug addiction** including heroin is the main reason for detoxification demand.

➤ Substitution treatment

The **number of patients** admitted to the national substitution programme has been decreasing (114) for the last 7 years, which is probably due to the increasing access to low threshold substitution provided by GPs. The proportion of female substitution treatment demanders (35% stable) is higher than the proportion of female PDUs in the overall drug treatment population. The **mean age** of clients has significantly increased compared with 1997 data (28Y2M) especially due to the step increase of the number of treatment demanders over 39. The proportion of **native substitution treatment demanders** has stabilised in recent years (70-75%). The **socio-economical** situation of substituted patients is consistently more beneficial than the one observed in other treatment demanders, which has been confirmed by the latest external evaluation (Dellucci, 2003). The number of patients who did receive substitution treatment by prescription **from independent general practitioners** is increasing very slowly (970 patients in 2005 multiple counts excluded).

➤ Low threshold services

The **number of contacts** indexed by low threshold agencies has increased dramatically over the last ten years (2005: 47,739 / 1996: 6,456), and so has the number of syringes distributed by the same agencies, although the number of syringes distributed in 2005 has stabilised for the first time since the existence of the national NEP. The proportion of **new clients** within low threshold settings is on the increase. The number of **female clients** has been showing a weak but constant decrease (currently stable at 21%). Approximately 70% of clients are aged between 18 and 35 years. An increasing proportion of clients are non-natives (40%).

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

No information available

5. Drug-Related Treatment

Overview

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

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

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

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

- **Outpatient treatment:** the patient receives drug treatment without staying overnight;
- **Inpatient treatment:** the patient is staying overnight, including detoxification;
- **Substitution treatment:** a type of medical treatment provided to opiate addicts primarily based on the delivery of a similar or identical substance to the drug normally used. Substitution treatment may be accompanied by psycho-social care;
- **Low threshold measures²⁶:** refer to measures aimed at reducing the harm associated with drug use without necessarily requiring a reduction in consumption.

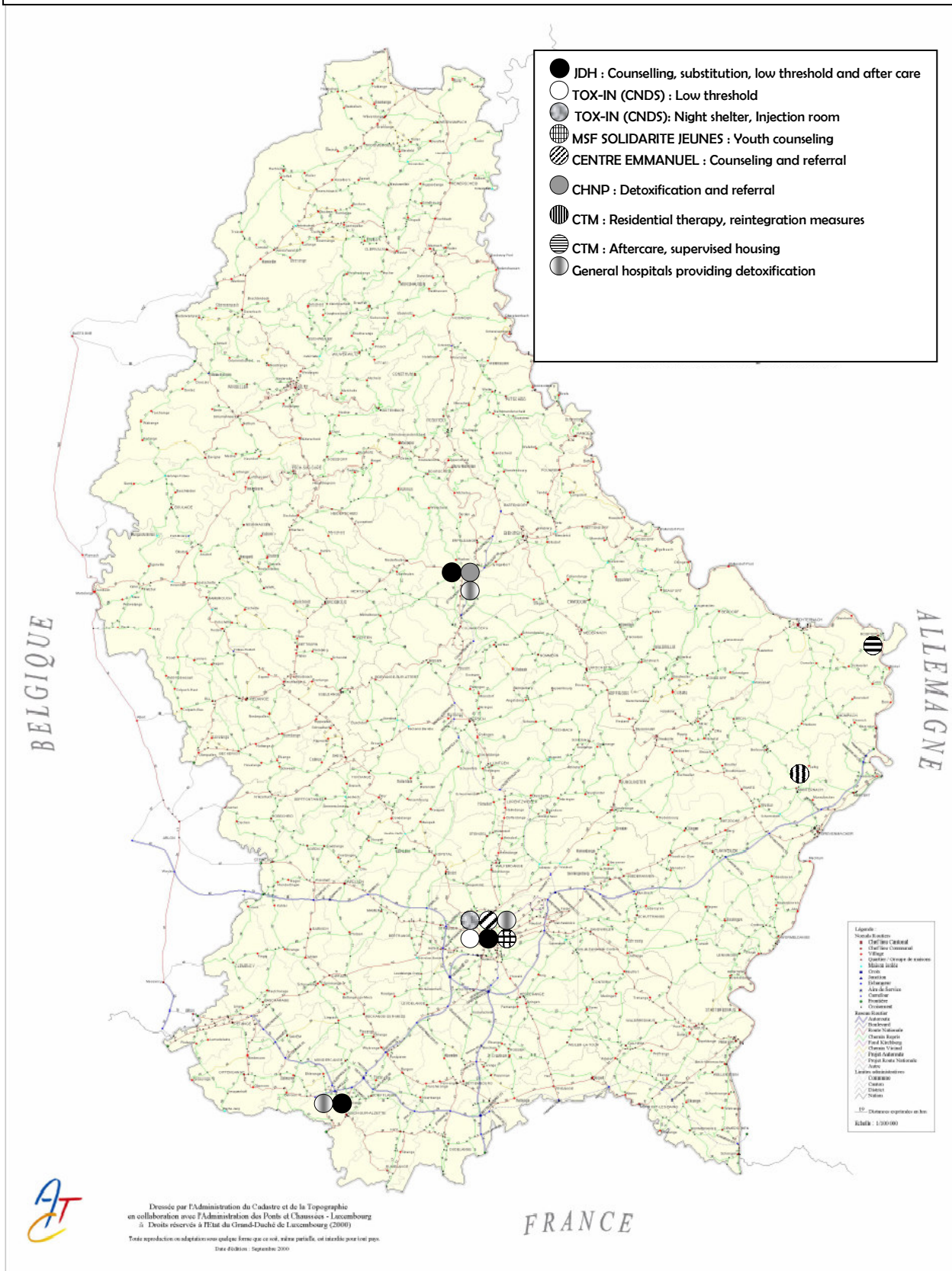
In recent years inpatient and outpatient drug treatment demand has been slightly increasing. A weak increase has also been observed in substitution treatment demanders and a very significant increase has been reported in low threshold care demanders. In general, a **continuous yet decelerating increase of the number of drug treatment demanders** is observed.

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

²⁶ Although harm reduction measures are specifically addressed under chapters 6 to 9, low threshold services are to be seen as a possible alternative to treatment and thus need to be included in the analysis of treatment demand patterns.

● Treatment systems

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



As can be seen in graph. 5.1 drug treatment facilities are regionalised showing however a high concentration and diversity within the area of Luxembourg City. All listed services are specialised with the exception of regional general hospitals providing detoxification treatment. A new service has been created in June 2005, namely 'The injection room for drug users' integrated in the 'TOX-IN centre' providing day care, night shelter and low threshold services to drug addicts.

All drug treatment infrastructures, general hospitals excluded, are relying on governmental support and control. Most of specialised agencies have signed a **convention** with the ministry of Health, which guarantees their annual funding. NGOs involved in drug treatment fall under the obligation of the so-called '**ASFT** law (8 /09 /98)²⁷ and the subsequent grand ducal decree of 10 December 1998²⁸, both regulating the relation (duties and rights) between State and NGOs or organisation providing psycho-medico-social and therapeutic care. The overall management of the referred agencies is ensured by a 'co-ordination platform' that includes 3 members of the concerned institution and at least one representative from the competent ministry. All major decisions have to be approved by the **co-ordination platform**. All referred institutions work in close collaboration and have to be viewed as an **interdependent therapeutic chain** even though there are no formal agreements between them. With the exception of detoxification departments, all treatment units or agencies accept any drug using patient independently of the type of substance(s) that are involved.

The **governmental quality standard certification**, as foreseen by the law '**ASFT**' of 8 October 1998, represents the main tool towards a standardised quality control. However, funding is not directly related to clearly defined evaluation requirements. The quality standard certification commits respective NGOs to undertake necessary evaluation measures of their activities by means, however, they deem adequate. mDrug treatment agencies have developed proper **evaluation strategies** mostly in collaboration with external evaluators. Recent examples are the evaluation of current offers in the field of socio-professional integration, which future development has been promoted by the national drugs action plan, the implementation of a computer based evaluation procedure by the national substitution programme and prevention interventions in schools by CePT.

Also, the **RELIS database** on problem drug users provides relevant data for evaluation purposes since it includes detailed data on drug consume patterns, socio-economic situation, risk behaviour and treatment or law enforcement contacts, etc. In the long run, drug 'careers' can be analysed by means of the RELIS indexing system, which allows following up treatment demands and law enforcement contacts of indexed drug users. These data can be used to assess the impact and the performance of specific treatment approaches. A practical example of the application of evaluation results is to be seen in the conceptualisation of the national drug action plan 2000-2004, which did greatly rely on RELIS data and ad hoc evaluation initiatives from field institutions. Table 5.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 2004. **Intra-institutional multiple counts** are excluded meaning that all treatment demanders indexed by a given agency is only indexed once by the referred agency during a reporting year. **Inter-institutional multiple counts** are not excluded since a given treatment demander may have contacted several national agencies during a given year. More detailed admission data, including low threshold agencies are produced in respective sub-chapters.

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

INSTITUTION	NUMBER OF ADMISSIONS (A) AND/ OR CONSULTATIONS (C) AND/OR CONTACTS (CO)							NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)						
	94	96	98	2000	2002	2004	2005	94	96	98	2000	2002	2004	2005
SPECIALISED OUTPATIENT TREATMENT														
SPECIALISED OUTPATIENT TREATMENT	1,664	1,093	1,104	1,444	1,936	2,692	3,002	467	618	764	867	1,052	1,136	1,157
SPECIALISED INPATIENT TREATMENT	48	58	39	43	57	53	35	48	55	56	56	52	70	55
INPATIENT - DETOX								≈ 308	≈ 277	243	316	289	382	568
LOW THRESHOLD AGENCIES		6,456	9,499	13,083	29,536	39,526	47,730							
DRUG TREATMENT ABROAD								≈ 50	55	71	102	101	112	121
TOTAL Number of drug treatment demanders (Multiple counts not excluded)								873	1,005	1,134	1,341	1,494	1,700	1,901
(Multiple counts excluded)								n.a.	n.a.	n.a.	637	n.a.	n.a.	n.a.

Source: RELIS 2005

²⁷ Loi du 8 septembre 1998 réglant les relations entre l'Etat et les organismes oeuvrant dans les domaines social, familial et thérapeutiques (entry in force: 24/09/1998)

²⁸ Règlement grand-ducal du 10 décembre 1998 concernant l'agrément à accorder aux gestionnaires de services dans les domaines médico-social et thérapeutique. (entry in force 18/12/1998)

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

● DRUG FREE TREATMENT

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

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

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

Outpatient treatment

RELEVANT TREND: Stabilization of total number of clients. Decrease of **first treatment rates**. **Stable gender distribution**. Increasing proportion of **clients over 30**. **Currently stable number of underage treatment demanders**.

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

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

Inpatient treatment

RELEVANT TREND: **Stable admission rates, aging clients and increasing proportion of natives**

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

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

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

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

Table 5.2 Drug treatment abroad covered by health insurance scheme (1996-2005)

AGE GROUP	199	199	199	2000	2002	2004	2005	Males (2005)		Females (2005)	
	6	8	9					N	%	N	%
< 20 years				3	5	3	3	2	2,4	1	2,7
20 à 25 years				33	33	37	29	17	20,2	12	32,4
> 25 years				66	63	72	89	65	77,4	24	64,9
TOTAL	55	71	91	102	101	112	121	84	100	37	100
Mean age				27Y9M	28Y	28Y5M		31		30	

Source : Administration du Contrôle Médical : Cures de désintoxication (drogues dures et polytoxicomanie) à l'étranger - Exercices 1996-2005

A new project foreseen by the 2005-2009 national drugs action plan relates to minor PDUs. A specialised residential centre for problematic youngster will be opened in the beginning of 2007 in the North of the country under the management of CHNP. The therapeutic programme of the centre should fill the current gap in the care system for minors. Further details will be reported in the 2006 report.

● MEDICALLY ASSISTED TREATMENT

○ Detoxification, in-patient

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

Physical drug detoxification is provided by 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 do not provide detoxification treatment anymore. A new hospital (Hôpital du Krchberg) has joined the list 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 therapeutic oriented institutions.

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

- Clinique St. Louis – Ettelbrück (North) – 15 psychiatric beds
- Centre Hospitalier Emile Mayrisch - HVEA (South) – 33 psychiatric beds
- Centre Hospitalier de Luxembourg – CHL (Centre) – 45 psychiatric beds
- Clinique Ste. Thérèse (Centre) – 12 psychiatric beds.
- Hôpital du Kirchberg

○ Substitution treatment, outpatient

RELEVANT TRENDS: Continuous decrease in number of patients in structured programme. Weak increase of low threshold substitution demands – Increase of female clients- Increase of mean age of substitution treatment demanders.

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 dose-digressive, out-patient low threshold maintenance to abstinence oriented (digressive doses) rehabilitation offers. The primary goal is the psychosocial and medical stabilisation of the patient by replacing 'street' drugs by quality controlled substitution drugs. The further development and outcome of the treatment is assessed individually. Both components, condition of the patient and reduction of public nuisance are considered.

Substitution treatment is provided at the national level since 1989 (JDH). Until the beginning of 2001, however, there has been no **legal framework** regulating drug substitution treatment. The

law of 27 April 2001 modifying the basic drug law of 19 February 1973 introduced a legal framework for substitution and maintenance treatment. The grand ducal decree of 30 January 2002²⁹ regulates the practical modalities of substitution. The new law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of **substitution treatment licenses** granted to MDs and specialised agencies, the application of training requirements for prescribers and adequate control mechanisms of **multiple prescriptions** (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a **structured substitution treatment programme** (JDH - mainly liquid oral methadone – 114 patients in 2005) provided by specialised agencies (JDH) and a **lower threshold substitution treatment** offer provided by freelance state licensed MDs (MEPHENON ®, METHADICT ® and SUBUTEX ®). A **central substitution register** is about to be implemented jointly by the 'Surveillance Commission on Substitution Treatment'³⁰, the national drug coordinator and involved specialised treatment centres. The permission for its creation has been granted by the national data protection commission in June 2006

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

Diverted MEPHENON ® (methadone in pill form prescribed by accredited MDs) is largely available on the national black market. This situation is primarily due to uncontrollable **multiple prescription** of mephenon® and dealing between patients and other drug addicts. Given that no centralised substitution treatment register does currently exist, prescribing MDs have major difficulties in determining rapidly whether their patient is simultaneously be prescribed a substitution drug by one or more of his/her colleagues. In that respect, it has been decided to set up a **national substitution treatment register** within the Directorate of Health in order to reduce illicit diversion of substitution drugs. The register should become operational in the course of 2007.

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

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

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

Source : Union des Caisses de Maladie 2004

A first scientific **evaluation** of the structured JDH substitution programme occurred in 1995. In 1998, new evaluation software has been developed in collaboration with the NFP, which, in the medium term, aims at the integration of substituted patients' data directly in the RELIS database. In

²⁹ The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>

³⁰ 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.

2003 a third evaluation by an external expert occurred on basis of data provided by the referred evaluation software.

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

- Significant improvements of residential status, social independence of patients, occupational situation, financial situation and indebtedness status, frequency of penal and judicial contacts, health indicators and frequency of risk behaviours,
- No significant improvement of parallel consumption patterns of illicit opiates by substitution patients.

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

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

6. Health Correlates and Consequences

Overview

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

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

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

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

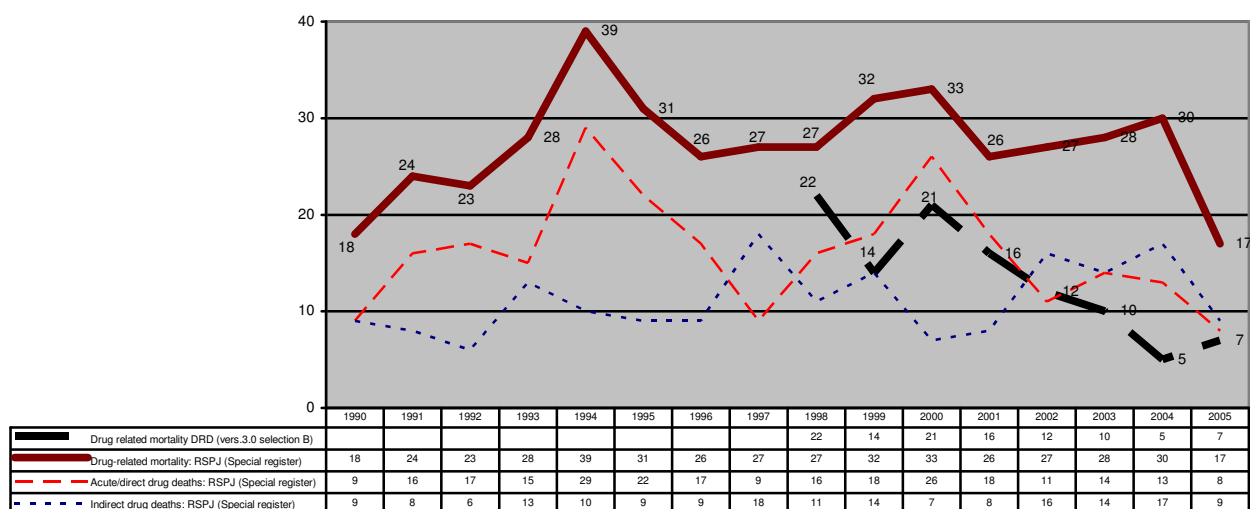
Infectious diseases, including HIV and viral hepatitis have to be reported following diagnosis to the Directorate of Health (Ministry of Health) that compiles data and is in charge of nation wide epidemiological follow up. The national drug monitoring system RELIS provides self reported data on infectious diseases in PDUs. Furthermore specific studies provide complementary information. The report includes data from the most recent Origer & Removille (in press) study on infectious diseased in PDUs applying blood test results to assess current prevalence rates.

● DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS

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

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

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



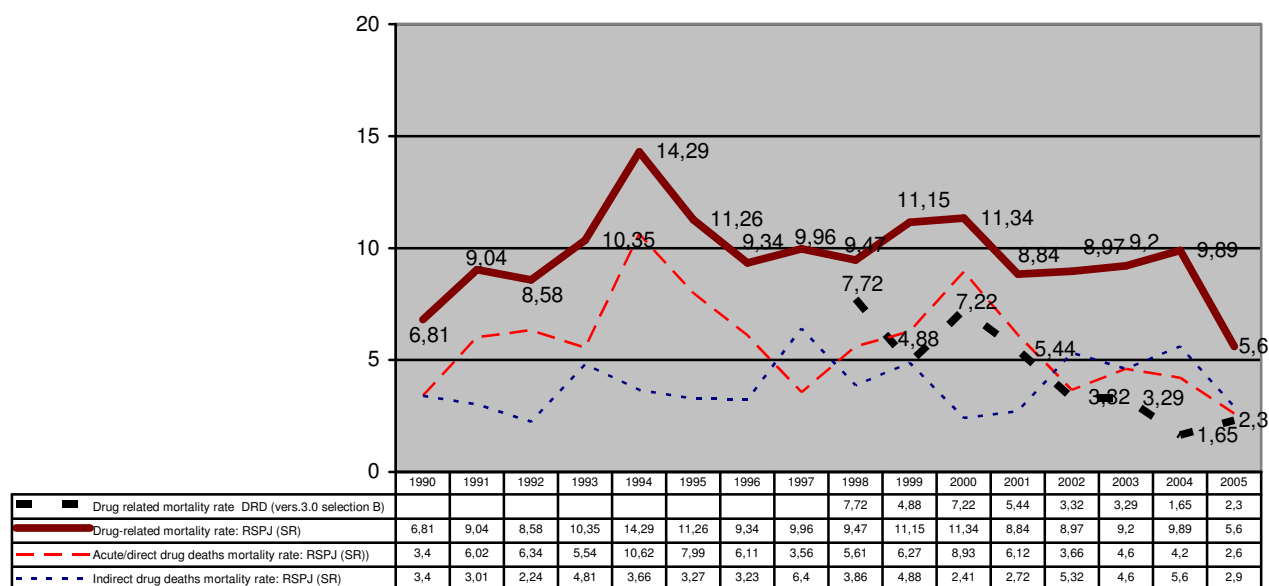
The number of **fatal acute overdoses** indexed at the national level has shown an increasing trend from 1985 to 1994 (29 cases), followed by a slow decrease until 1997 (10 cases). A similar evolution has been observed between 1997 and 2005, showing a peak in 2000 (26 cases) decreasing anew to almost historically low level of 8 cases in 2005.

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

The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants³¹ in 2000 (2.09 in 1997). An international comparison shows that the **overdose rate** of the G. D. of Luxembourg in 2000 was among the highest within EU Member states. 2001 and 2002 figures, however, show significant decreases. In 2005 overdose rates of 1.76 and 2.62 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed.

³¹ All age groups

Figure 6.2 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2005 (Origer 2006)



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

The decreasing trend from 2000 to 2002 may be a medium term consequence of the higher proportion of non-i.v. opiate users observed during that same period followed by a stabilisation around 4.5 percent. Also, availability and quality of drugs available on the national market, multiple-drug use, associate morbidity and contexts of drug-related deaths are some of the relevant topics that have been addressed by a study on drug-related deaths (Origer & Dellucci 2002). In 2005, 9 **indirect drug death cases** have been indexed by the RSPJ. The latest positive evolution of direct drug deaths is to be confronted to the implementation of a drug consumption room in 2005.

Since 1992, results of **toxicological analysis** performed on overdose victims refer to the presence of opiate traces in almost all direct drug death cases. **Heroin** has been detected in a vast majority of acute drug deaths, (average 171 heroin cases / 230 total acute drug death cases: 74,3%) either exclusively or as primary drug associated to other substances. In all reported cases heroin has been administrated intravenously.

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

Gender distribution of direct drug death cases reflects the sex ratio observed in the total number of drug-related deaths and in the overall drug population. There appears to be no consistent evolution trend during the last 10 years. (Although in 2005 100% of male victims have been reported – a situation to be reconsidered in 2006)

Figure 6.4 Mean age of acute drug deaths victims (1992-2005) (RELIS 2006)

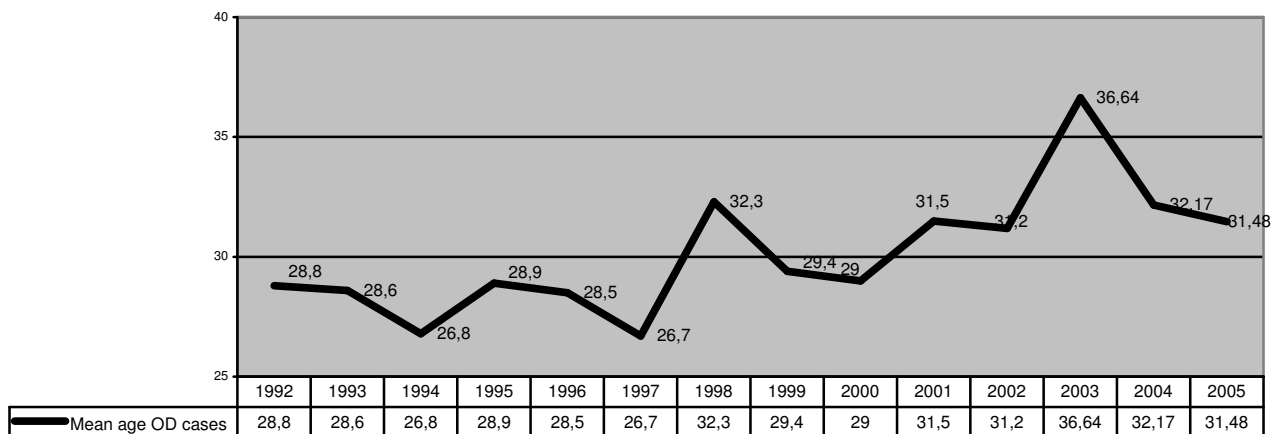
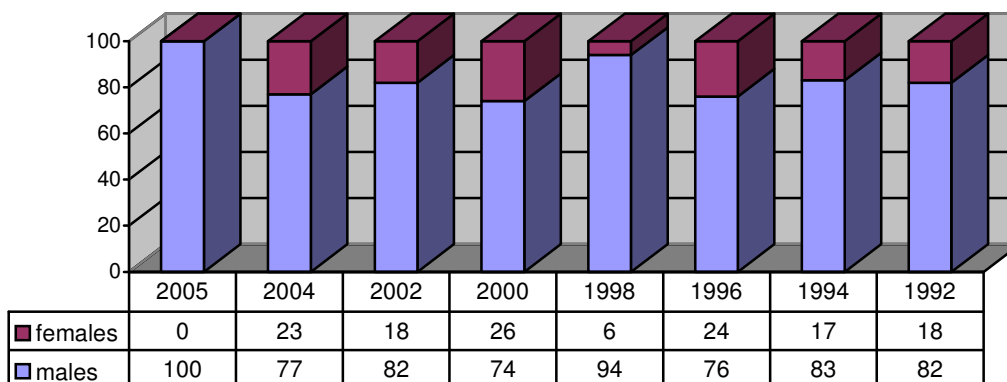


Figure 6.3 Gender distribution of direct drug-related death cases (1992 - 2005) (%)



Source: RELIS 2005

The **mean age of direct drug-related death cases** shows quite important fluctuations over time (mean age from 1992: 28.4 to 2004: 32.17 years and 31,48 in 2005). However, over an observation period of 14 years, it appears that the mean age of acute drug deaths victims follows a long term increase. This increase has been fairly spectacular in 2003 even though it has not been confirmed by 2004/5 data. Age group 20 to 34 years is most represented. Overdose victims are significantly younger than **indirect drug deaths cases**.

Table 6.1. Age distribution of direct drug death cases indexed from 1992 to 2005

	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	Total
< 20	1				2	1	1			1		3	3		12
20-24	2	1		4	2	8	3	2	2	5	6	6	6	6	55
25-29	1	4	2	1	5	6	6	5	5	5	10	13	2	6	73
30-34	1	3	4	3	2	6	3	2	2	4	5	6	3	3	46
35-39	1	2	3	1	5	4	3	4		1	2	1	1		28
40-44	1	2	3		2	1	1	3			2			1	16
45-49		1	2	2		1					1			1	7
> 50	1									1					2
Mean Age	31.48	32.17	36.64	31.18	31.5	29	29.35	32.3	26.7	28.5	29.85	26.8	24.6	28.4	239

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

An increasing majority of drug-related deaths cases (direct & indirect) are **natives** (82.3% in 2005). The same applies to direct and indirect drug deaths analysed separately. Over the last 10 years the **non-native** subpopulation of victims was primarily composed of Portuguese citizens, which proportion is much higher than the one observed in the general population. Portuguese natives are followed by Italians and citizens from border countries, whose proportion have remained fairly

stable during the last five years. A confirmed majority of acute drug death victims have been in **contact with law enforcement agencies** prior to their death (75% or 6/8).

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

In terms of **drug-related mortality** (direct and indirect deaths indexed by RSPJ), 17 cases have been indexed in 2005; prevalence has been showing small variations since 1996 figuring roughly 17 to 33 cases per year.

The above mentioned study (Origer & Dellucci 2002)³², 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 (17 in 2005 of which 8 direct/acute death cases).

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

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

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

Main **causes of indirect deaths between 1996 to 2005** are, in order of importance: suicide (32)³³ traffic accidents (22%), associated cardio-vascular or pulmonary complications (15%) undefined intoxication (11%), pharmaco-dependance (7%), liver failure (6%), HIV/AIDS (4%) and other (2%).

● DRUG RELATED INFECTIOUS DISEASES

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

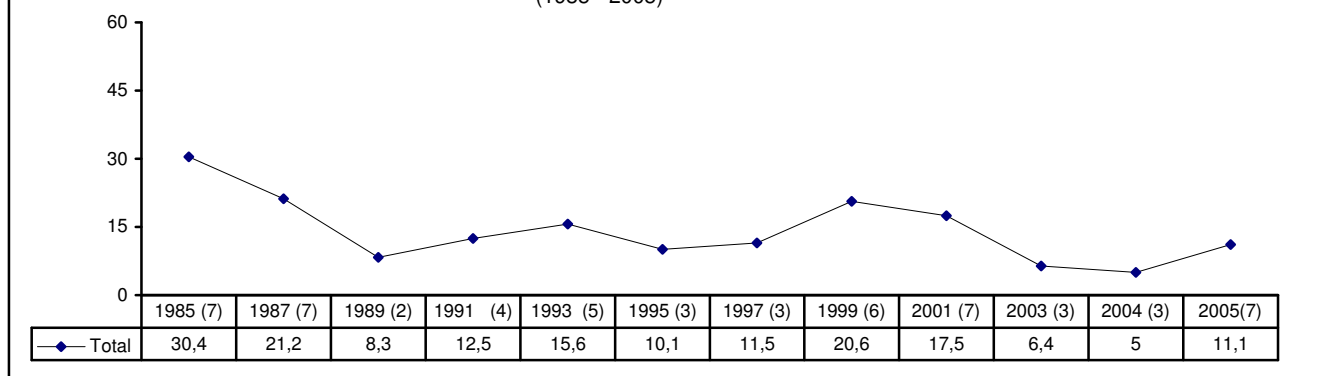
Official data from the national Retrovirology Laboratory of the CRP-Santé provide **the number and proportion of IDUs in HIV infected patients**. Between 1984 and 2005, 715 HIV infected persons have been registered at the national level; 99 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 13.8 per cent since the registration of the first HIV case in Luxembourg in 1984.

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

³² A full text version of the study can be downloaded under: <http://www.relis.lu>

³³ Valid percentage

Fig. 6.5 Proportion (%) of IDUs in newly infected HIV patients (1985 - 2005)



Source : Laboratoire de Retrovirologie – CRP-Santé. 2005

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2005, 76% of RELIS indexed PDUs reported a **test** during the last 5 months. Female PDUs tend to report higher testing rates than males.

In 1997, a significant decrease of **HIV rates in drug users**, mainly in IVDUs, occurred. Subsequently, **HIV rates in current IVDUs have been increasing to reach 3.96% in 2005. IVDUs treatment demanders** show the highest HIV prevalence rate (4.59%).

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

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

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

The study shows that the self reported data do not mirror validly the prevalence (both furnished by the study) but the latter show a satisfactory match between the self reported rates provided by the national drug monitoring system (RELIS).

The HCV prevalence rate of the total study sample is 71.4% and reaches 81% in ever injectors. The highest prevalence rate (86.3%) was observed in in-prison respondents, followed by those in inpatient treatment centres (75.4%) and those in outpatient treatment centres (58.2%).

The HBV prevalence (comprising acute/chronic infection and past cured infection) in the G.-D. of Luxembourg among PDUs is 21.6% and figures 24.7% in ever injectors. HBV prevalence in out-treatment centres is 16.4%, 15.1% in the in-treatment centres and up to 31.8% in prison. 32% of the PDUs could benefit from the vaccination against hepatitis B.

Concerning HAV prevalence, no case has been identified in the present study. It should be stressed, however, that 43% of the participating PDUs are not protected against hepatitis A.

The HIV prevalence among the PDUs provided by the study figures 2.9% for the overall population and 2.5% if exclusively referred to ever injectors. The HIV prevalence rate is 1.9% in the in-treatment centres, 7.7% in the prison centres and is null in in-patient centres.

One has to bear in mind that among persons infected by HCV, HBV and HIV, respectively 96%, 95.2% and 71.4% are ever injectors. It is important to note that the highest prevalence rates are

observed among the prison population. This has to be confronted to the fact that 56.1% of the respondents with current or past prison experience (N: 246) declare having consumed illicit drugs in prison whereof 54.3% report intravenous use during detention. Among these lifetime injectors in prison 20% reported exclusive use of new and sterile syringes, 53.3% declared never having exchanged syringes with other inmates and % report syringes' exchange in prison.

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

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

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

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

YEAR	1997	1998	1999	2000	2001	2002	2003	2004	2005
HIV rate in problem drug users (RELIS self-report)	3	2.9	2.9	4.3	4.07	4.49	3.88	3.98	3.31
HIV rate in problem drug users (Origer & Removille in press)									2.90
HIV rate in drug treatment demanders (RELIS self-report)	3.8	2.6	3.4	4.87	4.78	4.32	3.88	4.93	3.84
HIV rate in current IVDUs (RELIS self-rep.)	3.6	3.5	3.3	3.6	3.41	4.08	4.17	5.10	3.96
HIV rate in current IVDUs treatment demanders (RELIS self-report)	4.5	3.4	3.9	3.9	4.24	4.32	4.24	6.41	4.59
HIV rate in life-time IVDUs (Origer & Removille 2006)									2.50
HIV rate in current IVDUs prisoners (Schlink 1998)	/	4.4	/	/	/	/	/	/	/

Source: RELIS 2005

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

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

Source: RELIS 2005

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

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

YEAR	1997	1998	1999	2000	2001	2002	2003	2004	2005
HBV rate in drug users (RELIS self-report)	29	30	30	28	25	22	20.51	21.34	18.67
HBV rate in PDUs (Origer & Removille in press)									21.6
HBV rate in drug treatment demanders (RELIS self-report)	/	27	32	27	24	20	19.79	22.69	18.58
HBV rate in IVDUs (RELIS self-reports)	/	33	35	30	30	25	22.76	23.93	20.08
HBV rate in ever-injectors (Origer & Removille in press)									24.7

Source: RELIS 2004

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

YEAR	1997	1998	1999	2000	2001	2002	2003	2004	2005
Self-reported HCV rate in drug users (RELIS)	26	25	32	46	50	49	59.92	64.55	64.94
HCV rate in PDUs (Origer & Removille in press)									71.40
Self-reported HCV rate in drug treatment demanders	/	29	41	53	54	54	60.49	66.16	66.22
HCV rate in IVDUs prisoners (saliva tests)	/	37	/	/	/	/	/	/	/
Self reported HVC rate in IVDUs (RELIS)		45	50	53	56	53	67.97	74.14	74.38
HBV rate in ever-injectors (Origer & Removille in press)									81

Source: RELIS 2004 (Origer 2005)

Summarily, HBV infection prevalence in PDUs and in drug treatment demanders is fairly stable while HCV prevalence in general population and in PDUs has significantly increased during the last 4 years. HIV infection rates show a decrease especially referred to IVDUs.

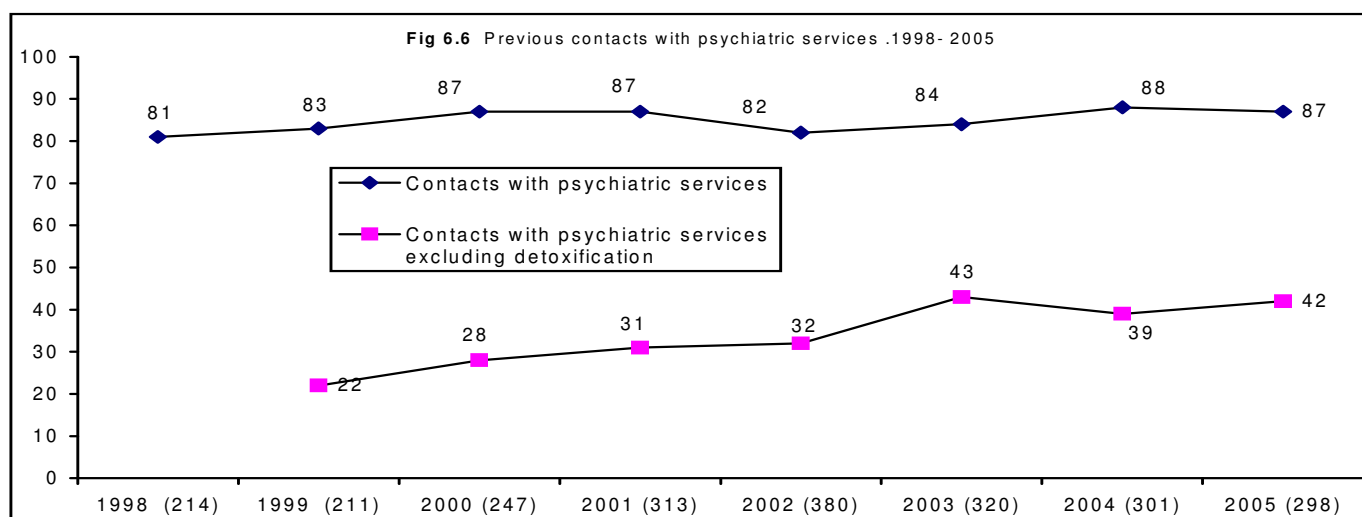
● **PSYCHIATRIC CO-MORBIDITY (DUAL DIAGNOSIS)**

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

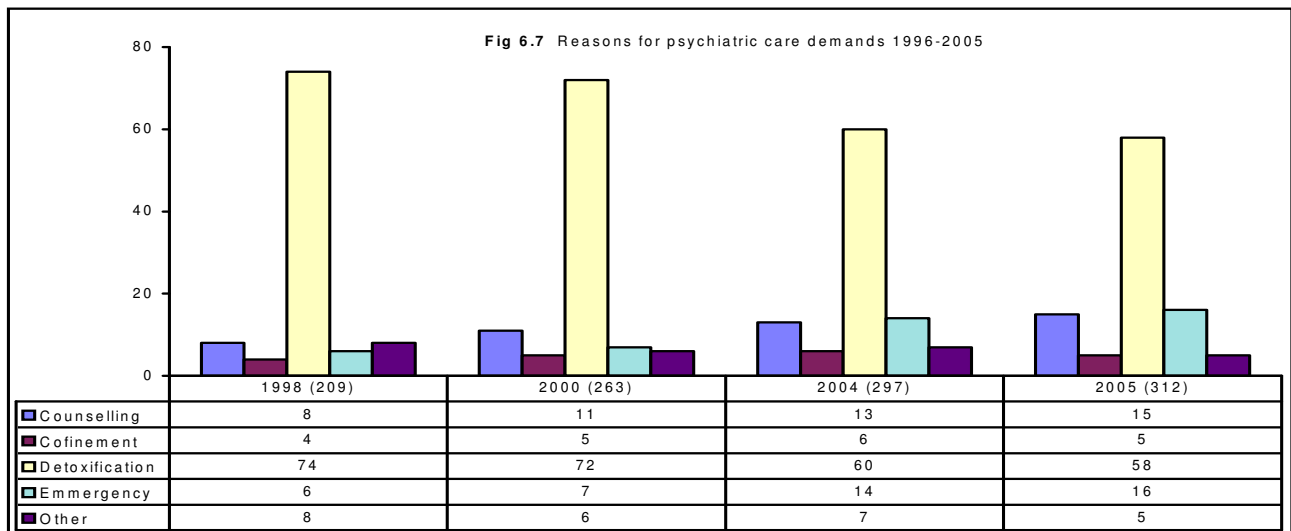
Most common mental disorders observed in clients seeking help in specialised drug agencies or in contact with other institutions are: anxiety, depression, neurosis, psychosis and borderline behaviour. Residential drug care settings estimate that 10% of their clients show psychotic symptoms.

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

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



SOURCE: RELIS 2005



SOURCE: RELIS 2005

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

Data from 1996 to 2005 reveal a quite stable proportion of PDUs showing a psychiatric history, unlike the proportion of clients reporting contacts for mental problems excluding detoxification treatment, which has been following an increasing trend in recent years.

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

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

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

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

administration and a series of specialised care agencies abroad. If the referral demand is approved, related costs are reimbursed by Social Security.

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

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

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

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

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

The pertinence of 'case management' has been recognised by professional during recent years. Although this method is cost and time intensive, it has proven to be most effective with double diagnosis patients. Not only tend the DD patients to have very specific needs; they also often present extreme variations in mood and behavioural patterns.

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

● OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDUs except for HCV prevalence. In 2005, 76 per cent of problem drug users reported a self-perceived satisfying general health condition against 53 per cent in 1997 (RELIS 2005). Half of indexed PDUs report single or multiple suicide attempt(s) during lifetime. No significant changes have been observed during the last 4 years.

7. Responses to Health Correlates and Consequences

Overview

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

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

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

● PREVENTION OF DRUG RELATED DEATHS:

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

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

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

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

- A majority of drug-related deaths cases (direct & indirect) are **natives** (64,6 to 90.9%). The same observation applies to direct and indirect drug deaths analysed separately. The **non-native** subpopulation of victims is primarily composed of Portuguese citizens, which proportion is much higher than the one observed in the general population. Italians follow Portuguese natives and citizens from border countries which proportion has remained fairly stable during the last four years.

The following measures have been recommended:

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

At the time of writing, 6 of 8 of these recommendations have been put to action.

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.

Finally, in the line of the recommendations of the Origer and Dellucci (2002) study, a low threshold service in collaboration with the Ministry of Health edited a documentation kit on overdose

prevention and emergency intervention by peers. The information kit includes flyers on following issues:

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

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

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

Articles 2 and 3 of the law of 27 April 2001 have set the legal framework for 'user rooms and other means duly licensed by State', which also includes controlled distribution of certain narcotics (e.g. heroin). The implementation of such facilities is included in the national drugs action plan 2005-2009 of the Ministry of Health.

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

In July 2005, the first injection room at national level has become operational and has been integrated in the low threshold emergency centre for drug addicts. Besides the drug consumption room, as it is called officially, the emergency centre provides the whole range of harm reduction services, counselling facilities, accommodation, washing, laundering and storing facilities. It should be added that the night accommodation is not to be seen as a permanent housing facility; there is indeed a daily admission procedure. Target population for the consumption room are primarily IVDUs. Inhalers might be admitted in a second phase. The main objective of the project is the reduction of drug-related harm and nuisances. More precisely it aims at reducing the risks of infectious diseases, overdoses and public nuisance in the neighbourhood, contact making with difficult to reach addicts, provision of special designed night shelter facilities and avoiding unnecessary prison journeys over night. The project was designed with the support of law enforcement agencies.

An expert group has been visiting similar projects in the EU in order to fine-tune the concept and implement quality control standards. The national drugs coordinator's office elaborated the operational concept of the injection room. All involved parties meet once a month to assess the current situation and emerging problems related to the functioning of the consumption room. Opening hours are currently from 4 pm to 12 pm from Monday to Friday.

According to the activity report of the injection room (TOX-IN 2006), during the first year of functioning (July 2005 – July 2006), 218 injectors had signed the mandatory user contract and proceeded to 5,028 injections supervised by trained staff. The facilities were mostly used by men (73%); the most commonly used drugs were heroin (81%), cocaine (11%) or both of them (7%); age category 25-34 is most represented (56%). No fatal overdose has occurred thus far but 11 overdoses have occurred and due to the immediate intervention of ad hoc staff the lives of these persons could have been saved; police forces were never called, medical emergency assistance were called for 7 times, no drug scene concentration and no disturbances or nuisance in the neighbourhood have been observed; 270 safer use counseling sessions have been provided to clients. The concept of the drug injection room can be ordered at the Ministry of Health (alain.origer@.ms.etat.lu).

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

regional sites. Concerned authorities have recently found an agreement on the geographical location of this facility.

It has to be stressed that the realisation of the 2000-2004 action plan, including the implementation of the drug injection facility, has been accompanied by a significant decrease of overdose cases in the Grand-Duchy of Luxembourg.

● PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES:

○ Prevention

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

The objective of these interventions is straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Traditionally harm reduction (HR) measures have been focusing on IVDUs since most exposed to a variety of health risks. Nevertheless, initiatives such as the provision of aluminium foils to heroin users and the current discussion on the future distribution of 'strawbags'³⁴ for sniffing purposes witness a progressive switch from IVDUs users to PDUs being considered as target groups. Furthermore infectious diseases prevention does not focus specifically on IVDUs as shows a recent action-research project on HIV and hepatitis infection among PDUs (Origer & Removille in press).

The most relevant measure in the field of prevention of infectious diseases in drug users is the **national needle exchange programme** established in 1993 and co-ordinated by JDH. In addition to free of charge needle provision by specialised drug and AIDS agencies, automatic syringes dispensers/collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy. Regarding the quantity of distributed syringes, table 7.1 shows an **increase of 470 per cent during the period 1996 to 2005**. 2004 figures witness a steady upward trend with regard to the number of distributed syringes and so do the return rates, however, reaching up to 88% in 2005. Obviously automatic dispensers show the lowest return rates.

Table 7.1 National needle exchange programme 1996-2005

	Distributed syringes						Collected used syringes					
	1996	1998	2000	2002	2004	2005	1996	1998	2000	2002	2004	2005
TOTAL	76,259	109,743	189,413	254,596	435,078	434,879	28,646 (38%)	58,886 (46%)	112,625 (59%)	211,621 (83%)	376,491 (87%)	381,251 (87,7%)

Source: RELIS 2005

Condoms and syringes are provided by the **Division of Preventive Medicine** (Directorate of Health) to field actors in the framework of the national programme on prevention of infectious diseases. Vaccination for HAV and HBV is free of charge for persons under 18. Several local outreach prevention activities have to be mentioned as for instance contact making with sex workers within their daily work environment for HIV and hepatitis testing and subsequent health care, if needed. These specific activities are currently further developed by the '**Drop In**' centre for drug users and prostitutes (RED CROSS).

Moreover, outreach interventions targeted at (drug using) prostitutes aiming to establish contact and to prevent dissemination of infectious diseases have taken place. According to EMCDDA's key indicators and with a view to improve quality of national data on infectious diseases, the NFP has set up an **action-research** with the objective to estimate HCV and HIV prevalence in PDUs based on medical diagnosis data (blood testing) and to implement required health care infrastructures (Origer & Removille in press).

³⁴ A 'straw bag' contains one-way straws especially designed not to hurt the nasal cavities, thus avoiding wounds and bleeding, a special liquid to smooth tissues, a professional condom and lubricants.

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

Additionally a quantitative questionnaire (questions based on socio-demographic, illicitly acquired drugs consumption, consume patterns, sexual behaviour, consumption in prison, piercing/tattoo) allowed to analyse of associated factors. Serological analysis identified the number of contaminated cases with hepatitis A, B, C and HIV. In case of medical indication a vaccination against hepatitis A and/or B has been offered. Drug users meeting the selection criteria were recruited in LTS, NSEP, Inpatient Treatment Centres, Hospitals and in the prisons of Luxembourg. The NFP has been granted a full financing of the project by the FLTS.

Hereafter some of the recommendations of the report:

- Increase knowledge of serological status among general population and risk groups
- Include drug users in the planning process of prevention strategies
- Reinitiate safer-use counselling for young and new drug users since they are often not aware of risk compared to older or more experience users
- Inform on ineffective disinfection and syringe elimination techniques. Often drug users think they do the right thing but there risk reduction strategies are ineffective due to a lack of knowledge (e.g. using only water for disinfection, throwing needles away and bringing only the syringe back to NEPs)
- Insuring 24/24 hours syringes availability and providing additionally spoons and filters in NEPs
- Ensuring a better vaccination coverage and above all vaccination follow up by involving the general health care network (e.g. providing GPs with free Twinrix®)

The full report will be made available on www.relis.lu. The final report will be available by the beginning of 2007.

○ **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 above-mentioned action-research aims at increasing the testing coverage of PDUs since it includes anonymous on-site testing and diagnosis transmission facilities. Furthermore, HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison.

Moreover the 2006 – 2010 HIV/AIDS action plan focus on outreach measures in order to better reach target populations and in particular vulnerable groups.

○ **Infectious disease treatment**

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

● INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

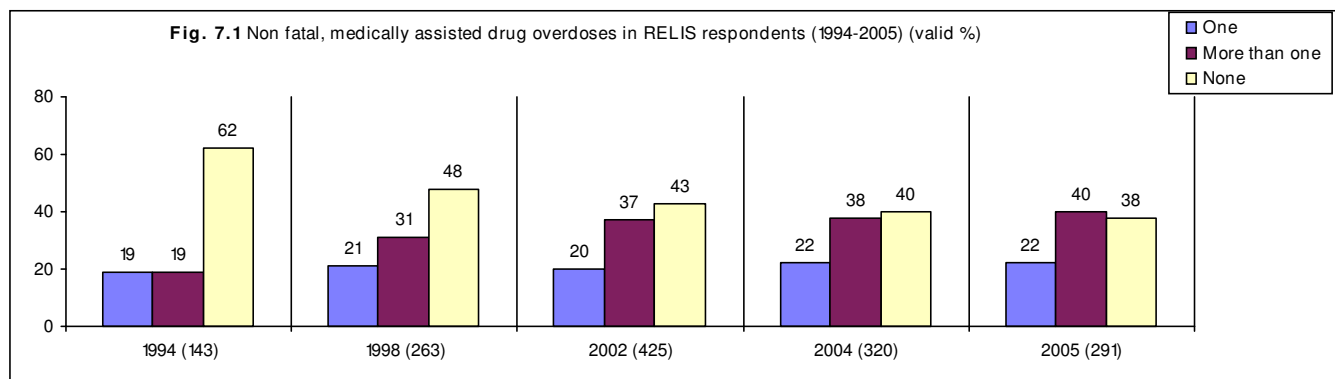
○ **Somatic co-morbidity**

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

In 2006 a concept of a specialised **addictology department** within a general hospital of Luxembourg-City has been presented to the Minister of Health. The concept foresees a holistic and network based care programme for patients presenting substance abuse and will be discussed by experts in the currently ongoing psychiatric reform in Luxembourg.

○ Non-fatal emergencies and general health-related treatment

No reliable data on drug related emergencies are currently available at the national level. Roughly estimated, 25% of emergencies are related to substance abuse (all substances included). (Rauchs 2006). Figure 7.1 refers to RELIS data on previous non-fatal and medically assisted drug overdose self reported by PDUs. The proportion of indexed drug users reporting at least one overdose (as defined) (62%) during lifetime has slowly increased during the last six years. This trend is partly due to an aging IVDU population.



Source: RELIS 2005

○ Prevention and reduction of driving accidents related to drug use

In 2004, the Minister of Transport introduced a project of law (N°5366) modifying the national traffic code and introducing illicit drug testing in vehicle drivers. The homologation of respective saliva and sweat tests has already been approved by the Council. The related grand ducal decree should enter in force in 2007. The application of these tests will provide a more accurate insight as far as the relationship between illicit drugs intake and traffic accidents are concerned. Also more severe penalties in regard to offences related to driving under the influence of alcohol, illicit drugs and excessive consumption of psychoactive medicaments are foreseen. Moreover monthly prevention campaigns are organised by the Grand-Ducal Police. In January 2004, an anti-drugs campaign focussing on the consequences of driving under influence of illicit drugs was launched.

○ Other health consequences reduction activities

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

○ Interventions concerning pregnancies and children born to drug users

Since several years and in the context of the development of social paediatrics at national level, child care professionals and paediatricians call for the implementation of specialized 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.

In order to meet the specific needs of children and parents at risk, especially children from drug dependant parents, the Ministry of Family and Integration currently implements a project of “out-of-hospital nursery” run by an association called “Anne” and addressing children aged 0 to 3 years which parents temporarily are not able to assure child care and education. The structure aims to provide temporary admission to these children and helps to compensate the lack of parent’s involvement in child care. Besides, the structure will offer therapy options, diagnostic testing and will function as a resource centre for parents. The project foresees a capacity for approximately 20 children and will start in spring 2007.

8. Social Correlates and Consequences

Overview

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

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

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

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

- *'Arrestation'* (Eng. *Arrest*) : Interpellation followed by a deprivation of liberty and notification to the attorney at law. The preliminary examination (instruction) refers to the subsequent judicial procedure that leads to public audience, which claims the sentence.

- *'Condamnation'* (Eng. *Conviction*) : Judgement by which the accused person is found guilty.

- *'Détenion'* (Eng. *Imprisonment*) : Deprivation of liberty. Distinction is made between protective custody (prior to the judgement) and regular detention (following conviction).

• **Social Exclusion**

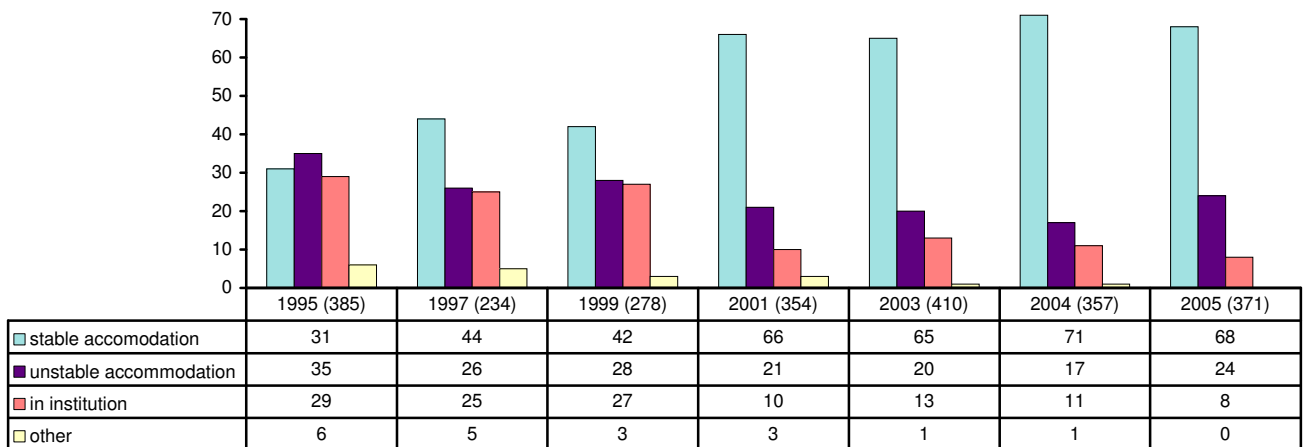
The question whether substance abuse leads to social degradation and exclusion or social factors (e.g. family situation, poverty, low education or job perspectives) lead individuals to substance use is an unsolvable one, although it tends to raise competence discussions between ministries. Fact is that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

- Homelessness

Housing status of registered drug users has markedly improved during recent years and tends to stabilise. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Currently 68 percent (71%) of PDUs report a stable housing situation. This positive evolution may be linked to an increased awareness of the housing problem and the set up of new

housing networks for socially deprived people by the Ministry of Health and specialised agencies referred to under chapter 9.

Fig. 8.1 Last known housing situation of problem drug users. 1995 - 2005



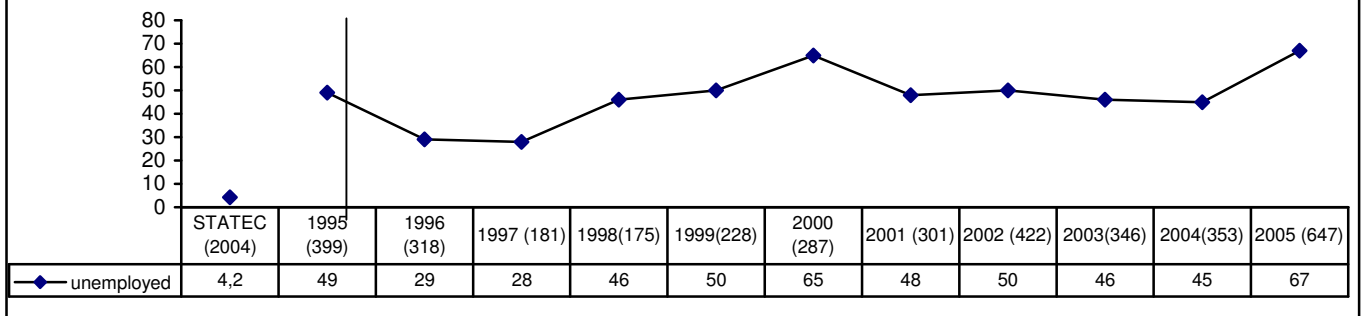
Source: RELIS 2005

- Unemployment and financial situation

Recent data suggest that the **employment status** of respondents tend to worsen. Also the **unemployment rate** has increased in 2005 (67%).

Fig. 8.2 Unemployment rate in problem drug users (1995 - 2005)

SOURCE: RELIS 2005



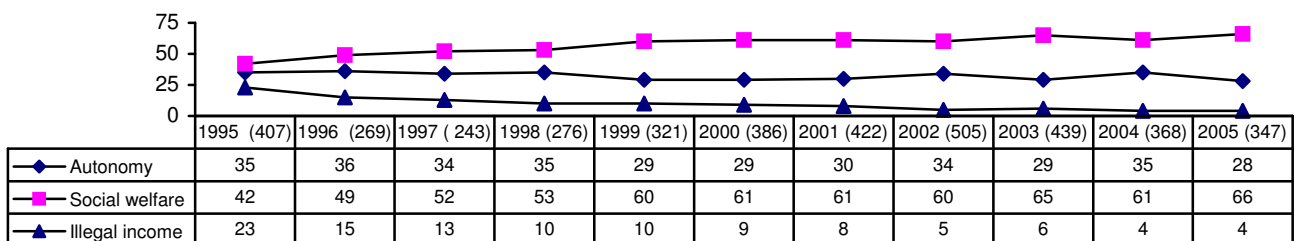
Source: RELIS 2005

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

Data on revenues confirm observed trends in occupational status:

- increase of social dependence associated to a stable **financial autonomy**. The Guaranteed Minimum Income constitutes the primary source of revenue of PDUs;
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 1995;
- a high proportion of respondents reporting **major depths** ($\geq 2,500$ EURO) (41%).

Fig. 8.3 Primary source of income of problem drug users (1995 - 2005)

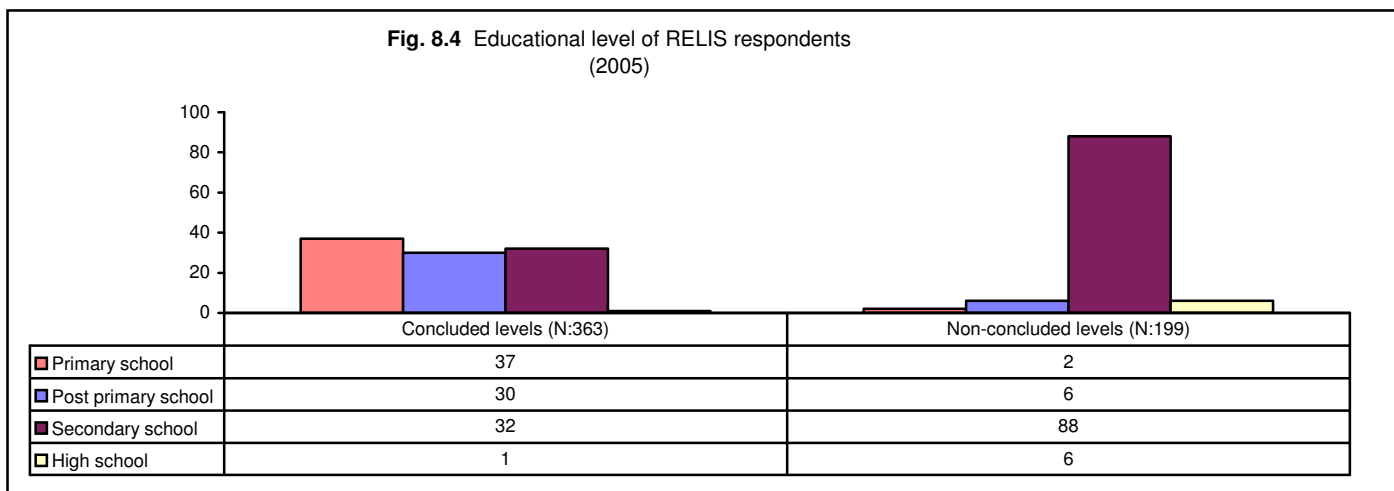


Source: RELIS 2005

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

- School drop out

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



Source: RELIS 2005

• **Drug related crime**

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

a. Drug related arrests data

As can be seen in tables 8.1 and 8.2, the total number of arrests (178) has increased compared to previous years. Traditionally heroin was the most frequent substance involved in drug-related arrests. In 2004 cocaine has turned to be the main substance involved in those arrests (confirmed by 2005 data), followed by heroin and cannabis. Since 2004, charges on drug traffic have known an important increase.

Table 8.1 Arrests broken down by type reporting institution (1995-2005)

Year	ARRESTS									
	1995	1997	1999	2001	2003	2004	2005			
S.P.J.	27	25	27	7	25	38	26			
Gendarmerie	8	15	15							
Police	32	32	32	45	82	103	94			
Customs	61	82	34	40	28	37	35			
Total	128	154	108	92	135	178	155			

Table 8.2 Arrests broken down by type of offence and substances involved (1995-2005)

Substance	Offence	1995	1997	1999	2001	2003	2004	2005
Heroin	Use & Traffic	68	57	48	41	21	32	28
	Traffic/Deal	21	53	18	8	22	19	14
	Use	24	7	27	8	4	20	20
	Total	113	117	93	57	47	71	62
Cocaine	Use & Traffic	20	27	21	27	19	21	21
	Traffic/Deal	7	23	9	9	30	64	42
	Use	10	6	12	4	3	9	15
	Total	37	56	42	40	52	94	78

Cannabis	Use & Traffic	25	18	32	23	52	16	17	
	Traffic/Deal	1	11	8	1	17	20	27	
	Use	4	4	3	15	9	14	25	
	Total	30	33	43	39	79	50	69	
Amphetamines	Use & Traffic		2	1	2	2	0	0	
	Traffic/Deal				0	0	0	1	
	Use	2			0	0	0	0	
	Total	2	2	1	2	2	0	1	
Ecstasy (MDMA, etc.)	Use & Traffic	3	3	3	1	1	1	3	
	Traffic/Deal	1	3		0	0	1	6	
	Use	1			0	1	1	3	
	Total	5	6	3	1	2	3	12	
LSD	Use & Traffic		1	1	0	0	0	0	
	Traffic/Deal				0	0	0	0	
	Use				0	0	0	0	
	Total		1	1	0	0	0	0	
Total number of arrest motives independently of involved substances	Use & Traffic					59	57	48	46
	Traffic/Deal					13	61	93	63
	Use					20	15	35	45
	Total	128	154	108	92	133	178	154	

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2005

b. Prosecution data

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP), stable between 1996 and 1998, showed an important increase from 1998 to 2003 (825 to 1,660) to stabilise from then on. (2005: 1601 police records)

The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 1998 followed by a subsequent increase. From 2003 onwards, one observes a fair stabilisation (In 2005, 2,034 drug law offenders). The number of arrests on the same charge has decreased from 154 in 1997 to 133 in 2003 to increase and stabilise again in 2004/2005. (2005: 155 arrests)(See table 8.2).

Table 8.3 records the total number of law enforcement interventions and number of 'prévenus' at the national level ensured by respective law enforcement actors that are the Specialised Drug Department of the Judicial Police (SPJ), Police and Board of Customs from 1995 to 2005.

Table 8.3 Number of national law enforcement interventions (1995-2005)

Year	DRUG LAW ENFORCEMENT RECORDS								PREVENUS (Offenders)							
	95	97	99	2001	2002	2003	2004	2005	95	97	99	2001	2002	2003	2004	2005
S.P.J.	123	137	343	216	288	239	267	225	152	182	434	321	469	369	336	287
Gendarmerie	198	255	782						319	335	916					
Police³⁵	199	177	189	1,126	1,261	1,326	1,072	1,152	371	280	283	1,272	1,605	1,753	1,268	1,417
Customs³⁶	244	236	173	113	89	95	129	224	421	408	306	182	143	148	204	330
Total	764	805	1,187	1,455	1,632	1,660	1,468	1,601	1,263	1,205	1,939	1,776	2,217	2,270	1,808	2,034

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** have been representing the majority of drug law offenders (52-68%). The spectacular increase in 2002-2003 of the proportion of **first drug law offenders** is not confirmed by 2004/2005 data reporting a decrease from 808 in 2003 to 657 in 2005.

Also the **percentage of minors** (< 18 years) among drug law offenders having increased between 1994 (4.9%) to 2003 (13.8%) shows a clear decrease in 2004 (8.7%) and 2005 (7.6%). Cocaine and heroin are the main drugs involved in first drug offences.

³⁵ The general activity report of the Government Grand-Duchy of Luxembourg can be downloaded from:

http://www.gouvernement.lu/publications/informations_gouvernementales/rapports_activite/rapports_activite_2004/index.html

³⁶ A summary of the general activity report of the "Anti-Drugs and Sensible Products" division of Customs can be found in annex H. The original report can be downloaded from : <http://www.gouvernement.lu/gouv/fr/doss/rapact2004/index.html>

Table 8.4 Socio demographic data on 'prévenus' (1986-2004) **Source:** Specialised Drug Department of the Judicial Police 2005.

YEAR	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004	2005
AGE														
0-14	9		7	6	1	3	7	27	21	11	15	41	24	9
15-19	121	212	179	320	169	270	249	415	413	399	647	602	334	436
20-24	264	569	383	527	403	447	321	519	497	566	650	557	510	617
25-29	119	220	278	371	309	304	220	448	354	299	388	375	278	345
30-34	49	67	124	159	186	191	187	269	208	194	219	254	250	230
35-39	17	29	27	52	65	80	76	131	113	139	177	162	190	174
≥40	17	19	43	46	21	42	78	84	108	113	82	174	126	153
unknown	27	21	30	50	20	31	32	46	44	55	40	106	99	70
TOTAL	623	1,137	1,071	1,531	1,174	1,368	1,170	1,939	1,758	1,776	2,218	2,271	1,811	2,034
Male	503	970	851	1,248	938	1,138	958	1,658	1,415	1,546	1,905	1,935	1,581	1,751
Female	120	166	220	256	209	173	193	248	241	215	292	288	181	237
gender unknown	0	1	0	27	27	57	19	33	44	15	21	48	49	46

Table 8.5 Distribution of 'prévenus' according to first offence and underage status (1992-2005)

	1992	1993	1994	1995	1996	1997	1998	1999	2000
First offenders	697	331	382	498	508	389	422	645	608
Offenders underage	96	48	57	92	102	84	79	155	154
TOTAL ('Prévenus')	1,531	890	1,174	1,263	1,368	1,205	1,170	1,939	1,758

	2001	2002	2003	2004	2005
First offenders	621	828	808	585	657
Offenders underage	100	145	189	103	86
TOTAL ('Prévenus')	1,776	2,217	2,271	1,808	2,034

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2005.

Table 8.6 Distribution of first offenders (use and use/traffic) according to substance involved ad minima (1992-2005)

	1992	1993	1994	1995	1996	1997	1998	1999
High risk substance involved ad minima								
Heroin	162	91	154	170	121	104	109	157
Cocaine	64	15	39	46	34	20	30	60
Amphetamines	5	0	15	11	11	12	18	14
Type ' Ecstasy '	1	3	9	47	20	26	26	6
Illicitly acquired medicaments	1	0	3	0	0	0	1	0
Substitution substances	0	0	1	0	0	0	0	0
TOTAL (substances HRC)	233	109	221	274	186	162	184	237

	2000	2001	2002	2003	2004	2005
High risk substance involved ad minima						
Heroin	133	91	114	97	103	110
Cocaine	37	47	64	112	125	86
Amphetamines	9	14	12	10	2	3
Type ' Ecstasy '	11	16	34	23	8	17
Illicitly acquired medicaments	7	1	0	3	1	1
Substitution substances	0	0	1	1	0	1
TOTAL (substances HRC)	197	169	225	246	239	218

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2005

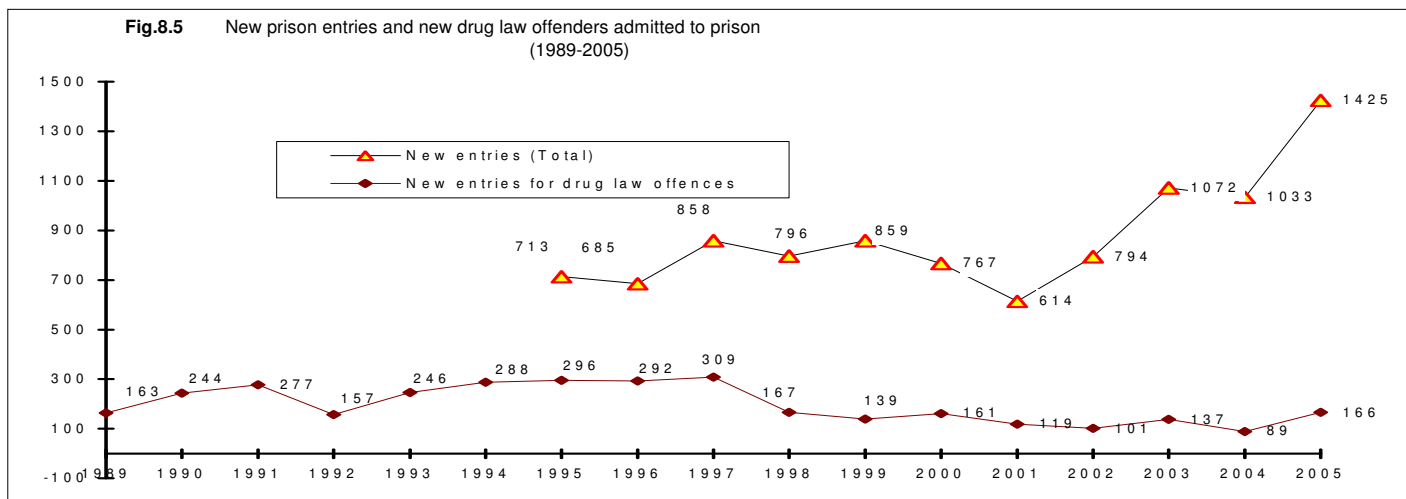
c. Convictions data and court sentences for drug offences

No data available.

d. Imprisonment for drug-related crime

The Grand Duchy of Luxembourg counts two state prisons; one situated in the vicinity of Luxembourg-City (CPL) and the other in the East of the country (CPG). The proportion of **prison sentences for drug law offences has been decreasing since 1998**. In 2005, 166 new entries

(11,6%) (1997: 36%) in national penal institutions referred to the 'DELIT- STUP ' (Drug law offence) codes have been reported. The recent increase of prison sentences is consistent with the increase of commercial drug trafficking previously described.



Source: Central Prison Administration 2005

e. Drug-related crime

The data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results are worth to be retained for 2005:

- 94% of drug users indexed³⁷ by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime. 76% (↘) of the total PDU population show multiple law enforcement contacts.
- The proportion of 'interpellations' for other reasons than presumed offences against the drug law (e.g. **petty crime**) has been decreasing since 1997 (38%) and has been fairly stable in recent years (2005:33%). The extension of substitution treatment and the intensification of socio-economic reintegration measures appear to have contributed to the currently observed situation.
- 73% of indexed PDUs have already served at least one **prison sentence** during lifetime. The proportion of PDUs having served more than one prison sentence at the time of reporting (34%) is still on the increase. Compared with previous years, a significant deterioration of the penal situation of indexed drug users must be stressed; associated, however, to a decrease of the duration of served prison sentences.

• Drug Use in Prison

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

MAIN RESULTS:

Drug use in prison

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

Risk behaviour

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

³⁷ Persons who have been indexed by the RELIS network during a reporting year.

The recent study "Prevalence of viral hepatitis A, B and C and HIV in problematic drug users of illicitly acquired drugs (Origer & Removille, in press) also addressed drug use and drug-related harm in prison settings. Among all settings (inpatient, outpatient treatment, low threshold, etc.) prevalence rates of HIV, HBV and HCV were highest in persons recruited in prison settings. Referred to the total study sample 56.1% of respondents who have prison experience (N:246) reported illicit drug use in prison, Differences in results in reference to the to the Schlink study are due to the fact that the Origer & Removille study addressed lifetime use and injections as well as current and previous prison experience.

● 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). Furthermore, the budget allocated by the Ministry of Health to drug related services and programmes, as foreseen by the national drug action plan, has known an increase rate of 354 % between 1999 and 2004. Concerning the 2005 budget 6,195,518.- EUR have been granted to involved services representing a progression rate of 7.4% compared to 2004.

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 the coverage of national accounting.

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

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

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

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

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

The impact of the illegal drugs-related activities for 2004 is estimated at 0,11% of the GDP (gross domestic product) and 0,08% of the GNI (gross national income). Although this impact is limited, it reflects those observed in the European Union countries having carried out similar estimates. Three substances have a major impact: heroin, cocaine and cannabis representing together more than 90% of the measured impact. Nonetheless, levels observed during the period 1999 to 2004 highly vary according to the evolution of the consumption and the traffic of heroin, which clearly has the most important economic impact in this field.

9. Responses to Social correlates and Consequences

• **Social Reintegration:**

Social reintegration measures and in particular improvement and diversification of housing offers for drug addicts have been one of the priorities of the 2000-2004 national drugs action plan. The 2005-2009 drugs action plan foresees the expansion of existing projects and the implementation of new decentralised reintegration measures based on the previously described principle on progressive reintegration through capacity building and the improvement of the social abilities and environment.

In the framework of the 2000-2004 action plan, the Ministry of Health, jointly with the City of Luxembourg opened a **night shelter (called Nuetsel) for drug addicts** in December 2003 which has evolved into 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 25 flats and apartments are rented by a drug-counselling centre and provided to drug addicts in need by means of tailor made renting contracts. One of the medium term aims of the project is to allow demanding drug addicts to take over the renting contract on basis of their own financial means and thus dispose autonomously of a stable accommodation. The project is jointly financed by the National Fund against drug trafficking and the Ministry of Health.

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

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

Stëmm vun der Strooss association (Street voice association) primarily takes care of homeless people in providing them with low threshold facilities and in offering social and professional reintegration activities. The **editing, printing, publication and distribution of a in house magazine** addressing social matters is supposed to help client to regain a sense of responsibility and to increase the level of acceptability in the general public. PDUs constitute a significant fraction of their clients.

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

● **Prevention of drug related crime**

- Assistance to drug users in prisons

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

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

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

Since 2003, both penitentiary centres offer individual and collective interventions. Discussion groups are guided by drug care services and RPT training, a programme to prevent drug related recidivism is organized by a specialised drug treatment agencies. Updated information on the TOX project is available in both prisons by members of the in-house services and by means of information desks. A voluntary group of inmates called "Tox-Contact" acts as a plate-form between the TOX project and the overall population of inmates.

All penitentiary in-house services, from prison probation service to the medical care service, are actively involved in the TOX project and collaborate with specialized drug treatment institutions.

At the beginning of 2004 the pre-therapeutic programme called "Switch" (change the lane) was set up and the **drug free unit of the CPG** got operational. The capacity runs up to 6 persons simultaneously. All candidates have to meet strict selection criteria. The programme ensures the preparation of post-release ambulatory or residential drug treatment and creates a dynamical process of drug prevention, care and staff education throughout the CPG and the CPL. Candidates from the CPL entering the programme are transferred from the CPL to the CPG.

The programme normally takes 8 months and includes individual and group therapy, social behaviour and social administration courses, sport sessions and therapeutic activities. Besides, a coordination office is at the disposition of all inmates interested in therapy, courses, CPG programme attendance and post-release preparation. The active implication of inmates as also the intensive network collaboration succeeded to implement in a long term syringe exchange, therapeutic programmes, prevention (health flyers, health cards), education and sensitization of prison staff.

In 2005, 102 clients (15 female clients) of the CPL asked for treatment and care and have either been followed up by the TOX project offers or by case management. Half of them (54) have formulated a demand to join the programme of the drug free unit of the CPG. 17 candidates had been chosen by the guidance committee and only 12 have been retained.

Concerning the drug free unit of the CPG, a total of 19 drug consumers have completed the programme since its beginning (5 persons in 2005), other 12 persons have received ambulatory treatment after release and two ex-participants have followed a residential drug treatment. None of the participants have re-entered prison since release. 11 clients have been supported by the drug care programme outside the drug free unit of the CPG.

Additionally, 129 inmates participated in the discussion groups. A total of 750 health flyers have been distributed in French, German and Portuguese languages to the staff, inmates and external associations of the CPL and CPG.

A special programme for female drug dependant inmates in the CPL got operational at the end of 2005. Psychological follow up is currently offered to 8 female inmates.

Results show a small proportion of inmates (16%) preoccupied with the preparation of their release and an increased proportion of inmates (57%) demanding short-term interventions as immediate psychosocial care or social actions. The activity report 2005 calls attention to the necessity of a proactive preparation of the release of drug dependant inmates.

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

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

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

Regarding **substitution treatment in prison**, no formal or binding guidelines do currently exist. 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.

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

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

- Other interventions for prevention of drug related crime
- Interventions to prevent recidivism (NNIA)

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

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

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

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

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

- Measures for young drug law offenders

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

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

Table 12.1 Clients core statistics MSF SOLIDARITE-JEUNES 1997 - 2005										
		1997	1998	1999	2000	2001	2002	2003	2004	2005
Number of clients		27	46	99	132	195	208	231	267 ↗	249
Referral from the criminal Justice system			26.1%	26.3%	41.4%	44.1%	44.2%	37.2%	179 ↗	136
Gender distribution	Female	26%	28%	26.3%	34.1%	32,3%	34.1%	31.6%	31,9%	31,3%
	Male	74%	72%	73.7%	65.9%	67,7%	65.9%	68.4%	68,1%	68,7%
Age distribution	< 15	7%	11%	16.1%	12.6%	13,8%	17.8%	23.8%	17,7%	25,7%
	15-17	82%	81%	73.8%	74.2%	80,9%	71.6%	63.6%	64,1%	48,6%
	≥ 18	11%	8%	10.1%	12.9%	11,3%	10.6%	12.6%	18,6%	25,7%
Main substance involved	Cannabis	45%	49%	65.7%	78%	72.3%	82.2%	83.1%	72,4% ↘	71,5%
	Heroin	33%	22%	21.2%	12.9%	7.2%	2.4%	3.5%	4,5%	5,6%
	Solvents	7%	11%	5.1%	1.5%	0.5%	0.5%	0.0%	0,4%	0,4%
	Ecstasy	4%	12%	3%	3.8%	3.6%	1%	0.9%	1,1%	0,4%
	Cocaine		3%	1%		2.6%	1%	0.4%	1,1%	
	Other	11%	3%	4%	3.1%	13.8%	12.9%	12.2	20,5%	22%

Source: Solidarité Jeunes (MSF). 2005

● Prevention of public nuisances

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

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

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

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

Public security is another crucial factor when it comes to public nuisance analysis. Basically all situations listed under the definition heading induce fear and feelings of potential insecurity. As problematic drug use became a more studied and mediatised phenomenon in the beginning of the nineties, public awareness and concern has also been increasing. Reports on increasing PDU prevalence and drug-related petty crime by officially recognised authorities have contributed to this evolution. Research, information and media have played a major role in public nuisance management. Whichever new measure is to be implemented, general public has to be informed and provided with clear contact details in case of questions or complaints. Complaints have to be taken seriously, followed up and feedback to be provided.

Public nuisance phenomena are geographically spread and are often limited to certain specific areas especially in urban regions. Typically, drug-related nuisance is most felt in surroundings where drug use and drug traffic occur simultaneously, such as central railway station or isolated lots near the dealers’ scenes. Understandably, a series of treatment and harm reduction facilities are to be implemented in the vicinity of those “hot spots”. The implementation of new infrastructures such as drop-ins, consumption rooms or night shelters for drug addicts is often perceived as a contribution cause to public nuisance, since they are said to attract PDUs and thus degrading local live quality. Fact is, that one year after the opening of the injection room in Luxembourg City, the situation in the most problematic railway area has improved and has not generated similar problems in the vicinity of the TOX-IN centre. Not surprisingly, the immediate surroundings of the centre constitute an assembly point for drug addicts but according to the latter more for consumption than for trafficking reasons because of the vicinity of the centre allowing to call for help rapidly in case of overdose. The immediate surroundings of the injection rooms are a typical example of the unconditional collaboration agreement between Health authorities, municipal authorities and law enforcement.

10. Drug Markets

OVERVIEW

Drug markets are of changing nature. They rely on factors such as supply mechanisms, on the economic situation and on the efficiency of law enforcement strategies. Availability and supply indicators should be interpreted with caution as they rely on the interplay of all these factors. Law

enforcement authorities, the National Laboratory of Health and special surveys have provided data presented in the present chapter.

2004 data confirm that **cannabis, heroin and cocaine are widely and increasingly available** on the national market. New distribution networks have developed in recent years and operate in an obviously professional way and by doing so have significantly increased drug availability and in particular the supply of **low quality cocaine**. In general, most drugs show increased quality of cannabis and heroin or while prices show broader ranges. **Broader price ranges as well as higher maximum prices** for cocaine and heroin have been observed in 2005 Cannabis and derivatives however have known certain stability during the last 5 years as far as street prices are concerned.

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

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

● AVAILABILITY AND SUPPLY

Law enforcement sources³⁸ indicate that currently the majority of illicit drugs consumed in the G. D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). Till the beginning of the nineties, most of the persons involved in illicit drug distribution were consumers who supplied themselves in the Netherlands or acquired limited extra quantities of drugs in order to sell them within restricted local networks. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market.

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

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

In 2005 no **clandestine drug-manufacturing laboratory** has been discovered at the national level. Local cultures of cannabis and magic mushrooms remain rather insignificant in terms of quantity.

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

³⁸ Non published information from the Specialised Drug Unit of the judicial Police

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

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

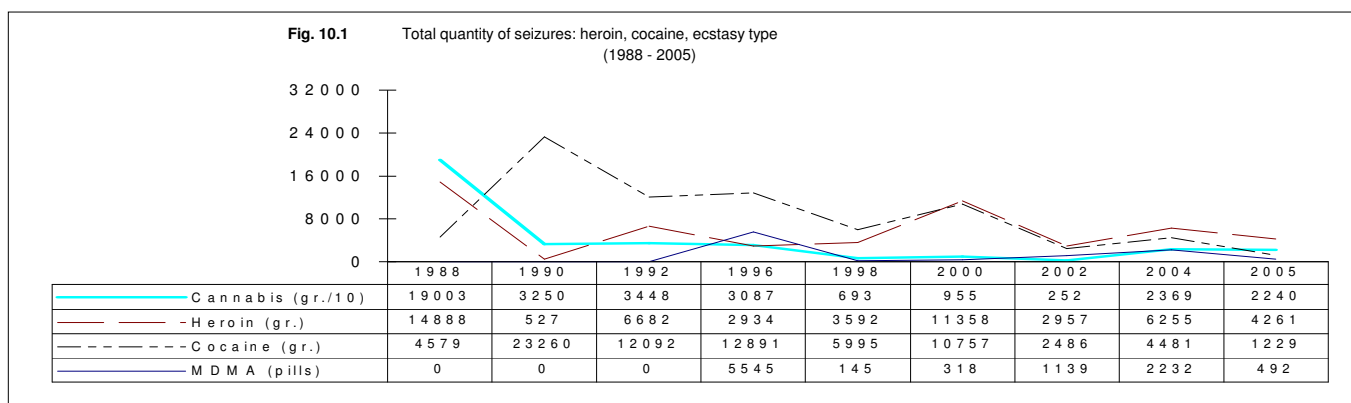
The results among the population of young people in Luxembourg lie within the scope of the European average. However the perception of ease of acquisition of drugs near schools and the immediate vicinity of the where the youngsters live is slightly more pronounced than the European average. The overall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

● SEIZURES (see ST 13)

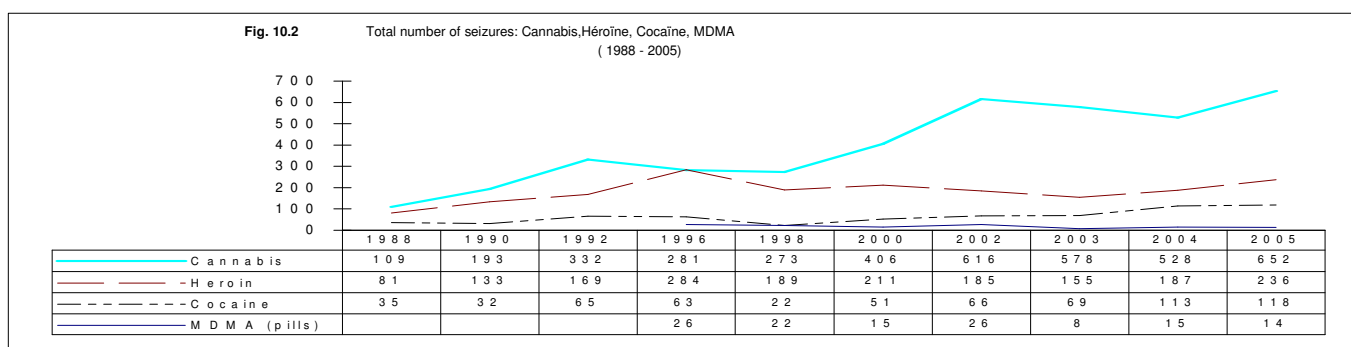
Striking variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analyses indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002³⁹. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. **Cocaine** seizures (quantity) are highly variable since the beginning of the nineties.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. Since 2000 the number of cannabis and cocaine seizures has clearly increased and the number of heroin seizures tends to stabilise. Markedly, the number of cannabis seizures has risen from 167 to 649 between 1994 and 2005. The total **number of persons** involved in traffic has followed a constant upward trend until 2002 and seems to have stabilised since then. A confirmed majority of offenders are involved in cannabis traffic and are non-natives. For detailed information, see standard table 13.

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



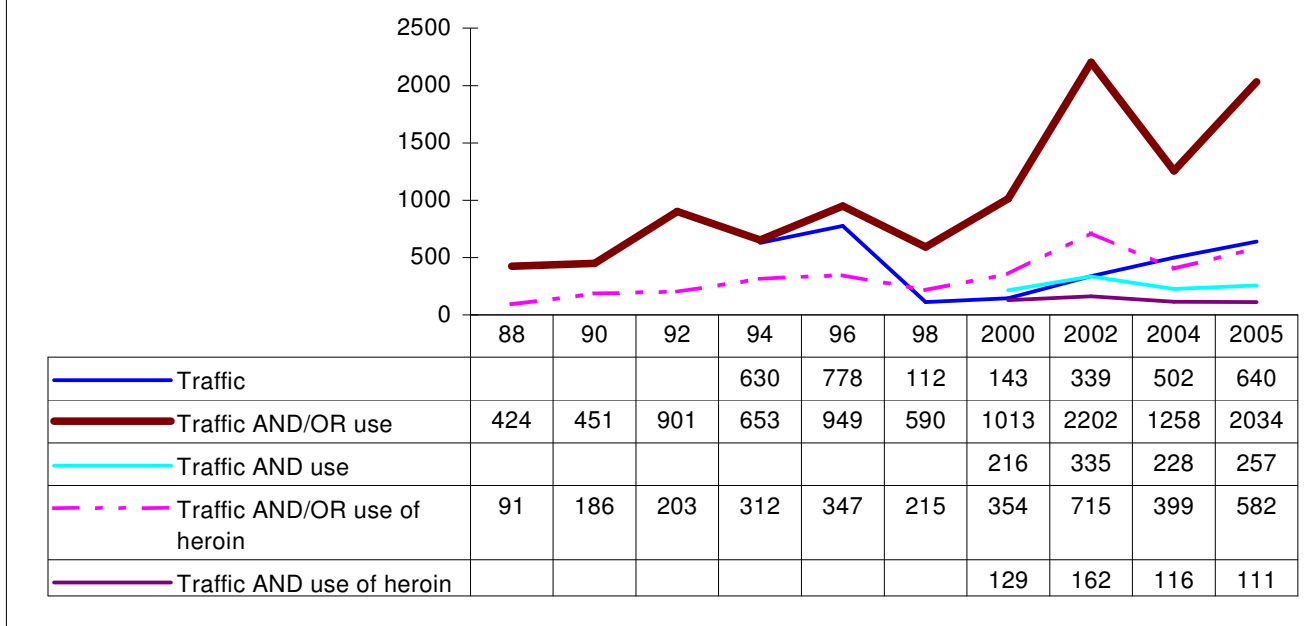
Source: Specialised Drug Department of the Judicial Police 2005



Source: Specialised Drug Department of the Judicial Police 2005

³⁹ Non –transit drugs destined to the national market

Fig. 10.3 Number of offenders involved in seizures according to type of offence (1988-2005)



Source: Specialised Drug Department of the Judicial Police 2005

● PRICE/PURITY (see ST 14)

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen from 1996 to 2002/2003 but broader price ranges as well as higher maximum prices for cocaine and heroin have been observed in 2005. Cannabis and derivatives however have known a fair stability during the last 4 years. Heroin is frequently sold as 'boulette (meat ball)' containing 0.2-0.4 grams for 12-25. - euros. Typical street retail cannabis is sold in pieces of 2.5 to 3 grams for 25. - euros.

Table 10.2 Price per unit evolution at the street level (1994-2005)

	1994	1998	2000	2002	2003	2004	2005
CANNABIS							
Haschisch	5-6	5 - 6	7,4	7	8.3	7.3	7.3
Marijuana		2,5 - 3	6,2		8.1	7.3	7.3
Cocaine	100-150	120 -170	90	50	30-85	20-120	20 - 110
Heroin (brown)	65-150	90 -150	74,4	50	40	82	80
STA		25-30	?	25	n.a.	n.a.	n.a.
Ecstasy		9 - 13	10,7	7	10	10	10
LSD	11-13	11 -13	?	n.a.	n.a.	10	10

Source: Specialised Drug Department of the Judicial Police 2005

Price: expressed in EURO at street level.

For cannabis, cocaine, heroin and amphetamines, price per gram is indicated.

For heroin and cocaine, minimum prices refer to traffic units. Maximum and average prices refer to street retail quantities.

For ecstasy and LSD, price per pill or unit are indicated.

As far as **purity** is concerned, samples of suspected substances analysed by the National Laboratory of Health show an increase of THC rate in cannabis derivatives and in heroin purity and a decrease in cocaine quality. In regard to other substances, tendencies are not clear. However, data from 2005 confirm a significant decrease of MDMA concentrations in ecstasy like substances for the last 3 years.

Table 10.3 Purity of drugs at street level (1994-2005)

	1996	1998	2000			2002			2004			2005		
	Pur. (%)	Pur. (%)	Pur. (%)			Pur. (%)			Pur. (%)			Pur. (%)		
	AVERAGE	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.
CANNABIS (THC)			2.65	11,7	8,03	0.7	19.3	7.96	0.64	14.0	6.94	0.6	22.26	10.92
Cocaine	60-90	60-90	28,3	92,2	60,25	14.6	90.4	62.99	9.65	94.9	62.37	27.75	94.9	51.52
Heroin (brown)	15-23	20-25	2,8	54,9	17,59	2.0	22.9	9.97	5.0	41.55	17.07	4.85	57.65	28.18
STA						3.5	55.5	15.09	1.25	40.65	9.44	1.2	35.01	12.22
Ecstasy⁴⁰ (MDMA) (MDEA) (MDA)			18,7	52,3	35,5 6,8	11.0	120.0	71.11	22.35 6.25	39.5 6.25	29.77 6.25	1.75	38.33	15.82
Psilocine								0.15	0.26	0.57	0.41	/	/	/

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

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

⁴⁰ Ecstasy : dose in mg/pill

11. Drug use and related problems among very young people (<15 years)

SUMMARY

Cannabis is the most popular illicit drug consumed by youngsters aged less than 15 years. The HBSC study 2002⁴¹ shows an intense increase of last 12 months **prevalence** of cannabis consumption from ages 11 to 15.

Data provided by the national drug monitoring system **RELIS** refers to a mean age of first regular consumption of cigarettes of 13 years and 9 months. On average, males start smoking later than females. At age group 10 to 13 years solvents and inhalants constitute after alcohol the preferred substance of first consumption of current PDUs. Youngsters aged 14 to 15 are most vulnerable in regard of starting drug use.

Minors rarely address **drug treatment** demands. A specialized drug treatment service for youngsters reports 4% of clients aged less than 14 and 21.7% aged 14 to 15 mostly referred by legal authorities or institutions. 71.5% of treatment demands are related to cannabis. Individual, family, school and socio-cultural **factors** combine in the development process of problematic drug use.

Youth polices are defined at municipal and governmental level. Since 1999, the Ministry of Health is competent of drug demand reduction measures, which are coordinated by the national drug coordinator's office in close collaboration with field actors. Youth policies at national level are coordinated by the Ministry of Family.

Concerning **public health** risks emanating from **tobacco and alcohol**, three legal amendments have occurred or will be implemented in the near future. Taxes on alcopops have been raised in January 2006 in order to make designer drinks less available for youngsters. The Minister of Health also submitted in January 2006 a project of law concerning, the prohibition of the sale of alcohol to minors aged less than 16. The newly approbated anti tobacco law, entered in force in September 2006, foresees, among other measures, a prohibition of sale of tobacco to minors aged less than 16.

Prevention strategies focus on specific age groups but are not substance specific. The drugs action plan 2005-2009 foresees among selective prevention programmes also specific needs assessment surveys targeting youngsters.

1. Drug use and problematic drug use among very young people

- **Prevalence**

Health Behaviour in School-Aged Children Study HBSC 2002 and HBSC 2005⁴²

In 1999 Luxembourg took part in the WHO study Health Behaviour in School-Aged Children (HBSC 2002). The main objective of the HBSC study is to assess periodically the wellbeing of youngsters aged 11 to 19 years. The study's questionnaire includes items of legal and illegal drug consumption. The study was conducted by the Ministry of Health and the Ministry of National Education and has been published in 2002. As Luxembourg's school system foresees a 6th primary class before entering secondary school, the HBSC study had to be conducted in two different school settings namely primary school and secondary school to reach the target group of youngsters aged 11 to 19 years. This explains the delay of the results concerning the HBSC primary school study having been published in 2005. For pupils aged 11 and 12 years from 5th and 6th primary school classes, the same method as the HBSC 2002 study has been applied. A total of 963 questionnaires had been retained (49.5% male respondents/50.5% female respondents).

⁴¹ Wagener Y., Petry P. (2002), Das Wohlbefinden der Jugendlichen in Luxemburg, MENFPS, MS, Luxembourg

⁴² Wagener Y., Henschen M., Petry P., (2005) Das Wohlbefinden der Jugendlichen in Luxemburg, 5. und 6. Klasse/Grundschule, MENFPS, MS, Luxembourg

Table 11.1 Lifetime prevalence (in bold) – Last 12 months prevalence (in italic)- BY GENDER (13 to 19 years)

	All %	BOYS %	GIRLS %
Cannabis	27.4	30.8 - 25.8	23.9 – 19.0
XTC	3.1	3.3 - 1.9	2.9 – 1.4
ATS	3.7	4.4 - 2.4	3.3 – 2.0
Heroin	1.2	1.2 - 0.7	1.0 – 0.5
Prescription drugs	2.5	2.4 – 1.2	2.8 – 1.8
Cocaine	2.3	2.5 – 1.6	2.2 – 1.5
Inhalants/solvents	3.8	3.8 – 1.6	3.6 – 1.4
LSD	2.1	2.3 – 1.2	1.9 – 0.9
Magic mushrooms	4.8	6.3 – 4.6	3.3 – 2.0

Source: HBSC 2002

Concerning lifetime prevalence and last 12 months prevalence, the most popular drug among youngsters aged 13 to 19 years, is cannabis. 27% of all youngsters have at least tried once cannabis during lifetime, 23.9% of girls and 30.8% of boys. Cannabis, ATS and inhalants/solvents come on first place and their consumption increases with age. However, results show a more sustained consumption of medicaments in girls.

A gender analyses shows that the probability to consume an illegal drug at least once during lifetime increases with age, boys being likely more concerned (5 to 10%) than girls.

Table 11.2 Lifetime prevalence – 5th and 6th primary school classes (11 to 12 years)

	All %	Boys %	Girls %
cannabis	2.0	3.9	0.2
XTC	0.2	0.4	0.0
ATS	1.2	1.7	0.6
prescription drugs	1.1	1.3	0.8
inhalants/solvents	3.7	3.7	3.6

Source: HBSC 2005

Substances most reported by children aged 11 to 12 are solvents/inhalants (3.7%) followed by cannabis (2%), ATS (1.2%) and medicaments (1.1%). More boys (11.4%) than girls (4.2%) from primary school report lifetime use of a psychoactive substance. The following table provides an overview of the prevalence of drug consumption among students aged 11 to 15 years:

Table 11.3 Last 12 months prevalence by age 11 to 15 years

	11 to 12 years %	13 years %	14 years %	15 years %
Cannabis	2.2	3,5	15,4	21,8
XTC	0.3	1,0	2,3	1,1
ATS	1.2	2,2	2,2	2,7
Heroin		0,3	1,1	0,7
prescription drugs	0.7	0,6	2,2	2,1
Cocaine		0,8	2,2	1,5
Inhalants/solvents	2.1	2,8	3,8	3,8
LSD		0,3	1,7	1,3
Magic mushrooms		0,3	2,3	3,2

Source: HBSC 2002 and HBSC 2005

Concerning last 12 months consumption in youngsters aged 11 to 15, a remarkable increase of cannabis consumption is observed (from 2.2% to 21.8%). Inhalants/solvents come on second place and ATS use on 3rd place. Magic mushrooms become more prevalent at the age of 14.

Table 11.4 Last 12 months prevalence by gender 5th and 6th primary school classes (11 to 12 years)

	Boys – 11 to 12 years %	Girls – 11 to 12 years %
cannabis	3.8	0.6
XTC	0.6	0
ATS	1.9	0.4
medicaments	1.1	0.4
glue	2.6	1.7

Source: HBSC 2005

Generally speaking more boys than girls consume referred drugs in primary schools as well as in secondary schools with the exception of prescription drugs, which prevalence is slightly higher in girls than in boys. Regarding the disposition to accept offered drugs, 3.5% of pupils aged 11 to 12

would accept cannabis if offered (4.9% of boys compared to 2.1% of girls). In secondary school, 22.2% would accept cannabis (24.1% boys/ 20.3% girls).

As far as peer assessment is concerned, 0.9% of respondents aged 11 to 12 stated to knowing friends, which have consumed illegal drugs (1.3% of boys /0.4% of girls).

The HBSC study recommends the strengthening of prevention in primary school setting. School surveys show that curiosity is one of the main reasons for trying/experimenting drugs.

- **Patterns of drug use**

The national drug monitoring system RELIS registered in 2005, 9% of youngsters aged 15 to 19 years among PDUs, thereof 4.6% minors. Nationwide the number of minors among PDUs is estimated at 100 to 150. The mean age of first consumption of illicit substances situated around 15 years and 2 months in 2005 (male: 15 years 8 months/ female: 14 years). In 2004, PDUs reported a far lower mean age of 12 years 8 months (male: 12 years and 2 month/female: 13 years and 11 months).

Concerning licit drugs, the mean age of first regular consumption of cigarettes is 13 years and 9 months (2004: 14 years and 4 months). On average, males start smoking later than females (14 years 1 month compared to 12 years and 10 months). In recent years lower ages of first contact with tobacco and illicit drugs have been reported. In 2005, however, an increase of age of first consumption of illicit drugs has appeared whereas the above mentioned trend subsists with regard to tobacco. This increase in age has to be analyzed with caution and with regard to the future evolution of ages of first consumption.

Table 11.5 Ages of first consumption of illicit drugs (valid %)

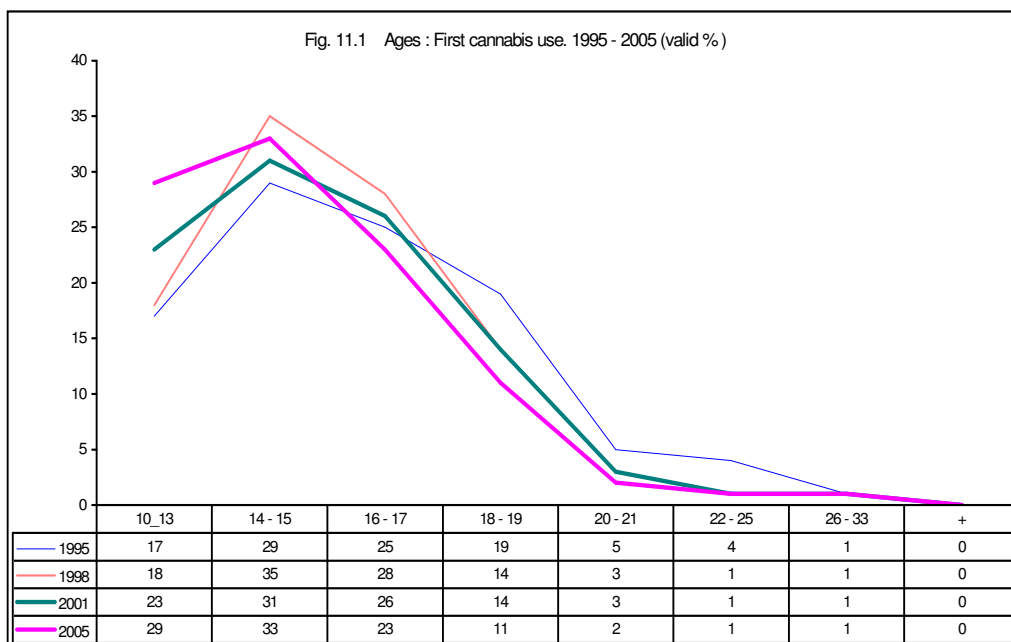
AGES OF FIRST CONSUMPTION OF ILLICIT DRUGS (valid %)	10 – 13 years						14 – 15 years					
	2000	2001	2002	2003	2004	2005	2000	2001	2002	2003	2004	2005
ALCOHOL	29	36	40	41	32	38	46	35	30	31	37	36
CANNABIS	22	23	26	27	25	29	34	32	33	35	35	33
SOLVENTS, INHALANTS	27	45	36	57	66	67	36	33	36	14	17	17
HALLUCINOGENS	12	13	10	9	8	7	36	31	37	38	41	37
HYPNOTICS AND SEDATIVES	9	6	9	6	5	7	12	11	8	14	15	5
STIMULANTS												14
MDMA (XTC)	8	2	0	2	2	8	28	37	45	48	37	43
Amphetamines	4	6	13	11	7	14	20	12	11	8	7	11
Crack							0	20	12.5	33	33	20
Cocaine	3	1	0	3	2	1	8	10	9	13	7	8
Cocaine iv	2	1	1	1	1	0	13	15.5	14	13	11	11
OPIOIDES								50	50	25	25	17
Substitution products (illegal consumption)												
Substitution products (prescribed)	4	4	3	0								
Heroin and other opiates	6	2	6	7	6	6	13	11	13	13	7	10
Heroin and other opiates (iv)	3	3	5	3	5	4	12	15.5	17	18	15	14
OTHER PSYCHOACTIVE SUBSTANCES	4	6	6	5	18	8		3	3	0	0	0
N	1101	1101	1334	1105	1105	1059						

Source: RELIS 2000-2005

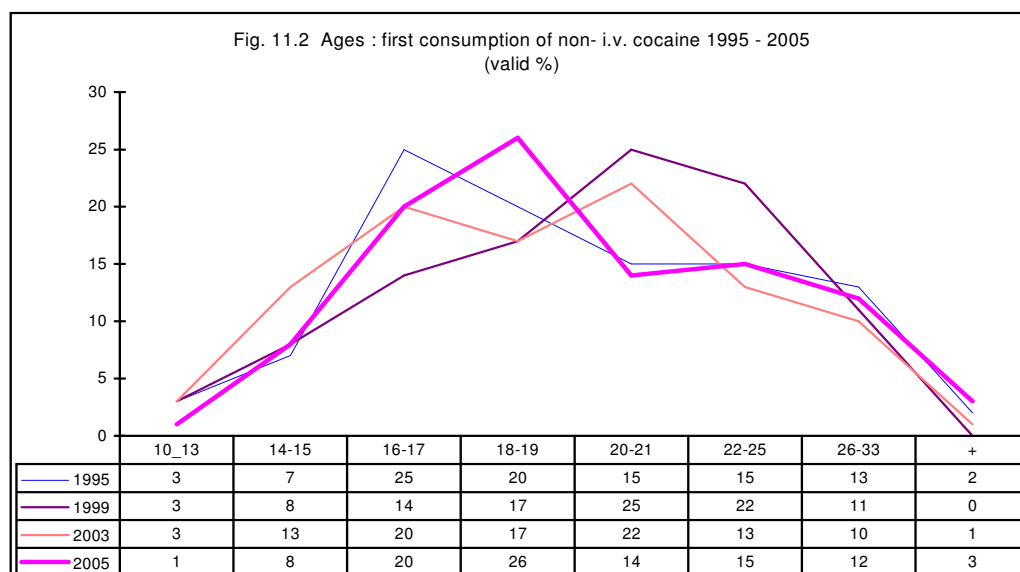
In 2005, 67% of current PDUs reported first solvents' and/or inhalants' use at the ages of 10 to 13 years. On second place, 38% of PDUs declared having consumed alcohol at the ages of 10 to 13 years. Cannabis consumption was reported by 29% of PDUs at this early age. In other words, 29% of respondents had not yet reached the age of 14 years at the moment of the first consumption of cannabis.

It appears that for age group 10-13 years solvents and inhalants constituted after alcohol the preferred substance of first consumption of current PDUs.

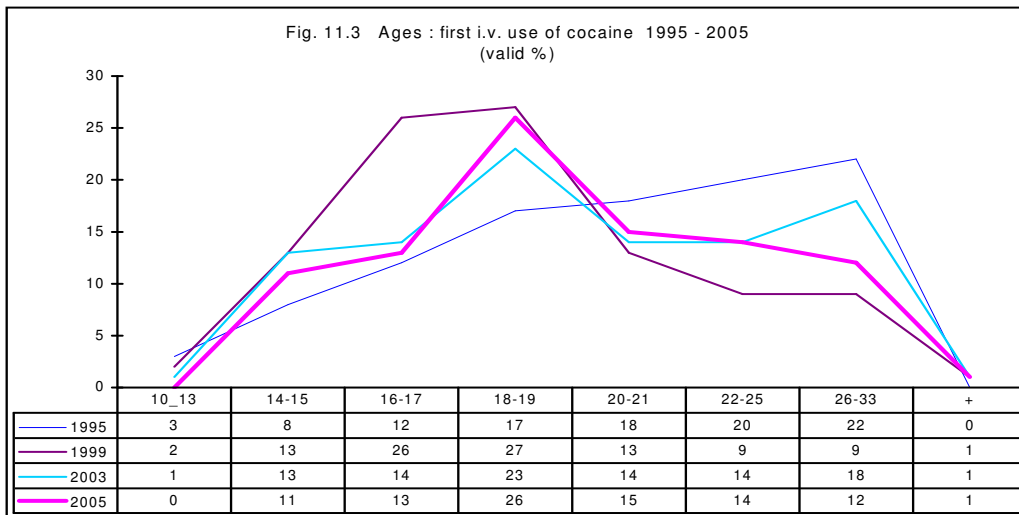
Last 5 years' evolution shows a more sustained consumption of alcohol, cannabis and inhalants/solvents at the ages 10 to 13, whereas at the ages 14 to 15, first consumption of hallucinogens and stimulants, especially XTC, increases.



The first consumption graphs indicate a peak for first cannabis use in the age group 14 to 15 years. The graphs from 1995 to 2005 show similar evolution with an earlier start of consumption in recent years. To be noted that 62% of PDUs reported their first consumption of cannabis at ages 10 to 15 years.

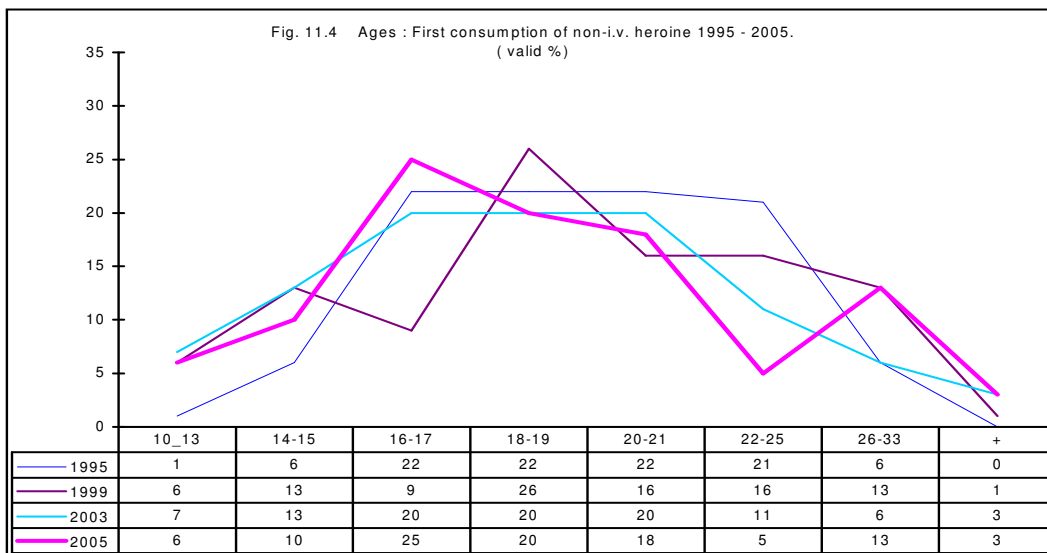


Source: RELIS 2005

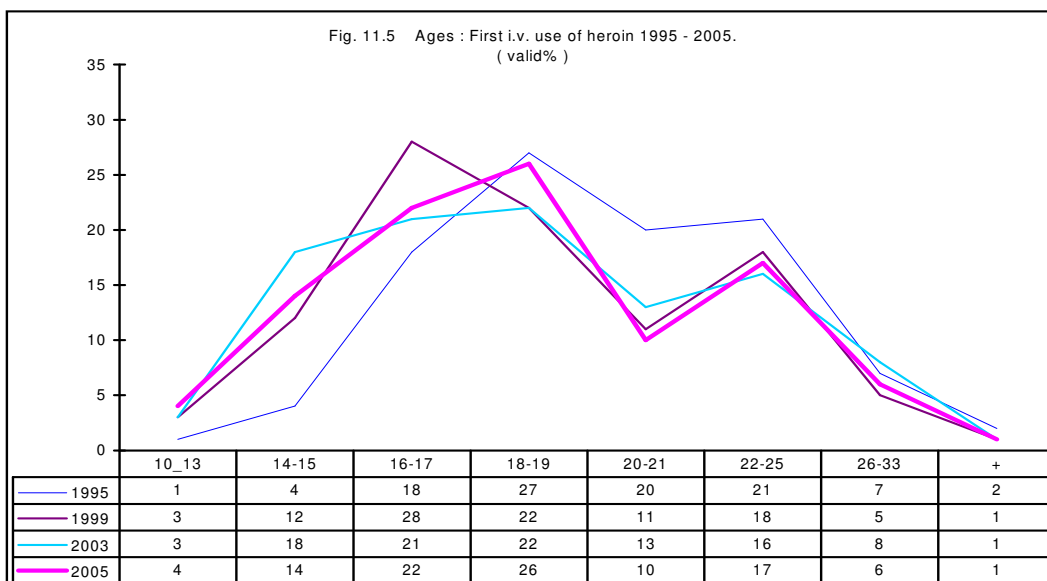


Source: RELIS 2005

RELIS data show an increased proportion of first time **cocaine injectors and non-injectors** (11%) at an early age of 14 and 15 years between 1995 and 2003. It has to be stressed that 24% of PDUs have been minor of age while having injected cocaine for the first time.



Source: RELIS 2005



Source: RELIS 2005

40% of PDUs were minors when injecting heroin for the first time. An increasing proportion of PDUs reported their first intravenous heroin use under 14 years.

Table 11.6 Ages of first contact with illicitly acquired drugs

AGE/ First Contact (2005)	< 12	12-13	14-15	16-17	18-19	20-21	22-23	24-25	> 25
% (n= 370)	8	24	30	19	10	2	2	1	3

Table 11.6 shows that the age groups 14 to 15 are the most vulnerable in regard of starting drug use (30%). 24% of current PDUs started drug use at the age of 12 or 13 years and even 8% declared first drug consumption at an age lower than 12 years.

- **Social and geographical profiles**

Due to the geographical size of the Grand-Duchy of Luxembourg, considering social profiles is more pertinent than addressing geographical profiles. In the framework of the “Youth community Plan” of Luxembourg City⁴³, a quantitative telephone survey of youngsters (total number of questionnaires: 876) aged 12 to 25 has been performed. Regarding age group 12 to 14, 79% lived with parents and 20.9% lived with either mother or father. In order of importance, the meaning of leisure time for youngsters aged 12 to 14 is acceptance from friends (61.3%), relaxation (59%) and autonomy (55.7%).

As far as leisure time management is concerned, problems related to excessive alcohol consumption increase with age. However, according to the same survey, more than 20% of youngsters aged 12 to 14 are confronted occasionally with alcohol problems. Drugs related problems also occur at this early age.

Table 11.7 Problems encountered in leisure time (n=873)

	Age group	Not or rarely	sometimes	Often or very often	Total
Excessive alcohol consumption	12-14	77.6%	15.4%	7%	100%
	15-17	54.3%	29%	16.7%	100%
Drug consumption	12-14	92%	6%	2%	100%
	15-17	70%	16.2%	13.8%	100%
Racing, driving under the influence of alcohol	12-14	87.5%	8.5%	4%	100%
	15-17	81%	11.9%	7.1%	100%
Destruction, vandalism	12-14	82.6%	14.4%	3%	100%
	15-17	69.4%	23%	7.7%	100%

Source: “Youth Community Plan” of Luxembourg City – tome III (2004)

A majority of youngsters from age group 12 to 14 (45.3%) dispose of less than 25 Euros per month for leisure time activities. These youngsters are all students and their financial situation is often dependant on financial resources provided by parents. The table below shows that Luxembourgish youngsters dispose of larger leisure time budgets than non-natives.

Table 11.8 Leisure time expenditure of youngsters aged 12 to 14 by nationality (n=192)

	EURO	Nationality (most common 4)					Total
		Luxembourgish	Portuguese	Italian	French	Other	
What amount has your personal budget for monthly leisure time expenses?	<25	28.4%	51%	60%	66.7%	54.3%	45.3%
	25-50	51.4%	26.5%	30%	20.8%	22.9%	34.9%
	>50	20.3%	22.4%	10%	12.5%	22.9%	19.8%
Total		100%	100%	100%	100%	100%	100%

Source: “Youth Community Plan” of Luxembourg City – tome III (2004)

⁴³ Meyers C., Willems H. (2004), Youngsters of Luxembourg City, tome III, final report of the “Youth Community Plan”, Cesije

Also 48.3% of youngsters between 12 and 14 years declared spending most leisure time at home, 20.9% at public spaces like cinema, swimming pool, pub, etc., 18.4% on streets or public areas (outdoor) and 12.4% at home with friends. Only 3.5% frequent pubs, 17.9% visit cinema and 20.4% do sports.

- **Trends in the last 10 years**

The last ten years, alcohol consumption as well as tobacco use have been increasing in youngsters; alcohol being more prevalent in men and tobacco in females. In recent years, binge drinking and an increased preference for alcopops have been observed in youngsters. Cannabis is currently the most popular illegal drug among youngsters.

The final report of the project “Streetwork – Youngsters in Urban Area”⁴⁴ outlines that the consumption of drugs of youngsters aged 12 to 13 years constitutes a relatively new phenomenon. Very young drug consumers come into contact with older drug consumers in drug scene areas. Legal and ethical aspects of drug use change with age (intravenous drug use, prostitution). The study recommends that these two groups have to be separated to avoid that very young people at risk of drug consumption are socialized by older PDUs. Preventing very young people from beginning a drug career includes the development of specific offers for these youngsters.

2. Treatment Demand Indicator

- **Prevalence**

MSF – Solidarité Jeunes (MDs without Frontiers – Youth Solidarity) is a specialized drug counselling service for minors in conflict with law, school and family and is financed by the Ministry of Health. Demands addressed to MSF originate for a large extend from parents and youth authorities or institutions. Demands addressed directly by minors are very rare because they often do not consider their drug consumption as problematic as well as they do not consider themselves as legally responsible. In 2005, MSF intervened in 249 (2004: 267) different situations. A so called ‘*situation*’ unites an adolescent with his family or institutional environment. More than half of the situations (55%) constituted new demands.

A proportion of 4% of clients are younger than 14. 21.7% are aged 14 to 15, 48.6% are aged 16 to 17 and 25.7% aged more than 18. One quarter of clients is younger than 16 years. 68.7% are male clients and 31.2% female clients. 76.3% of young clients live with their family (biological, mono-parental or recomposed) while 11.2% live in an institution (out of home placement), 5.6% alone or with friends and 4.4% live in a foster family or with adoptive parents. 24.1% of all youngsters have experienced one or several out of home placements by judicial authorities of youth protection. It is important to note the high prevalence of adolescents at risk among the clients of MSF.

- **Primary drug**

As stated, cannabis is the most consumed drug among youngsters in Luxembourg. MSF Solidarité-Jeunes reports 71.5% of treatment demands related to cannabis, 11.2% related to other illegal drugs and 3.2% related to legal substances. Also the preferred drug of the youngsters in contact with MSF-Solidarité Jeunes is cannabis (35.7%) followed by tobacco (18.1%) and alcohol (5.25%).

Since 2004, an internal evaluation provides mean ages of first drug consumption:

Table 11.9 Mean ages of first drug consumption

Substance	Mean age – first consumption 2004	Mean age 2005 – first consumption
Tobacco	13.3	13.1
Cannabis	13.8	13.9
Alcohol	14.4	14.4
Hard drugs	15.5	15.2

Source: MSF- Solidarité Jeunes - Activity report 2005

The mean ages of first consumption of cannabis and tobacco situate between 13 and 14 years.

⁴⁴ Berg C., Milmeister M., Schoos J., Problematic Behaviour of Youngsters in the City (2004), Luxembourg, Centre d’Etudes sur la Situation des Jeunes en Europe - Cesije

- **Patterns of drug use, Social profile, Trends in the last years**

Concerning these subchapters, please see chapter 1 on “Drug use and problematic drug use among very young people”.

3. Profile of main groups of young people at risk of drug use and of problematic use

According to the national statistical institute STATEC, 459,500 inhabitants have been registered in Luxembourg on January 2006, thereof 18.6% of children aged 0 to 14 years. A proportion of 6.28% of youngsters are aged 10 to 14 years (total number: 28,892).

The committee on children’s rights (ORK), an independent national authority created in 2002 with the aim to promote and guarantee children’s rights, reports in its annual report 2005, that from 2004 to 2005 1,984 children have been early school leavers (school attendance from 4 to 16 years), 900 youngsters have been without an apprenticeship, 748 children lived in institutions or foster families, 200 youngsters annually declared having been abused etc. It is important to note that individual, family, school and socio-cultural factors are at stake when it comes to explain the development process of problematic drug use.

In 2004-2005, the Juvenile Court proclaimed 69 judgments, thereof 7.2% of cases (5 boys) related to drug issues. Concerning drug related criminality, 9 youngsters aged less than 14 have been incriminated compared to 151 youngsters aged 15 to 19 and 907 (the max.) aged 20 to 24. Youngsters aged less than 14 only represent 0.4% of drug related incriminations.

4. Correlates and consequences of substance use among very young people

Since the nineties, designer drinks are increasingly found on the national market and have become very popular among youngsters. Youngsters aged less than 16 procure themselves alcohol preferably in petrol stations and supermarkets.

The HBSC 2002 study reveals that among youngsters aged less than 16 years, 46.2% of boys and 31,4% of girls declared alcohol consumption at least once a week. Concerning the consumption of designer drinks, a total of 31.2% of boys and 33.5% of girls reported drinking one alcopop at least once a week and 8% of youngsters declared even drinking an alcopop daily. 34.3% of boys and 50% of girls declared having been drunk at least once in their life.

In primary schools (HBSC 2005), 55.9% of pupils aged 11 to 12 years reported having tried alcohol (males: 60.8%/females: 51.0%). 9.4% declared having been drunk at least once (11.2%: males/ 7.6%: females).

Table 11.10 Alcohol consumption of pupils aged 11 to 15: item “Have you ever been drunk?”

age	never	1x	2-3x	4-10x	>10x
11 to 12	90.6	7.5	1.3	0.5	0.1
13	85.2	8.8	3.5	1.4	1.1
14	71.5	14.7	7.7	2.5	3.6
15	62.1	16	11.7	5.8	4.4

Source: HBSC 2002 and HBSC 2005

As for tobacco, alcohol consumption increases with age. Compared to 1992 data from the study of Matheis, Prussen, Reuter⁴⁵, the percentage of “strong” drinkers (having been drunk >10x) has increased from 16.7% in 1992 to 18.1% in 1999.

The HBSC study 2002 and 2005 in secondary and primary schools show the following proportions of pupils’ tobacco use:

⁴⁵ Matheis J., Prussen p., Reuter P., (1992), Schüler und Drogen: eine repräsentative Untersuchung bei Schülern der 5. Klasse des allgemeinen und technischen Sekundarunterrichts in Luxemburg, Fentingen, Livingen, Institut d’Etudes Educatives et Sociales, 1995

Table 11.11 Daily and weekly tobacco use of pupils aged 11 to 15

age	smokes each day %		smokes at least once a week %		Have you tried tobacco at least once? %	
	boys	girls	boys	girls	boys	girls
11	0.5	0	2.1	1.5		
12	1.7	0	1.7	2.7		
13	5.0	5.5	9.2	8.0	39.4	38.8
14	16.3	13.6	22.4	19.7	55.1	53.9
15	20.2	21.0	24.7	26.1	59.6	57.9

Source: HBSC 2002 and HBSC 2005

To be noted that tobacco use clearly increases with age, which also underlines the high addiction potential of nicotine.

5. Policy and legal development

Drug offences are covered by the law of 19 February 1973 concerning the sale of medicinal substances and the fight against drug addiction that was modified by the law of 27 April 2001. The protection of youth is covered by the law of 10 August 1992 and by Civil Law. The Public Prosecutor decides upon the opportunity to close or to prosecute a drug related case of a minor. A minor can be prescribed compulsory treatment via MDs without Frontiers – Youth Solidarity before his case is brought to Court. On the other side, the Juvenile Court can proclaim educative assistance, out of home placements, treatment or social work supervised by central service on social assistance (SCAS).

Youth policies are defined at governmental, ministerial and community level. Children and youth policies are a competency of the Ministry of Family, whereas drug demand reduction policies are a competence of the Ministry of Health since 1999. Other ministries are involved in youth policies as the Ministry of Justice, the Ministry of National Education etc. The aim of youth policy at governmental level is a social, societal and professional integration of youngsters into the multi cultural society of Luxembourg. Youth community plans and youth action plans are instruments of cooperation and coordination between ministerial and community level.

In reaction to an increase of alcohol consumption in youngsters, the minister of health deposited In February 2006 a project of law concerning the prohibition for selling alcoholic drinks or mixture drinks with more than 1.2% of alcohol volume in commercial and public settings to minors aged less than 16 years. Currently this prohibition only concerned pubs, restaurants or bars.

Furthermore, due to the development of the designer drink market targeting particularly youngsters; the Government raised an additional tax on these drinks.

The recently adopted anti-tobacco law entered in force in September 2006 and foresees, among other measures, a prohibition of sale of tobacco to minors aged less than 16. Also access to specifically installed smoking rooms will be denied to youngsters aged less than 16.

6. Prevention and Treatment

The national addiction prevention centre CePT is coordinating and implementing prevention actions at national level. Regarding the target group of youngsters aged less than 15, the CePT offers prevention projects at school and community level. In the last 5 years statistical data of the CePT drug helpline run by volunteers, however, show a particular low usage of only 0.1 to 0.5% youngsters aged between 12 to 15 years.

Prevention campaigns in the framework of “juvenile delinquency” are also organized by members of the Grand-Ducal Police including drug prevention programmes for the 6th classes of primary school (pupils aged 12 years) and substance prevention programmes for the 7th classes of primary school (13 years).

In January 2006, MSF-Solidarité Jeunes launched the early intervention project called “CHOICE”. The project aims at youngsters aged 12 to 17 brought to the attention of police for drug related problems. Youngsters are requested to contact MSF within a period of two weeks and participate either in interactive conscious raising group sessions or individual therapeutic sessions. Judicial authorities get feedback from MSF on the participation of youngsters. In case the youngster does

not contact MSF, judicial authorities apply the normal legal procedure which is more longsome and, depending on the case, eventually more repressive.

The special service "Parenthood" run by JDH since 2003 addresses drug dependent parents and supervised in 2005, 51 adults (39 females, 12 males) and 58 children whereof 21 have been placed out of home.

In regard of treatment, the only specialised medico-psychiatric service at national level for minors aged 14 to 18 years, is the "Service national de psychiatrie juvénile", operational since 2003 and situated in one of the main city hospitals "Hôpital de Kirchberg". A total of 15 beds are available and 500 youngsters have been treated since its opening and stayed on average 25 days. A specialized paediatric psychiatric unity for children under 14 years is planned to be implemented in the "Centre Hospitalier Luxembourg" (CHL). A day admission structure after residential treatment with a capacity of 15 places is further planned. 140 youngsters are currently (2005) placed abroad in residential treatment centres.

In the framework of the psychiatric reform launched by the Ministry of Health, the necessity of implementation of specialized treatment and care structures for youngsters especially for those with addictive, antisocial and problematic behaviour has been outlined. The Neuro-Psychiatric Hospital Centre (CHNP) elaborated in 2005 a concept concerning the implementation of a treatment centre for youngsters with addictive, anti-social and behavioural problems aged 12 to 18 years with a capacity of 18 clients.

The Ministry of Family plans for 2008 a specific structure for minors on the run. Furthermore, "security units" will be implemented in the framework of the socio-educative state centres in order to avoid that minors come in contact with adult prison settings.

The drugs action plan 2005-2009 further foresees actions related to the target group of youngsters aged less than 15 years:

- prevention programmes in homes for children and youngsters (CePT),
- exploratory study in regard of assessing the needs of treatment and care for PDUs minors of age (PFL),
- "rapid assessment" in regard of cocaine, alcohol and gambling (CePT),
- study on social and family cohesion and psycho-social protective resources in regard to dependency, violence and psychiatric disorders,
- exploratory study in the techno scene to develop risk, damage and nuisance reduction interventions,
- implementation of a specialized residential/rehabilitation treatment structure for minors(CHNP) with addictive behaviour.

12. Cocaine and crack – situation and responses

SUMMARY

In recent years cocaine and crack have increasingly appeared on the **national drug market** being made available at low prices and quality levels.

Thus far, no representative general population survey on drug use has been performed at national level. Cocaine use among students show an increasing last 12 month **prevalence** (0.8% at age 13 to 5.3% at age 19). All in all, only a low proportion of youngsters try high risk drugs.

RELIS data suggest that first consumption of cocaine (non i.v. and i.v.) most frequently occur at the age of 18 or 19 years. A majority of PDUs consume cocaine in addition to other substances. Crack is currently not a popular drug among PDUs. A total of 24% of PDUs have been minor of age while consuming cocaine for the first time.

Treatment demands related to cocaine vary from 3.9% to 5.5%. The high number of syringes exchanged in the framework of the national syringe exchange programme reflects the increased offer of cocaine on the national drug market more than a change in preferences. As quality is

generally low cocaine injections have to be more frequently repeated as heroin injections, which has an immediate impact on the number of used syringes.

At national level, 8 lethal **overdoses** and 33 non-lethal overdoses have been registered by the Judicial Police in 2005. From 1999 to 2004 cocaine associated to heroin was increasingly found in overdose victims.

Drug treatment services are client and need oriented and able to adapt to new consumption patterns as well as to a change in clients' behaviour.

In 2005, 22.7% of all drug law **offences** concerned cocaine. Since 2004, more than half of arrests motives concerned cocaine offences. In 2003 to 2004 was observed the strongest increase of seizures indicating a more important supply of cocaine on the national market.

1. Prevalence, patterns and trends of cocaine and crack use

In recent years (especially in 2004) cocaine and crack have increasingly been appearing on the national drug market and were available at low prices and quality levels. As a consequence, PDUs increasingly consumed cocaine or heroin-cocaine mixtures.

- **Cocaine use among the general population and among school students**

As no representative general population survey on drug use has been conducted at national level no prevalence data on cocaine use in general population is available. It can be assumed that in addition to the PDU drug scene "covert" cocaine consumption occurs in a professional and recreational context where cocaine is used as a performance enhancer. The extent of this consumption is not known, as these users generally do not make use of national drug treatment services.

The HBSC 2002 study assessed data on cocaine use among school students aged 13 to 19. The table below shows last 12 months prevalence of cocaine consumption by students aged 13 to 19 years.

Table 12.1 Last 12 month prevalence of cocaine consumption – students aged 13 to 19 years

age	13	14	15	16	17	18	19
cocaine	0.8	2.2	1.5	1.6	2.3	2.0	5.3

HBSC 2002

It should be stressed that cocaine consumption shows highest last 12 month prevalence in the age group of 19 years.

Concerning the disposition to accept offered drugs nearly 3.5% of students aged 13 would accept XTC, amphetamines and cocaine compared to 5.5% of students aged 19. Generally speaking, only a small proportion of students have tried HRC drugs (approximately. 4-5% of students aged 18). Even if a certain proportion of youngsters do try hard drugs, few of them will become regular users and develop a addictive behaviour. Crack use has not been reported for this age group. The general results of the HBSC 2002 study regarding drug consumption clearly show gender specific differences. More male students than female students consume drugs with the exception of medicaments. Also illegal drug consumption decreases with higher school levels.

- **Prevalence and patterns of use among specific populations**

It is important to stress that the vast majority of PDUs consume cocaine additionally to other substances.

The national drug monitoring system (RELIS) allows assessing current and past cocaine consumption prevalence. Poly-drug use is the main consume pattern of PDUs (92%). Opiates constitute the preferred substance of problematic drug users (70% in 2005) compared to 20% in regard to cocaine. Secondary substances in order of importance are cocaine (38%), cannabis (22%), heroine 16 % and amphetamines/MDMA 7%. Among PDUs, crack is not a popular drug as it does not appear in the rating of preferred substances and shows a very low prevalence in regard of second or third preferences. However, an increased prevalence of problematic consumption of cocaine is observed among PDUs. The preference for cocaine increased constantly from 8% in 1995 to 20% in 2005. This trend is clearly also function of the increased offer of cocaine on the national drug market. Additionally, a regular follow-up of PDU clients of the drug consumption room

implemented in Luxembourg City since July 2005, shows that heroin is the most consumed drug (81%) followed by cocaine (11%) and heroin-cocaine “cocktails” (7%).

Cocaine is rarely reported (1%) as a drug of first use and crack not at all. The first sustained contacts with psychoactive substances concern cannabis (74%) and alcohol (18%) compared to cocaine (1%). A majority have consumed at least 2 other substances before using cocaine.

In 2005, the age group of 18-19 years showed the highest prevalence of first cocaine consumption (26%) (See figure 11). First cocaine use shows higher proportions in the age group of 16 to 19 years. PDUs tend to start cocaine consumption at a later age than heroin consumption.

The age group 18-19 years also shows the highest proportion of first intravenous cocaine use (26%) (see figure 11.3). It has also to be stressed that 24% of PDUs are minor of age while consuming cocaine for the first time.

2. Problems related to cocaine and crack use

• Treatment demand for cocaine

The Youth-and Drug Help Foundation (JDH) is one of the main drug treatment services at national level. Admission statistics of all counselling services of JDH show that demands related to cocaine (amphetamines, LSD, XTC included) varied in 2005 between 3.9% and 5.5%. Opiates and poly drug use constituted by far the highest proportion (up to 40%) of demands. In regard to drug treatment of minors, MSF Solidarité Jeunes registered 0.4% of demands related to cocaine use in 2005.

The annual assessment of the total number of syringes exchanged in the framework of the syringe exchange program showed a constant increase until 2004 and stabilized in 2005. This increase has not been function of an increase of the number of consumers but of a change in consumption patterns. In fact, due to an increased offer of cocaine on the national market, problematic cocaine use increased as well as the number of injections, which have to be repeated more frequently in order to reach desired effects as quality level are generally low.

• Other problems related to cocaine use

African asylum demanders are highly involved in cocaine street traffic, which has led to an undifferentiated discrimination of this population as they often are perceived as potential drug dealers.

Clients of the national methadone programme have been showing more concomitant cocaine use the last 3 years. Results of toxicological urine analyses in the framework of the substitution treatment showed a clear increase of positive cocaine tests.

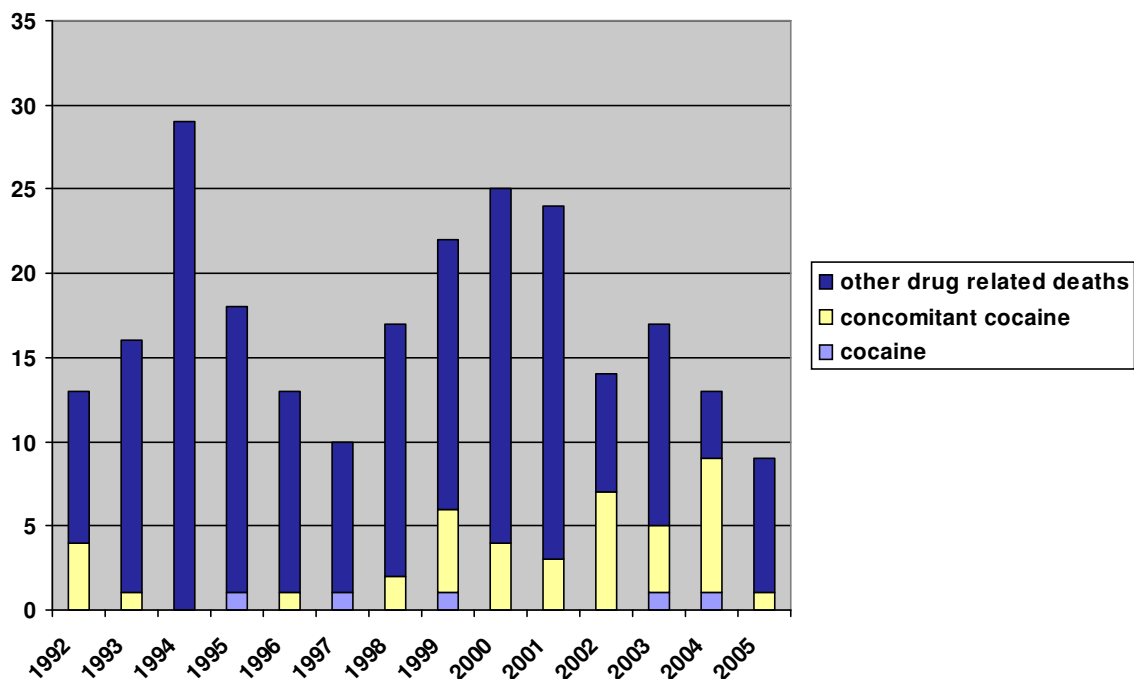
A distinction has to be made between preferential cocaine use and offer dependant cocaine use. Consumption patterns of PDUs are more function of the local drug offer than of the actual preference. One should therefore be cautious in regard to the statement that a new and increased cocaine demand has developed. Common heroin users have not changed their preference out of the blue; their consumption is highly depending on what drugs are actually available.

Concerning the population of recreational drug users, recent data do not allow to conclude that cocaine use prevalence has increased in this group.

During 2005, 8 lethal overdoses and 33 non-lethal overdoses were registered at national level by the Judicial Police.

The table below shows results of toxicological analyses of lethal overdose victims from 1992 to 2005 according to presence of cocaine in post mortem blood analysis.

Figure 12.1 : Number of fatal overdose victims and number of cocaine or concomitant cocaine deaths



SOURCE: National Health Laboratory -Toxicological Unit. Data formatted by NFP. 2006

Toxicological analyses show that the main illicit drug involved in overdose deaths is heroin. From 1999 to 2004, cocaine associated to heroin was increasingly found in toxicological analyses samples of overdose victims. As can be seen in figure 12.1, overdose deaths specifically due to cocaine are very rare.

Concerning acute poisoning cases in general population, results of toxicological analyses from the LNS in 2005 show that benzodiazepines, alcohol and opiates have been the substances most prevalent in acute poisonings. Cocaine acute poisonings came on 8th place. In 2004, cocaine came on 6th position. Regarding cocaine, 1.7 % to 1.9% of samples analysed from 2000 to 2003 have been positive on cocaine, whereas in 2004 and 2005, 5.3% respectively 4% related to cocaine.

Table 12.3 Results of toxicological analyses of acute poisoning cases in general population from 2000 to 2005

	2000	2001	2002	2003	2004	2005
Total number of cases	252	259	268	291	261	187
Total number of samples analyzed	419	413	363	390	358	294
	Number of positive samples					
Cocaine %	7 1.7%	7 1.75%	7 1.9%	7 1.8%	19 5.3%	12 4%

SOURCE: National Health Laboratory -Toxicological Unit. 2006

3. Responses and interventions to cocaine and crack use

- **Treatment for cocaine**

All national drug care and treatment services are client and need oriented. Traditionally they are specialised in opiate treatment and therefore had to adapt to the obvious increase in cocaine use and the associated behaviour patterns in order to meet client needs. Problematic drug users often showed increased aggressive and short tempered behaviour due to cocaine use. Excessive phases of consumption are followed with phases of exhaustion. Physical and psychological degradation as well as psychiatric disorders are possible outcomes of cocaine abuse. However it seems that in 2005 heroin regained in importance although cocaine remained more present than in the last years. Specific treatment interventions for PDUs of primarily cocaine are currently developed.

- **Harm reduction responses to cocaine**

The drug help-line run by the CePT registered in 2005, 6.6% of calls related to heroin and cocaine. All drug treatment agencies as well as low threshold services inform clients on cocaine specific problems and provide information on intravenous use and additional consumption. The national syringe exchange programme aims to reduce risks in case of intravenous cocaine use. Drug care services provide clients with drug injection prevention kits. The drug consumption room currently offers the possibility to inject illegal substances (opiates, cocaine, amphetamines and derivatives) but has no inhaling/smoking facilities.

The study “Prevalence and propagation of viral hepatitis A, B and C and HIV in problematic drug users of illicitly acquired drugs (Origer & Removille, in press) analyzed among others the relationship between the exchange of straws for cocaine “sniffing “ and the transmission of hepatitis C. Due to the small proportion of cocaine intra-nasal users in the study sample, the hypothesis of an increased transmission of hepatitis C while sharing straws could not be verified. Several studies however outline the presence of HCV in nasal secretions of infected patients.

- **Law enforcement activities in response to cocaine**

In response to cocaine no specific law enforcement activities have been carried out or planned. However, a general strengthening of police forces involved in the fight against drugs has taken place recently.

- **Policies and strategies in response to cocaine use**

Following an increase of the visibility of the drug scene and related nuisances in 2004, the municipality of Luxembourg City organised a “hearing” concerning security and social problems in the railway station area. Following this hearing, social services including several drug treatment services met in plate forms to discuss and improve the social network of Luxembourg City and assess the opportunity of the method of case management. By assuming its responsibility, the municipality implemented a street work service acting as a buffer between citizens and socially marginalized people.

Drug treatment services, as cited above, had to adapt to new consumption patterns as well as to behavioural changes in clients. The intervention teams had been more cautious in their contacts to PDUs.

4. Cocaine-related crime and cocaine and crack-markets

- **Cocaine-related crime**

The Judicial Police registered in 2005, 2,034 records (86% males/ 12% females/ 2% gender unknown) for drug related offences (1995: 1,205/2000: 1,758).

Table 12.4 Records: number of offence records related to cocaine

Substance	Offence	1999			2003			2004			2005				
		N	i.v.	total	N	i.v.	total	N	i.v.	total	N	i.v.	total		
Cocaine	Use & traffic	85	34	204	63	13	350	54	24	506	85	32	462		
	Traffic only	31			158			270			180				
	Use only	88	31		129	36		182	86		197	97			
Total number of offence records						1,939			2,270			1,808			2,034
% of cocaine offences						10.5			15.4			28			22.7

SOURCE: Judicial Police, Drug Section (Data formatted by NFP)

In 2005, 22.7% of all drug law offences concerned cocaine (28% in 2004/15.4% in 2003/ 10.5% in 1999). In 2004, the number of cocaine related offences prevailed for the first time the number of heroin related offences (2004: cocaine: 506; heroin: 469/ 2005: cocaine: 462; heroin: 657). In comparison to previous years, cocaine related offences have increased but show a fair stability in 2005.

Concerning the number of cocaine related arrests; the table below shows the evolution of the last decade.

Table 12.5 Arrests: type of offence by substance - cocaine

Substance	Offence	1995	1997	1999	2001	2003	2004	2005
Cocaine	Use & traffic	20	27	21	27	19	21	21
	Traffic/deal	7	23	9	9	30	64	42
	use	10	6	12	4	3	9	15
	Total	37	56	42	40	52	94	78
Total number of drug related arrests		128	154	108	92	135	178	154
% of cocaine arrests		28.9	36.4	38.9	43.5	38.5	52.8	50.6

SOURCE: Judicial Police, Drug Section (Data formatted by NFP)

More than half of arrest motives (50.6%) were related to cocaine in 2005. This proportion has reached its maximum in 2004 (52.8%). In 2004 and in 2005, for the first time, cocaine has been the first motive of arrest compared to other illicit drugs, especially heroin and cannabis.

- **Cocaine markets**

The global number of drug seizures at national level has been increasing constantly since 1998 from 533 to 1,196 in 2005. In 2005, 123 seizures have allowed to seize a total quantity of 1.187 kg of cocaine. The number of cocaine seizures has been increasing constantly (1986: 11/1995: 48/2005:123) whereas the quantity of cocaine seized varies annually. Coca leaves and paste are very rarely seized. The strongest increase of seizures was observed from 2003 to 2004 (69/113) strengthening the idea of an increased supply of cocaine on the national drug market.

Table 12.6 Number and quantities of controlled substances seized – coca and derivatives

Coca and Derivates	1986		1990		1995		2000		2004		2005	
	Q	N	Q	N	Q	N	Q	N	Q	N	Q	N
Coca leaves	2.045	10	0.090	4								
Coca paste	0.690	2	1.000	1								
Cocaine	6.475	11	23.260	32	0.525	48	10.757	51	4.481	113	1.187	123

Source: Judicial Police, Drug Section

Concerning the street retail price of cocaine, one observes a constant decrease of price from 1996 onwards to reach a consistently broad price range from 2003 to 2005. The table below shows average prices of retail cocaine:

Table 12.7 Average prices of retail substances – cocaine (per unit)

Price/Euro/gr	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Cocaine	100-150	100-150	120-170	90	90	76,5	50	30-85	20-120	20-120

Source: Judicial Police, Drug Section

Concerning purity of retail street cocaine, the table below shows the evolution of purity of the last decade. Concerning cocaine, purity is expressed in % of pure active substance of street retail. High price differences may indicate a diversification of involved distribution networks.

Table 12.8 Purity of retail substances – cocaine (per unit)

	1997	1998	1999	2000	2001	2002	2003	2004	2005		
	Pur.(%)	Pur.(%)	Pur.(%)	Pur.(%)	Pur.(%)	Pur.(%)	Pur.(%)	Pur.(%)	Pur. (%)		
	mean	mean	mean	mean	mean	mean	mean	mean	min.	max.	mean
Cocaine	60-85	70.66	70.66	60.25	56.09	62.99	58.5	62.37	27.75	94.9	51.52

Since 2003, an increasing number of asylum demanders are implicated in drug trafficking, especially cocaine. These criminal associations are well organized and originate mainly from Ivory Coast regions. Numerous drug traffickers changed from heroin to cocaine traffic. The sale techniques of drugs have become increasingly aggressive; dealers frequently put clients or persons on the street under pressure.

13. Drugs and driving

SUMMARY

The **governmental declaration** of August 2004 stresses the importance of prevention and repression in the framework of traffic security. A project of law submitted in 2004 and currently under preparation, aims, among other measures, to implement on site drug testing.

The **Toxicological Unit** of the Laboratory of Health provides data on cannabis consumption of drivers implicated in traffic accidents, which show a serious increase of positive cases tested.

A **study** conducted in the framework of the LNS analysed the prevalence of drug consumption in drivers having been previously tested for alcohol. Alcohol was detected in 88.1% of blood specimens, medicinal drugs in 22.9% and illicit drugs in 10.5% of samples. Concerning cannabis and benzodiazepines, a proportion of 9.5% and 10.9% respectively have been detected.

The **Grand-Ducal Police** registered over the last 3 years on average 63 cases with driving under the influence of illicit drugs per year and 1,800 cases related to driving under alcohol influence.

National **prevention** campaigns focus on drugs, speed and security measures. 'Drugs and driving' has become a major topic since the publishing of toxicological analyses results and studies from the LNS. Several prevention measures regarding the risks of driving under the influence of drugs, targeting above all youngsters, have been implemented.

1. Policy

The governmental declaration of August 2004 stresses the importance to combat vigorously traffic accidents by substantially reinforcing measures and actions in favour of traffic security. [...] *The fight against traffic accidents causing inadmissible human tragedies and losses constitutes an absolute priority. In order to improve traffic security, the Government focuses on prevention and repression. [...] Concerning repression, the Government will combat primarily excessive, non adapted speed, the major generating factor of deadly accidents on the roads of the Grand-Duchy of Luxembourg, even more when associated to aggressive behaviour and to the consumption of alcohol and drugs [...].*

Traffic related offences are addressed by the law of 14 February 1955 concerning the regulation of circulation on public roads. In 2003, a proposition of law concerning the implementation of roadside drug testing was submitted to Parliament as driving under influence of drugs as well as the increasing tendency to poly-consumption associating drugs and alcohol have become a major concern in regard to traffic accidents.

In July 2004, the Ministry of Transports elaborated a project of law modifying the 1955 law, concerning among other measures, systematic road side drug testing in case of traffic accidents with injuries or in the framework of preventive controls and the upgraded qualification of driving under the influence of drugs as an offence (previously only contravention). The 2004 project of law outlines that rapid roadside drug tests, which consist of mobile saliva and sweat tests only are considered as auxiliary means of detecting drug consumption of drivers and must be confirmed by a blood and urine analyses to be admitted as legal evidence.

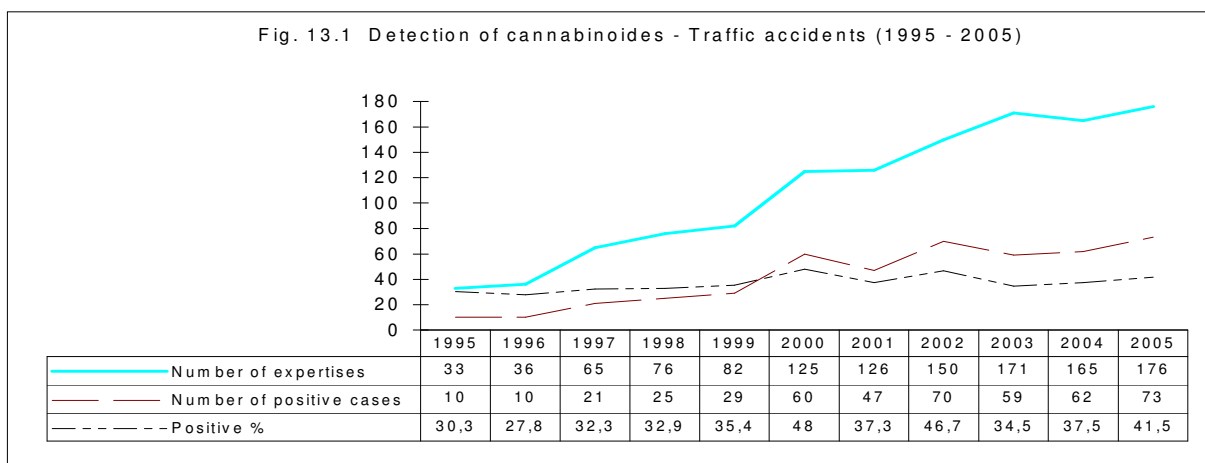
A project of a grand-ducal decree concerning technical modalities and homologation criteria of instruments assessing the state of consumption of alcohol, medicaments or narcotics of drivers also has been elaborated in 2004. Whereas the principles of roadside drug testing are foreseen to be integrated into the 1955 modified law, the project of grand-ducal decree fixes the conditions of approval and utilization of sweat and saliva, the modalities of blood and urine analyses, of the medical exam and the transcripts. The 2004 project of law was subject to governmental modifications following notifications from the Council of State in 2005 and had been revised and made public in 2006. Concerning repression of driving under the influence of illicit drugs, it was emphasized that the principle of "zero tolerance" (no difference between soft and hard drugs and quantity consumed) would be applicable at the moment of detection in the organism of one of the substances foreseen by the article 7 of the modified drug law of 19 February 1973. In case a sweat or saliva test is conclusive, the presence of a substance has to be assessed by a blood and urine

analyses. The Government also intends to decrease the legal blood limit from 0.8 to 0.5‰ and discusses currently a decrease to 0.2‰ for young and professional drivers.

2. Prevalence and epidemiological methodology

The Toxicological Unit of the National Laboratory of Health is the state's reference laboratory in regard to detection and dosage of alcohol, medicinal and illicit drugs of biological samples from drivers. Since 1995, the Toxicological Unit of the Laboratory of Health provides toxicological evidence concerning detection of cannabinoids in persons involved in traffic accidents. The figure below shows that 30.3% of expertises completed in 1995 included traces of cannabinoids. This proportion went up to 48% in 2000 and figured 41.5% in 2005.

Fig. 13.1 Results of toxicological expertises regarding detection of cannabinoids in persons involved in traffic accidents.



SOURCE: National Laboratory of Health, Toxicological Unit, 2006

National epidemiology concerning traffic accidents is shown in table 13.1⁴⁶

Table 13.1. Substances detected and percentages of positive results concerning the biological samples of drivers involved in traffic accidents.

Substances	Suspected drugs n= 481*	Suspected EtOH n= 198**
EtOH	39.1%	88.0%
Cannabinoids	39.9%	10.1%
Amphetamine derivates	3.1%	nd
Benzodiazepines	26.2%	10.6%
Cocaine	10.8%	2.0%
Heroin	21.6%	0.55
Methadone	14.1%	0.5%

* Years 1999-2002, ** Prospective anonymous study from 2001 to 2002, n = number of cases, nd = not detected

From 2001 to 2002, a prospective anonymous study⁴⁷ analysed blood samples of randomly selected 210 (179 male/ 31 female) drivers having previously been analysed on blood alcohol concentration (BAC), thus representing one third of all alcohol cases per year in Luxembourg. These drivers were additionally tested for medicinal drugs, illicit drugs and chronic alcohol abuse. Reasons for being submitted to blood alcohol analyses have been systematic controls, traffic accidents, positive breath alcohol tests and inability or refusal of a breath test while suspected to be impaired. A mean-age of 39 years was noted for males and females. Alcohol was detected in 88.1% of blood samples, medicinal drugs in 22.9% and illicit drugs in 10.5% of samples. Poly-drug use was observed in 27.6% of cases (90.6% of drug consumers). Chronic alcohol consumption was found in 29.5% of cases.

Medicinal/illicit drugs without alcohol were detected in nine drivers, whereof only two cases testified psychoactive substance consumption; the other medicinal/illicit drugs detected were not psychoactive or originated from therapeutical prescription. Benzodiazepines and antidepressants have been the most frequent classes of medicinal psychoactive drugs detected in 10.9% and 7.6% of cases respectively. Generally, medicinal psychoactive drugs had been detected in a greater

⁴⁶ R. Wennig R. (2005). Alcool, pharmaceuticals, illicit drugs and driving, Laboratoire National de la Santé, Toxicologie, Université du Luxembourg, Campus Limpertsberg, Bull. Soc. Sci. Med. N°1 2005.

⁴⁷ Appenzeller M.R. B., Schneider S., Yegles M., Maul A., Wennig R. (2005), Drugs and chronic alcohol abuse in drivers, Forensic Science International 155, 83-90

extend in females without however being significantly gender-dependent in the target group. The presence of benzodiazepines increased with age. Statistical analyses showed that benzodiazepines were significantly associated with higher BAC but not with chronic alcohol abuse. Medicinal drugs have clearly been associated to two or more psychoactive substances (poly drug use).

Concerning illicit drugs, 9.5% of cases were related to cannabis consumption, a prevalence close to the general EU population. Only one case in three showed detectable traces of THC. Also cannabis consumption decreased with age and was not found above 45 years.

Prevalence of medicinal psychoactive substances in drunken drivers was one of the highest from existing studies throughout Europe.

3. Detection, measurement and law enforcement

The modified road traffic law of 14 February 1955 does not establish any distinction between specific drugs but refers to hallucinogenic substances, drugs and toxic, soporific and psychotropic medicines. Alcohol preventive controls are organized on the basis of the Public Prosecutor's requisition. In that event drivers have to undergo alcohol tests even in case of apparent sobriety.

Blood analyses are mandatory:

- for each driver involved in traffic accidents in case of injuries,
- in case of strong suspicion of impairment due to alcohol or drugs

In case cannabis and benzodiazepines consumption is suspected, the legal instrument of testing consists in a medical exam and a blood analyses. The grand-ducal decree of 19 March 1982 defines the modalities of the medical exam and of blood and/or urine sample ordered in case of presumption of illegal use of narcotics or toxic, soporific or psychotropic substances. Blood samples taken at the police station are transferred to the National Laboratory of Health. The laboratory proceeds to the search of narcotics and other toxic substances in blood and urine samples and assesses their dosage. The Laboratory applies two different methods of analyses of which at least one is specific of the suspected drug. The result is communicated to the Public Prosecutor. The medical exam has the objective to determine if a person is under the influence of a substance and is executed by an MD by means of a questionnaire. Two different grand-ducal decrees of 19 March 1982 define the modalities of the questionnaires in case of medical exam and in case of blood and urine sample respectively.

Members of the grand-ducal police involved in traffic controls get further training in regard of drug consumption and related impairment. Article 12, paragraph 1, of the modified law of 14 February 1955 (traffic code) incriminates impaired driving (vehicle/animals - pedestrians) as it represents a danger for the driver him/herself and for third persons with fines ranging from 251 Euros to 5,000 Euros and/or prison sentences from 8 days to 3 years.

Even if the presence of cannabis and benzodiazepines is assessed throughout blood samples/analyses, the legal system does not lay down minimum nor maximum levels of these substances. Only alcohol levels have legal evidence and are categorized. All in all, the Public Prosecutor based on police, medical and testimony reports, will decide upon all the circumstances on the further prosecution of the case.

The Special Commission of the Ministry of Transports is in charge of driving licences suspension, partial restitution, prorogation of driving etc. and processed in 2005 1,606 cases (1,354 in 2003). This increase is mainly due to alcohol and drug problems, which are transferred to the Medical Commission. The commission recommends deprivations of driving licences in case of alcohol or drug dependent persons. Cases of youngsters with drug dependencies, often soft drugs, are reported to increase and have to be followed up.

In the framework of traffic controls, the Grand-Ducal Police⁴⁸ registered the following drug and alcohol penalty records from 2003 to 2004:

Fig. 13.2 Drug and alcohol penalty records from 2003 to 2004

	2003	2004	2005
Driving under the influence of alcohol	1,711	1,992	n.a.
– in relation to a traffic accident	308	308	
Refusal of compliance to alcohol detection	34	37	n.a.
Driving under the influence of drugs	69	56	65

Source: Grand-Ducal Police 2006

4. Prevention

In the framework of traffic security, national prevention campaigns lay priority on alcohol, speed and security measures. In 2004, the Grand-Ducal Police organized a specific anti-drugs prevention campaign with special attention to cannabis.

The association for traffic security ‘Sécurité Routière’ created in 1960 aims to prevent traffic accidents and conceptualizes in collaboration with several associations and Ministries, especially the Ministry of Transports, Justice and Education, prevention campaigns at national level. The association also acts at the level of child education, sensitisation of young drivers, general public and organizes practical courses for traffic offenders.

At the national level, traffic accidents constitute the primary mortality factor of youngsters aged 14 to 25 years. In 2005, 13 youngsters died of traffic accidents, representing 28% of road victims. In reaction to this evolution, a joint project “Mobilité et Sécurité de la Route” (MSR) of the Ministry of National Education and the Ministry of Transports aims to sensitise youngsters on traffic dangers by integrating special practical and theoretical education programmes in the post primary school curricula at national level. Also the Grand-Ducal Police, the Civil Protection, the Automobile Club and the Training Centre (Centre de Formation) are active partners in this project. Educative programmes are also organised in the framework of primary schools. An interactive internet page www.msr.lu provides actually pedagogical files concerning the impact of drugs and medicaments in driver’s ability.

Since the implementation of the ‘point driving licence’ in 2002 (credit 12 points), the “Centre de formation pour conducteurs” organises training sessions for drivers allowing them to recover points. These sessions include practical and theoretical programmes. The theoretical level includes psycho-education and analyses of driving behaviour to reach a change in driving attitudes. Offences are individually discussed with psychologists. On a practical level, pedagogical explanations, exercises and demonstrations regarding safety distance, speed, alcohol, medicaments and drugs are provided.

The Information Centre for Youngsters published in September 2003 a prevention flyer concerning cannabis, which is still available online. One of the prevention messages concerns the dangers of driving under influence of cannabis.

The Ministry of Transports supported the recent introduction of the late night buses implemented in Luxembourg City and several municipalities preventing impaired youngsters to drive.

The association “Responsible young drivers”, implemented in Luxembourg since 2003, aims to sensitize young drivers of traffic dangers in recreational and school settings by means of peer approaches. Rapid alcohol tests and drug saliva tests regarding cannabis and amphetamines are provided in party settings.

The amount of public funds provided for year 2006 regarding traffic security runs up to 760,000 Euros. This amount includes 250,000 Euros of subsidies concerning the organization of “Late Night Busses” for municipalities, 310,000 Euros of subsidies for associations acting in the field of traffic

⁴⁸ Activity reports of the Grand-Ducal Police, 2003, 2004, 2005

security and 200,000 Euros for measures against traffic accidents concerning preventive measures as publicity, sensitization and information.

Currently, information notices of medicaments include information on influence in driving abilities. Also MDs inform patients on the extent of impairment resulting from the use of a specific medicament.

Media often address illicit drugs. Discussions in the media especially targeting drugs and driving are frequently related to discussions at parliamentary and ministerial level. Cannabis is by far more often addressed to than benzodiazepines.

**** END OF REPORT ****

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- Relevant data bases and information systems

- a. RELIS drug monitoring system

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

The main objectives of RELIS are the following:

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

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

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

To avoid multiple counting and to allow for a follow-up of drug users' careers, RELIS is based on a 9-digit numerical code obtained by indating 3 core variables (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 a simple HP calculator that runs an attributor-to-code transcription programme based on a multiple-step algorithm.

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

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

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

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

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

- b. Register on drug law offenders (SPJ)

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

- c. General Mortality Register (GMR)

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

- d. Special Overdose Register (SR) of SPJ

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

related death data is encoded at the SPJ and transmitted to the NFP according approved standards. Data on indirect drug deaths that are still paper based is also provided to the NFP.

e. AIDS and HIV register (CRP-SANTE)

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

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

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

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

The new mandate of the **Inter-ministerial Group on Drugs** (November 2000), which represents the top decision level in the field of drug policies, 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 are involved in the data providing process in terms of routine data transmission on new trends. Recently two new agencies have joined the EWS network, namely a counselling centre for drug users underage and a low threshold project. The first does provide relevant data on new consume patterns and trends within youngster population and the second focuses on opiate users. One has to stress that the key-informants network does mainly provide data on trends in drug use but not on toxicological characteristics of substances since the referred agencies do not propose substance related services.

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

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

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

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

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

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

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

g. Documentation Centres (NFP / CePT)

The **Centre Logistique de Documentation sur les Drogues et les Toxicomanies (CLDDT)** is a logistic documentation service run by the NFP since 1995. CLDDT runs the only computer-based national documentation management base specifically focusing on licit and illicit drugs. The CLDDT indexes about 2,900 documents mainly in French, German and English language. Users of information services provided by the CDTL are mainly researchers, journalists, policy makers, drug treatment and prevention specialists, and general public. The majority of indexed documents are paper-based and abstracts are provided.

In addition to its function of documentation base, CLDDT also ensure the conceptualisation and execution of drug documentation dissemination strategies as required by the NFP. Topic-specific mailing lists have been developed and maintained by active contact making and demand response.

CLDDT is linked to the **Centre de Documentation du Centre de Prévention des Toxicomanies** run by CePT since 1996. The CePT documentation centre mainly focuses on primary prevention, training and evaluation in the fields of licit and illicit drugs. The current stock approaches 1,000 documents or media supports. Queries are handled manually and no computer-based consultation facilities are provided.

- Alphabetic list of relevant Internet addresses

<http://www.ceps.lu/>
<http://www.cept.lu/>
<http://www.crp-sante.lu/>
<http://www.ecbap.net/>
<http://eldd.emcdda.eu.int/>
<http://www.emcdda.eu.int/>
<http://www.etat.lu/>
<http://www.etat.lu/MS/>
<http://www.gouvernement.lu/>
<http://www.ilres.com/>
<http://www.jdh.lu/>
<http://www.legilux.public.lu/>
<http://www.msf.lu/>
<http://www.msr.lu/>
<http://www.police.public.lu/PoliceGrandDucal/>
<http://eddra.eu.int/>
<http://www.relis.lu/>
<http://www.statec.lu/>
<http://www.unodc.org/>
<http://www.who.int/>

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