



European Monitoring Centre
for Drugs and Drug Addiction



**2007 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**

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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 EMCDDA focal point of the Grand Duchy of Luxembourg.

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Summary

Annual National Report on the Drug Situation (Edition 2007)

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

Political, legal and organisational framework

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

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

An effective drug strategy should rely on **two pillars**, namely on demand reduction and supply reduction as also on **four transversal axes**: risk, damage, nuisance reduction, research and information, international relations and finally coordination mechanisms. The national drug coordinator, jointly with the Interministerial Committee on Drugs (ICD), follows up the implementation process of the national drug action plan. In 2006 the national drugs coordinator has been appointed chair of the ICD.

The **global budget of the Ministry of Health** granted to drug-related services and programs went up from 1,270,169 EUR in 1999 to 5,770,643 - EUR in 2004, indicating a progression rate of 354% since 1999. The 2006 budget figures 6,584,000 - EUR representing a supplementary raise of 14.9% in reference to the 2005 budget. In regard to the 2007 budget, 6,689,000 - EUR have been allocated to concerned services representing an increase of 1.6% compared to 2006. Human resources dedicated to specialised state financed drug agencies have known a significant increase from 30.75 full time posts in 2000 to 73.5 in 2007.

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

In the last decade, the most important increase besides cannabis, applies to ATS (including ecstasy) followed by cocaine and opiates. A similar evolution is observed within the EU and the micro-geographical level of the Grand Duchy of Luxembourg, however accompanied by more or less sustained local variations 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 2006 figures 4,571 (2002: 4,701) (in this figure double counting is included meaning that a given person could have been indexed twice and more by different institutions. It is thus not representing the actual prevalence, which has to be assessed by other methods). For comparison, 2,383 users have been indexed by national specialised drug demand reduction agencies and 2,318 drug law offenders by supply reduction agencies in 2002. In 2006 the same agencies have indexed 2,755 and 1,816 persons respectively. As the frequency of multiple contacts did not change over recent years, these figures suggest that in total and since 2002 fewer people have come in contact with drug agencies and even more positive is the fact that an increasing proportion of PDUs seek contact with treatment services and less show contacts with law enforcement agencies.

10% (5%) of respondents are first treatment demanders, all treatment centres included. More recently, one has observed a stabilization of treatment demands in outpatient drug agencies and inpatient therapeutic centres whereas detoxification demands and contacts with low threshold drug agencies are clearly increasing.

Socio-demographic profiles of PDUs

The **male/female ratio** of the PDU population is 3:1. The last ten years the proportion of indexed non-native PDUs has 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. Although the proportion stabilised since then, it is still consistently higher than the one observed in general population. Notably, one observes a remarkable increase of PDUs of French origin (22%). This trend is confirmed by last 6-years data on drug law offenders.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 30 years and 11 months in 2006. The gap between youngest and oldest PDUs continues to grow, notably by the increase of PDUs aged 40 and more. 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 an important but currently decreasing proportion of minors among drug law offenders. For the first time since reliable data are available **rates of first cannabis use**, in **11-13 years** old youngsters are over 35%. Respectively 88% and 43% of current PDUs have tried cannabis and heroin (i.v.) while being minor of age. In 1995 the same proportions figured 71% and 23%. Most interestingly, evolution of drug use patterns tend to accelerate in terms of shorter time spans separating first non-iv use from first iv-use. This acceleration is also observed as far as first treatment demands are concerned. PDUs tend to contact drug treatment facilities at an earlier stage, which may be due to a more diversified offer currently available.

The **residential status** of indexed respondents has improved over the last years. In 1995, 31% of the users were disposing of a stable accommodation; in 2006 the same proportion figures 76%. This improvement is partly due to various accommodation and housing projects for addicted people set up in the framework of the drug action plan. An increasing number of PDU report to live alone. This evolution should be paid particular attention to since it increases overdose and other health-related risks.

All indicators included, **employment status** of PDUs did not improve over the last years. After a high level stabilisation (46-50%) during the past 5 years, the **unemployment rate** is still significantly high, and settled at 67% in 2006.

Problem drug use prevalence and consume trends

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

Intravenous heroin use associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. As already reported, the switch to intravenous drug use occurs earlier. The ratio of intravenous opiates consume to the inhalation mode has stabilised at 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 and stabilised in 2005-2006. **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** (88% in 2006) is stable after a record level of 92% in 2004. The average ages at **first time consumption** of a preferred drug and illicit drugs in general, show a slow but continuous decrease for the last 8 years. In 2006, 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 well as the gap between these two groups.

Drug-related morbidity and mortality

HBV (hepatitis B) and the HIV/AIDS prevalence among PDUs have not been increasing in recent years while the **infection of HCV (hepatitis C)** showed a clear progression. Data from the Laboratory of Retrovirology of the CRP-Santé suggest a long term and discontinuous decreasing tendency of average proportion of IVDUs in newly diagnosed HIV cases until 2004. HIV infection rates in IVDUs situate around 4 percent and are witnessing a currently stable trend. A new study (Origer and Removille, 2007) based on serological testing, confirmed a significant increase in HCV prevalence in PDUs and IVDUs during recent years, especially in prison settings.

The implementation of the 2000-2004 and 2005-2009 action plans has been accompanied by a significant decrease of **overdose cases** in the Grand-Duchy of Luxembourg (2005: 8 cases). This decrease is mainly observed for male victims, the number of female overdose victims has remained stable for the last 5 years. Expressed in the number of overdose cases in the general population of the Grand-Duchy of Luxembourg, this proportion figured 1.76 overdose deaths per 100,000 inhabitants in 2005 (2000: 5.9 cases per 100,000 inhabitants). In 2006, 4.13 overdose deaths per 100.000 inhabitants have been registered, thus showing a new increase likely to be confirmed by 2007 figures. An expert working group currently analyses possible reasons for this evolution such as high purity variation of street drugs currently on the market and generalized polydrug use including a series of pharmaceuticals with potentially dangerous interactions patterns with illegal drugs. **Forensic data** from 1992 to 2006 show that the most frequently involved substance in drug-related death is heroin, followed by methadone and cocaine. Since 2000, methadone traces in blood samples of overdose victims have been increasingly detected.

The vast majority of victims are male (83%) and their mean age at the moment of death has been showing an important increase over the past 10 years (in 1992: 28.4 years and in 2006: 32.5 years). The number of victims aged less than 20 years remained relatively unchanged during observation period. A confirmed majority of acute drug death victims are known by law enforcement agencies for their drug user "career", which average durations of 10 years. Worth mentioning also that more than 80% of the known victims

followed at least one treatment before their death and half of the latter had an accommodation that could be qualified as stable.

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

In 2006, 19 **indirect drug death cases** have been indexed. Main causes of indirect deaths between 1996 and 2006 are, in order of importance: suicide, traffic accidents, undefined intoxication, associated cardio-vascular or pulmonary complications, drug (pharmaceuticals) addiction, liver failure and immune deficiency diseases.

The overall number of indexed direct and indirect drug death cases informs about **drug-related mortality**. Drug-related mortality prevalence has been showing small variations between 1996 and 2005 figuring roughly 26 to 33 cases per year. In 2006, 38 drug-related deaths have been reported (19 direct and 19 indirect drug related death cases).

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.

Seizures of all substances have increased in terms of quantity compared to 2005 although the number of seizures is stable and the number of offenders involved in seizures has been showing an overall decreasing trend. This may suggest that greater quantities of drugs are trafficked by smaller groups of traffickers. A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

The 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 ten years.

Drug law offenders and prison sentences

The **number of police records** for presumed offences against the modified drug law of 1973 went from 764 1995 to 1,200 in 2006. A similar evolution has been observed with regard to the number of drug law offenders. In 2006, 225 (155 in 2005) arrests for presumed offences against the modified 1973 drug law have been reported. However, in recent years, the number of police records, the number of drug law offenders and the number of persons arrested on the same charge have stabilised or even decreased 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**

¹ If not specified, data refer to 2006. Figures between brackets refer to 2005 if not specified.

² Non-transit drugs destined to the national market

offenders went from 50% to 66% (68%). In 2006, 30% 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 6.7% in 2006. National prison data of 2006 refer to 1,043 (1,341) new admissions of which 243 (23.3%) were related to drug law offences; a proportion having represented 42.6% in 1996.

Profile of the national drug market

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

For several years, expansion of **more structured distribution networks** by organized criminal associations has been reported. The national market increasingly attracts “drug professionals” aiming to set up a purely commercial distribution network. The proportion of non-natives involved in drug trafficking has been increasing over the last four years and may be stabilising according to 2006 data. Asylum demanders implicated in illicit cocaine trafficking mainly originate from West African countries, particularly the Ivory Coast. Currently also Albanian citizens are of particular concern to law enforcement authorities. In regard to heroin trafficking, no predominant profile of nationality has been reported. A large number of drug traffickers come from North Africa by transiting through Belgium. Numerous traffickers have changed from heroin to cocaine traffic and currently are also involved in cannabis traffic. Given the geographical position of Luxembourg, the national police forces closely cooperate with border countries and the Netherlands and do participate in large scale joint operations in the framework of international policy cooperation agreements aiming at the setup of a surveillance and intervention mechanism to fight illicit drug traffic originating from the Netherlands and drug trafficking and consumption at the regional level

Overall, the national **drug market has become of a more aggressive nature** in terms of selling techniques. Dealers increasingly tend to actively approach confirmed or potential clients.

Compared to the situation in 2003, **purity** of all reported substances are lower in 2006 except for cocaine that is showing a fairly stable quality during the same period. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (over 25%) in cannabis samples seized in Luxembourg in 2006. **Prices** show broad ranges for heroin and cocaine, and a still ongoing decrease for ecstasy like products. Cannabis and derivatives however have known certain stability during the last 5 years as far as street prices are concerned.

Since 2003 no new clandestine drug laboratory has been dismantled thus far. Local cultures of cannabis and magic mushrooms are rather insignificant in terms of quantity and quality. The perceived illicit drug availability in general population is high and follows a weakly increasing trend according to recent surveys.

Harm reduction activities

The number of **sterilised syringes** (2006: 332,347/ 1996: 76,259) distributed in the framework of the national needle exchange program has been constantly rising from the start of the latter until 2005. The same trend is observed with regard to the number of used syringes collected [2006: 282,909 (85%)/ 1996: 28,646 (38%)]. An increasing majority of injectors (35%) 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 from 2004 onwards (2006: 63,129 / 2005: 47,730/ 1996: 6,456). The number of syringes distributed by the same agencies has been following a similar evolution although stabilising for the first time in 2005 and even decreasing in 2006.

The number of clients of the national **methadone substitution programme** went from 30 in 1993 to 105 in 2006 (decreasing since 1998). In addition to the methadone substitution programme financed by the Ministry of Health, PDUs also address substitution treatment demands to **licensed GPs**. Data delivered by the Union of Health Insurance Funds refer to 939 different patients who did receive substitution treatment in 2006 (2002: 889 patients) by means of the prescription of methadone or buprenorphine containing medicaments by 121 prescribing GPs (1999: 125).

Most Relevant Trends

All indicators included an overall stabilization of PDU prevalence has been observed from 2004 onwards. However, quality of street drugs went down, which had as a consequence a fairly spectacular increase in syringes distributed (with low quality drugs more injections are necessary to reach the same effect) and the overall spread of polydrug use. The number of drug-related deaths has been decreasing significantly with the implementation of the national drug action plans. The recent increase of overdose cases is thought to be associated to changing consume patterns and high variations of purity of street drugs and not to an increasing overall PDU prevalence. There is a great concern about infectious diseases in drug users and in particularly IVDUs. HIV is low and stable; however, hepatitis C in PDUs has been increasing continuously. Latest research results based on serological testing (Origer & Removille, 2007) suggest HCV infection rates over 70% and even higher prevalence rates in prison populations.

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

Consistency between Indicators

Demand reduction indicators are highly consistent with supply reduction data (see fig. 4.2). Both indicators are suggesting a stabilisation of problematic drug use at the national level. Interestingly harm reduction activity indicators are witnessing an inverse evolution if compared to DR and SR data. For instance the number of distributed syringes has been increasing until 2004 and the number of contacts registered in low threshold agencies also went up consistently. Possible explanations of this evolution are the decrease in street drugs' quality inducing more frequent injections and an important increase and diversification of low threshold offers during the same period. Thus, the latter trends are not in contradiction with a confirmed general stabilisation of PDU prevalence.

Part A: New Developments and Trends

1. National Policies and Context

Overview

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

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, an adapted approach towards law enforcement by means of legislative amendments and the promotion of harm reduction measures, were appropriate.

In June 2005, the Minister of Health presented the new drug strategy and action plan 2005 – 2009, elaborated by the National Drug Coordinator who was also appointed chair of the Interministerial Committee on Drugs (ICD) by the Minister of Health in 2006. The referred action plan is based on the evaluation outcome of the previous action plan and the assessment of current and future needs. 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). A mid-term evaluation of the state of implementation of the 2005-2009 drugs action plan will be published by the end of 2007.

- LEGAL FRAMEWORK (NNIA)
 - Laws (2000-2007)

The **basic national drug law**, namely: ‘Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie⁴’ 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 2001⁵** modifying the basic drug law of 19 February 1973. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of harm reduction and maintenance measures, namely, drug substitution treatment, needle exchange and other state accredited means, which, in addition to article 13 of the grand ducal decree of 30 January 2002 (see below) could materialise in shooting galleries or medically controlled heroin distribution programmes.

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

⁴ Official gazette A 1973, p.319

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

- **law of 14 June 2001⁶** 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 2006⁷** on the fight against tobacco regulates advertising of tobacco and related products, the prohibition of smoking in certain areas and the prohibition of sale of oral tobacco. Main legal amendments concern an increase of the number of smoke free public areas, a prohibition of smoking in catering establishments, a general prohibition of advertising, the prohibition of tobacco sale to minors under 16 and the prohibition of import and sale of tobacco in forms of candy or toys. The prohibition of smoking in spaces where food is served can be compassed by the implementation of separate smoking rooms, not exceeding 25 % of the total area, with specifically installed smoke extraction systems. Access is denied to youngsters aged less than 16 years. Pubs and bars are only concerned during core hours as far as they serve meals. Hospitals are allowed to install one smoking room exclusively reserved to patients.

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

- **law of 18 September 2007⁸** lowers the **alcohol concentration tolerance level from 0.8‰ to 0.5‰** and the introduction of a level below **0.2‰ for specific categories of drivers (young drivers and professional drivers)**. Fines are applied and driving licence “points” are subtracted if alcohol level is equal or superior to 0.5‰, respectively 0.2 ‰. An immediate driving license withdrawal will be applied for 8 working days:

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

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

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

o Grand Ducal Decrees (2004/2007)

- The **grand ducal decree of 16 March 2006⁹** defines maximum prescription periods for methylphenidate, oral morphine, transdermic fentanyl, buprenorphine, hydromorphone and methadone.

⁶ Official gazette A 2001, p.1708, (Adoption: 14/06/2001, Entry in force: 17/06/2001)

⁷ Official gazette A 2006, p.2265, (Adoption: 13/07/2006, Entry in force: 05/09/2006)

⁸ Official gazette A 2007, p.33475, (Adoption: 18/09/2007, Entry in force: 01/10/2007)

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

- 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 substances used in the illicit production of narcotics and psychotropic substances
- Grand ducal decree of 6 **February 1997** regarding substances listed in schedules III and IV of the UN Convention on psychotropic substances of 21 February 1971.
- Grand ducal decree of **30 January 2004** modifying the grand ducal decree of 2 February 1995¹³
- Grand ducal decree of **13 February 2007** on the surveillance and commerce of drug precursors¹⁴

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

¹⁰Official 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>

¹³ Official gazette A 2004, (Adoption: 13/02/2007, Entry in force: 22/02/2007)

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

¹⁴ Official gazette A 2007, (Adoption: 30/01/2004, Entry in force: 13/02/2004)

Règlement grand-ducal du 30 janvier 2004 modifiant le règlement grand-ducal modifié du 2 février 1995 relatif à la fabrication et à la mise sur le marché de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes.

- 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 regimentation¹⁵ (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. Meanwhile the referred law has been voted.

- 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**¹⁶ modifying the basic drug law of 19 February 1973 by decriminalising cannabis use, and enhancing the differentiation of penalties according to the type of drug offences and the nature of controlled substances involved and the **grand ducal decree of 30 January 2002**¹⁷ on substitution treatment, have largely contributed to increase the congruity between drug legislations and prosecution routines. Also, current drug legislation and prosecution policies put higher priority on drug dealing and trafficking than on drug consumption and promote harm and risk reduction measures.

- INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES (NNIA)

- Coordination arrangements

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

¹⁵ Loi modifiée du 14 février 1955 concernant la réglementation de la circulation sur toutes les voies publiques. (Entry in force: 07/03/1955)

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

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

At the national level, the co-ordination among the competent ministries takes place in the *Inter-ministerial Commission on Drugs (ICD)*. In 2006, the national drugs coordinator has been appointed chair of the ICD by the Minister of Health. The ICD is composed of senior delegates from the main governmental departments and delegates from selected NGO's and constitutes the top decision level with respect to co-ordination and orientation of actions. Both, the ICD and the Ministry of Health are responsible for the implementation of national drugs strategies and action plans, supervise field activities and are bound to guarantee an effective consultation process with other involved ministries (e.g. Justice, Foreign Affairs). The ICD meets 4 to 6 times yearly. There are four permanent agenda items: the implementation of action plans, the early warning system on drugs, emerging trends and legal changes and international affairs. Outcomes of the ICD meeting are transmitted to all competent ministers and national media in order to ensure complete public visibility.

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 as an advisory body to the government.

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

At the micro-level the drug coordinator meets monthly with conventioned NGOs (collaboration platforms) in order to share information and elaborated responses to emerging trends. A new forum called 'COCSIT' has been created by the specialised drug agencies with the objective to follow up drug trends and to advice national authorities. The national drug coordinator is regularly invited by COCSIT and participates actively in its work.

- National plan and/or strategies

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

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

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

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

A mid-term evaluation of the state of implementation of the 2005-2009 drugs action plan will be published by the end of 2007. A final external output evaluation will be undertaken in the course of 2009.

- Implementation of policies and strategies

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

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 welcomed drug action plans since it enables them to follow up public efforts to fight a problem that is of great concern for them and to compare announced objectives with achieved actions.

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.

As far as the mid-term evaluation of the 2005-2009 drugs action plan is concerned, first results indicated a high progress level in terms of project implementation and increase of required resources.

- BUDGET AND PUBLIC EXPENDITURE¹⁸
 - 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 EMCDDA, a national study on direct economic costs of drug policies and interventions has been performed from 1999 to 2002 and refers to data from 1999 (Origer 2002 b). (*Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies*). The original research report can be accessed under: <http://www.relis.lu>. In the framework of 2006 EMCDDA contractual requirements an update of the Origer 2002 study has been performed and main results are produced in the selected issues section.

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. Figure 1.1 shows the budgetary progression since the implementation of the first drugs action plan (2000 - 2004) and figure 1.2 summarises the annual progression of budget of the Ministry of Health and human resources allocated to drug-related activities to the mid-term evaluation period.

¹⁸ See related chapter in Part B

Fig. 1.1 Annual budget of the Ministry of Health allocated to drug-related activities 2000 - 2006

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)

Fig. 1.2 Annual progression of budget of the Ministry of Health and human resources allocated to drug-related activities 2004 - 2007

Budget Year	2004	2005	2006	2007
Budget (EUR)	5,771,000.-	6,196,000.-	6,584,000.-	6,689,000.-
Annual progression rate	Reference year	7.36%	6.27%	1.59%
Annual cumulative progression rate	Reference year	7.36%	14.09%	15.91%
Dedicated human resources (Full Time Equivalent)	59.5	63.5	69.25	73.5
Annual progression rate	Reference year	6.72%	9.06%	6.14%
Annual cumulative progression rate	Reference year	6.72%	16.39%	23.53%

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

- Funding arrangements

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

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

- SOCIAL AND CULTURAL CONTEXT
 - Public opinions of drug issues (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.

o 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 drugs¹⁹” 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 (nat. representativity).

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

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

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

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

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

¹⁹ EORG (2002). Public opinion regarding attitudes and opinions of young people in the European Union on drugs

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

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

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

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

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

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

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

- Initiatives in Parliament and civil society

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

The amendment of the national driving code allows police forces, among other changes, to use new drug detection devices for roadside testing. A new anti-tobacco law came into force in 2006 that among other measures prohibits smoking in restaurants and the selling of cigarettes to minors. Taxes on so-called "alcopops" were also increased significantly. The construction project of a permanent building in Luxembourg City hosting the TOXIN centre, which includes the national injection room, was subject to major discussions between the Ministry of Health, the City of Luxembourg and civil society. Although the necessity of such a centre is widely recognized, the location this permanent centre should be constructed on is largely controversial.

- Media representations

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

The NFP performed routine analysis of main daily and weekly Luxembourg newspapers published between August 2006 and July 2007. The screening revealed that nearly 30% of the articles covered themes of supply reduction. They mainly addressed drug traffic, drug seizures, arrests and court decisions and addressed the evolution of the drug scene in the area of the main railway station of Luxembourg City. Special interest was put on the impact of the drug consumption room. The future construction of a permanent building (replacing the temporary structure near the central railway station) was frequently mentioned in press. Articles covering themes like driving under influence (of alcohol, cannabis or other substances) have been largely discussed. The danger of designer drinks (alcopops) for youngsters, as well as alcohol abuse, continue to be important topics. Articles concerning NGOs mainly referred to annual reports and their local activity. Some major weekly newspapers focussed on national drug policies and the national drugs action plan. The tendency to refer to a more holistic concept of addictions has been observed. Gambling and other addictive behaviours have been largely discussed. A number of articles informed about the launch of the EMCDDA annual report 2006 as also the launch of the national focal point RELIS 2006 report, including main information about the European and national drug situations. The Reitox Academy on public expenditures was also an important topic in several local newspapers.

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 General Population and specific sub-groups

Overview

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

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

Prevalence estimations on drug use in the general population are based on data collected in more (e.g. schools) or less (general population: age group 15-64 years) targeted and representative samples of the national overall population. According to the most recent surveys, cannabis and 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 (NNIA)

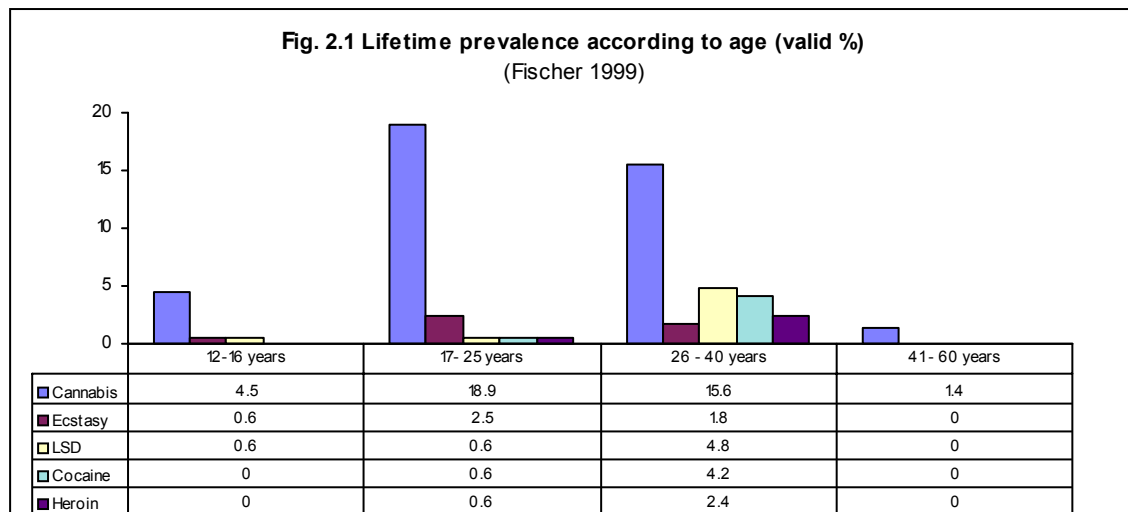
To date, no national, large-scale (representative) general population survey on drug use has been conducted. Several community or targeted population surveys however allow estimating current prevalence. It should be stressed that a new HBSC study is underway. The section on drug use in youngsters will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

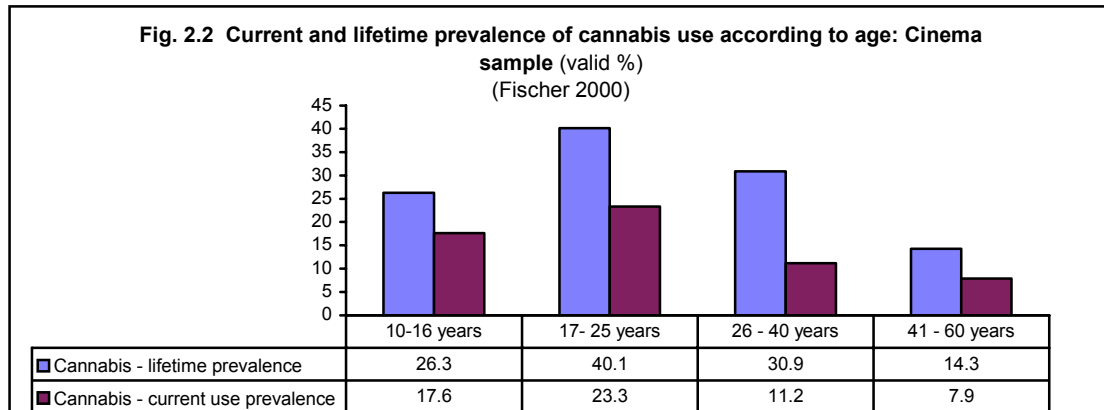


A second survey organized by the CePT was published in 2000 (“Fischer 2000 study”). Even if cannabis consumption was the main subject of the study, several other substances have been taken into account. The samples have been drawn on the one hand from a cinema visitor’s population in Luxembourg City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

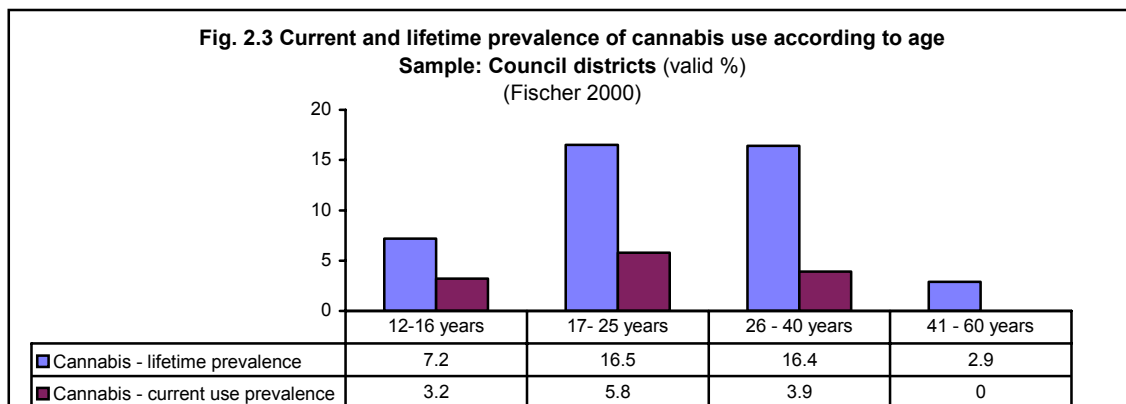
Year of data collection	1999
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	Cinemas in Luxembourg-City
Age range	15-64 years
Data coll. Procedure	On-site interviews
Sample size	991 valid cases
Sampling procedure	Random sampling of cinema customers

Remark *Detailed results of both surveys are provided in EMCDDA standard tables*



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

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



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

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

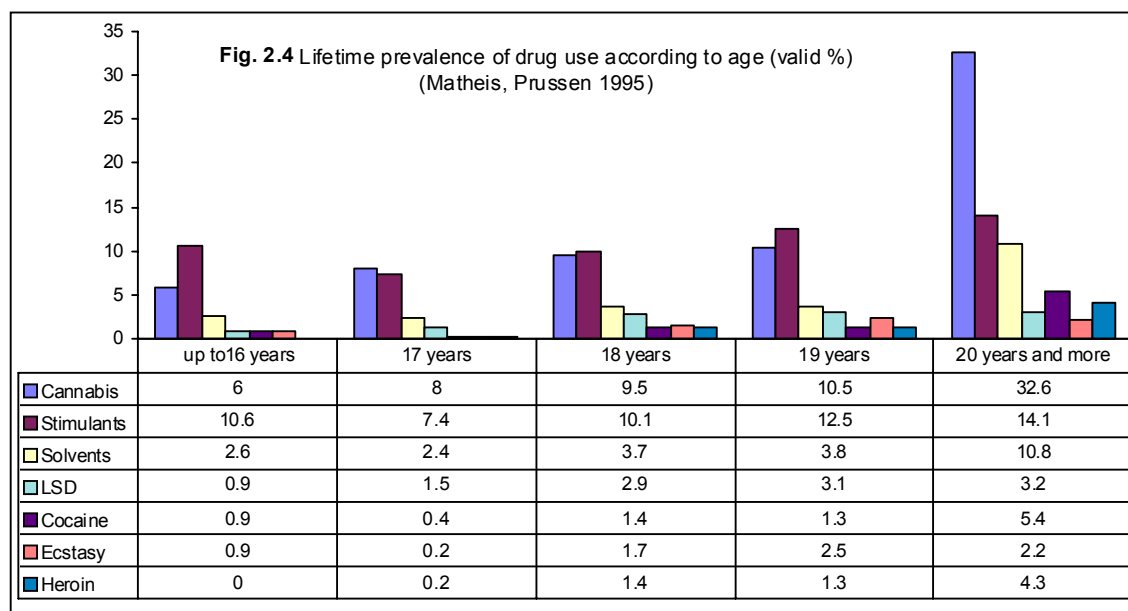
- DRUG USE IN THE SCHOOL AND YOUTH POPULATION

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

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.

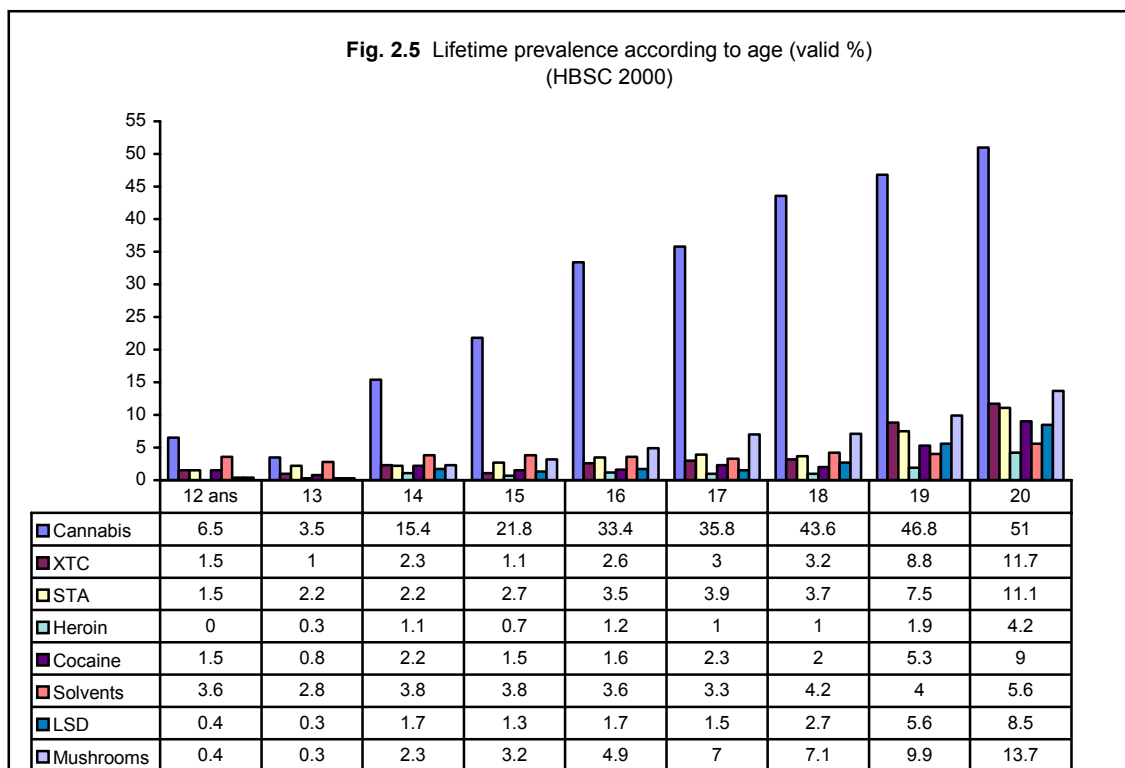


REFERENCE 2:	Dickes P. et al. (1996), La consommation de drogues légales et illégales des élèves des 6^{ième} de l'enseignement secondaire et des 8^{ième} de l'enseignement secondaire technique, CEPS/INSTEAD. Luxembourg. EN.: The use of licit and illicit drugs by students in 6th and 8th classes of national secondary schools.
Year of data collection	1994
Single/repeated study	Single study
Context	Drug prevention. Commissioned by the National Drug Prevention Centre (CePT)
Area covered	City of Luxembourg
Type of school	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 : Dickes 1996

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

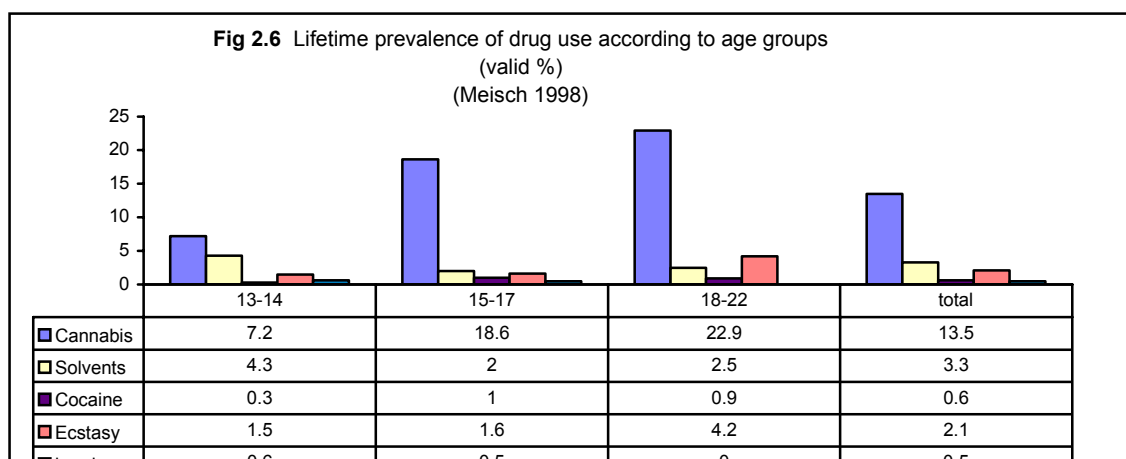


The consumption of illegal drugs has clearly increased the last years. A comparison of the Matheis 1992 study and the most recent HBSC 2000 study reveal that in 1992, 18.1% of secondary school students of 5th class in secondary school (16-20 years) declared having had contact with illegal drugs. In 2000,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

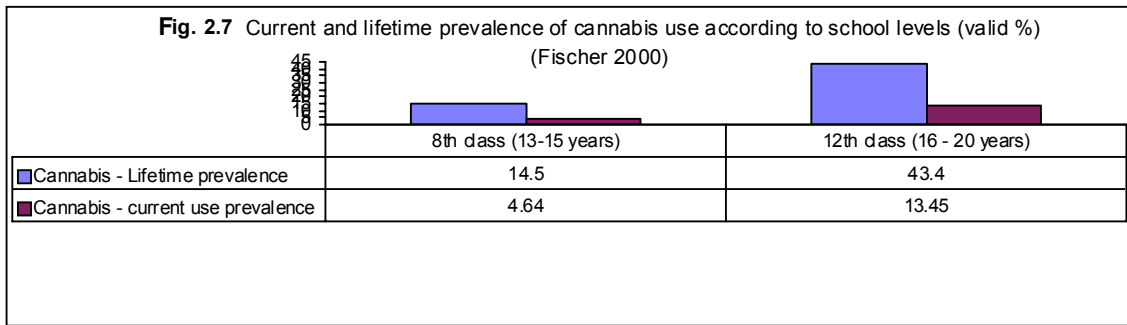
proportion effectively develops a related dependency. Cannabis consumption however increased the last years. A major proportion of students (15.1%), not especially youngsters from risk groups, reported repeated cannabis consumption over the last year.

Surveys: category 2

REFERENCE 4 :	Meisch, P. (1998), Les drogues de type ecstasy au Grand-duché de Luxembourg, CePT, Luxembourg. EN: Ecstasy type drugs in the G. D. of Luxembourg
Year of data collection	1997
Single/repeated study	Single
Context	Public Health – primary drug prevention
Area covered	Nation wide
Type of school	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%



SYNOPSIS OF MAIN COMPARABLE RESULTS AND OBSERVED TRENDS

LIFETIME PREVALENCE: SCHOOL POPULATION:

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

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

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

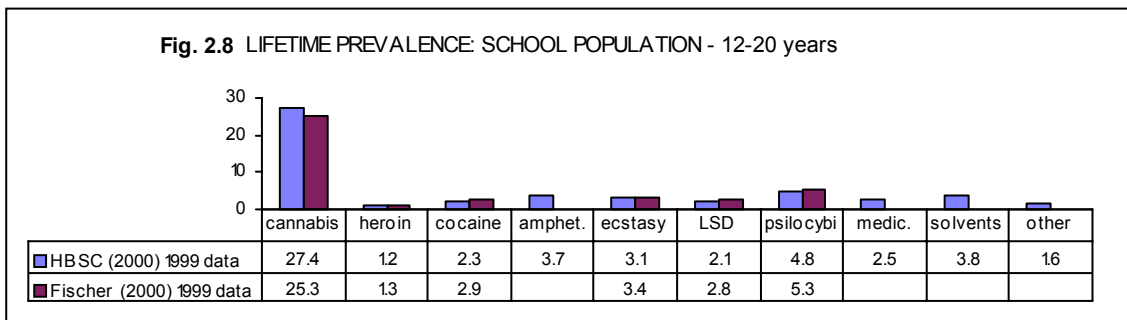


Fig. 2.9 LIFETIME PREVALENCE: SCHOOL POPULATION - 16-20 years

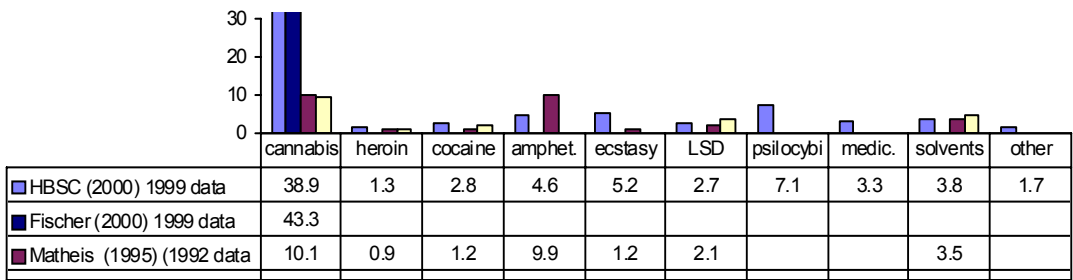


Fig. 2.10 LIFETIME PREVALENCE: SCHOOL POPULATION - 13-14 years

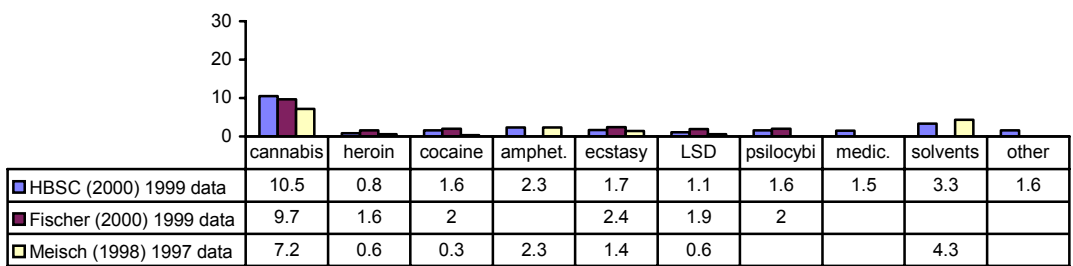
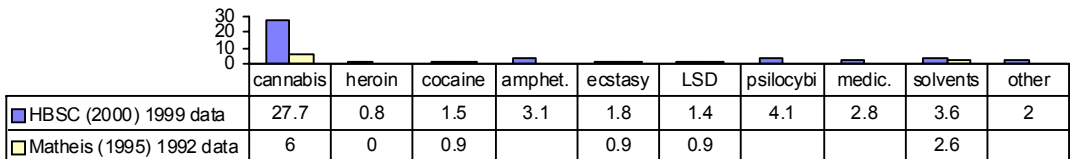


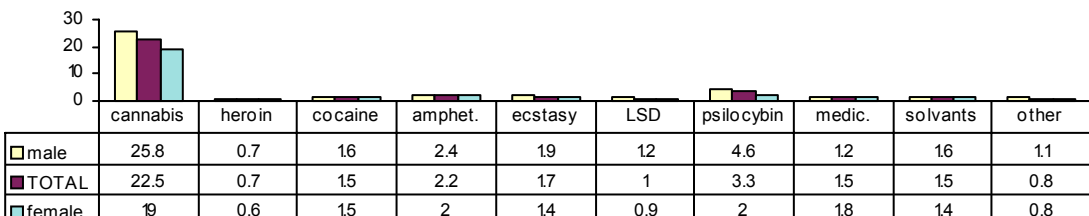
Fig. 2.11 LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years



LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

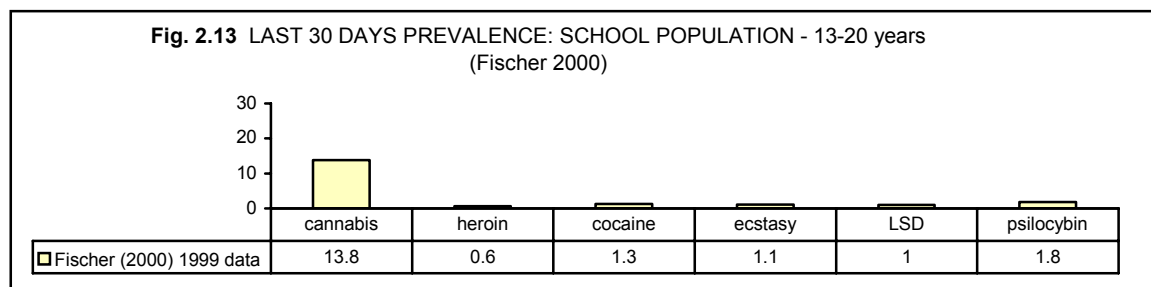
The HBSC survey (2000) is the only to provide last 12 months national prevalence figures in 12 to 20 years aged schoolchildren. Results mirror respective proportions of lifetime prevalence rates with particular emphasis on high cannabis (22.5%), psilocybin (3.3%) and amphetamines (2.2%) prevalence. Gender 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.

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



LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

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



- DRUG USE AMONG SPECIFIC GROUPS

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

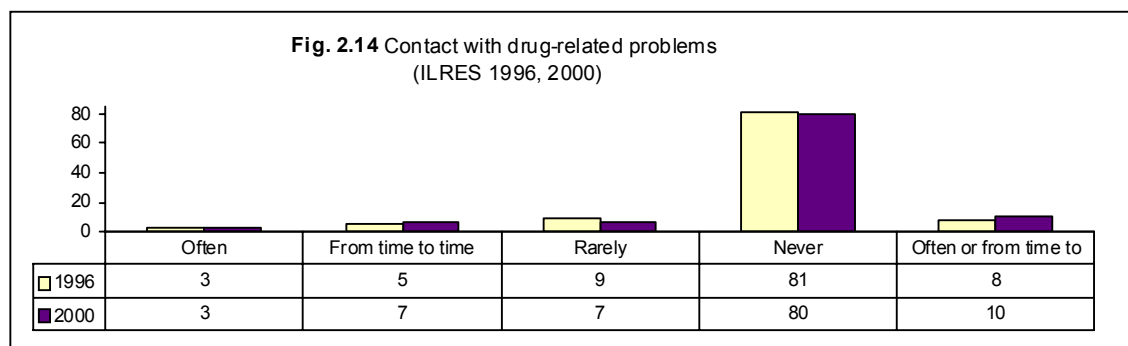
REFERENCE c.1	Origer A., Removille N., (2007) Prévalence et propagation des hépatites virales A,B,C et du HIV au sein de la population problématique de drogues d'acquisition illicite, Point Focal OEDT / CES / CRP-Santé. Luxembourg. EN: Prevalence study on HIV, HCV, HBV and HAV in PDUs In Luxembourg
Year	1995
Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence national PDU population
Area covered	In- and outpatient drug agencies and national prisons
Type sample	Random sampling during 8 months in 2005
Age range	> 17
Data coll. Procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES AND SEROLOGICAL TESTING
Sample size	366
Sampling frame	Random sampling
Response rate (M, F, T)	33.96%
MAIN RESULTS:	
<ul style="list-style-type: none"> - 67.21% of PDUs reported at least 1 prison stay during the last 10 years - of which 56.1% report drug use in prison - of which 54.3% report IVDU in prison 	

- ATTITUDES TO DRUGS AND DRUG USERS

Worth mentioning here are the serial surveys performed by ILRES in 1996 and 2000 in the framework of EUROBAROMETER wave surveys n°44.3 (1996) and 54.4 (2000) (EC 2001).

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

Figure 2.14 presents the distribution of answers to the question: ‘Over the last 12 months, how often were you personally in contact with drug-related problems in the area where you live?’ (e.g. seeing people dealing in drugs, taking or using drugs, finding used syringes, etc.).



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 specialised²⁰ 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 'Recherche et Innovation Pédagogiques et Technologiques (SCRIPT)' department is actively involved in the referred training activities. The Department for Scientific and Applied Research may finance training activities following request. In the framework of its 10th anniversary, the CepT published a manual on the training of multipliers in primary drug prevention available at www.cept.lu.

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

²⁰ 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.

- UNIVERSAL PREVENTION
 - School

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

The **CPOS** is permanently represented in all secondary schools by at least one trained psychologist and several ad hoc teachers. In major schools there are supplementary trained social workers. Among other tasks, they are supposed to detect, at the very early stage, problems or behaviours in relation to substance abuse. Drug and addiction topics are included in more general courses as for instance, hygiene or ethics, which might not be mandatory. However, on the school director's demand, trained staff from the CePT does intervene. Furthermore, the Grand-Ducal Police organises school courses for the 6th classes of primary school and 7th classes of secondary schools provided by specialized police teams out of regional police units and from the drug department of the Judicial Police.

In recent years particular attention has been paid to:

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

In 2006, 800 hours of information sessions have been provided to 130 schools and other organizations. The same amount of hours has already been provided in October 2007.

In 2000, the CePT in collaboration with the SCRIPT started a pilot project called 'd'Schoul op der Sich' (**School on quest**) (see EDDRA and standard table 19) running for two years and having been evaluated in 2003. The aim of this participative project consisted in creating prevention groups among all participating secondary schools in order to initiate a process of reflection on drug related themes.

Meanwhile, three basic training sessions were offered to the project partners by the CePT and the Police, a two-years training module for teachers was offered by the SCRIPT and a further training of "multipliers in primary prevention" was organised by the CePT.

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

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 Institut (NL), the CePT actively participates in the development of improved and innovative instruments and approaches in the field of drug prevention in schools. Specific workgroups address concepts such as multipliers, evaluation or monitoring systems. A European manual on drug prevention in schools documents the final outcome of the EHSD project. In 2002 was published the manual “Making schools a healthier place- manual on effective school-based drug prevention”.

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

- Family

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

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

been released in 2002. In 2004, seminars on the “prevention boxes” took place in different communities participating in the project of addiction prevention in local communities.

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

- Community

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

Generally speaking, local and regional communities do rarely dispose of a comprehensive drug prevention strategy. Commonly, a given national agency initiates projects, defines the general intervention framework and seeks active collaboration with community authorities in order to meet local needs. The observed situation is mainly due to geographical parameters of the Grand Duchy. At present only two agencies focus on interventions in recreational settings, namely the CePT (community project²¹) and the MSF Solidarity Youth (on site-interventions planned).

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

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

- SELECTIVE

- 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.

²¹ 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.

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

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

In this respect, the demand reduction activities organised by the “Mondorf Group” (joint initiatives of border regions of France, Germany, Belgium and Luxembourg) jointly with the CePT and SNJ combine a **non drug-centred approach** with **intercultural components** in organising corporate leisure activities for youngsters from border countries based on the concept of “**adventure pedagogy**”. The annual “**adventure weeks** ²²” 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.

²² See EDDRA

The **law of 29 June 1989** on taverns (inns)²³ 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 Labour²⁴ and the ministry of Health.

The governmental declaration of 2004 puts emphasis on the risks of alcoholic mix-drinks (alcopops) and the high prevalence among youngsters. A special working group chaired by the Ministry of Health has proposed further measures to reducing the consumption of alcohol and alcopops. Measures implemented by 2006 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 special working group continues its work for an undefined duration.

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, but not performed thus far.

- 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 assessing whether a participation in the CHOICE project or an individual psychological follow up is indicated. A CHOICE group consists of four interactive sessions (6 to 8 participants) which provide information on drugs, legislation and treatment services, promote auto-reflexion, reinforcement of personnel skills and motivation to change attitudes towards drugs.

In a first phase, the project is regionally limited to the judicial district of Luxembourg City. Police 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. In 2006, 52 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 youngsters with regard to polydrug use and in particular the increasing use of alcoholic mix-drinks.

²³ Loi du 29 juin 1989 portant réforme du régime des cabarets. Entry in force 29/06/1989

²⁴ 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.

Furthermore, special attention is currently given to Youngsters and to the local **Portuguese community**. In the framework of the EU PIC-Equal programme, a project on ethno-specific prevention measures is about to be set-up. The latter focuses on linguistic and socio-cultural specificities of ethnic minorities and in particular Portuguese natives. Budgetary means are foreseen for 2007 to implement specific prevention and treatment options for **recent immigrants**. More precisely a project called "DIM" (Early intervention mobile) is meant to inform on risk behaviour and provide free infectious disease testing in difficult to access populations, such as 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.

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

- INDICATED PREVENTION
 - Children at risk with individually attributable risk factors

See Part B, chapter 12 (vulnerable groups).

4. Problem Drug Use and the Treatment Demand Population

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.

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

Intravenous heroin use associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. The recent increase in low quality cocaine use in combination with heroin has not been confirmed by 2006 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'²⁵ recently detected in other EU Member States has not been reported thus far.

All indicators on **cannabis use** (problematic and recreational) have been on the increase for several years but tend to stabilise more recently. Cannabis showing high THC concentrations (max: 25%, 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 **PDU 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.

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 7 years. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2006.

- PREVALENCE AND INCIDENCE ESTIMATES OF PDU

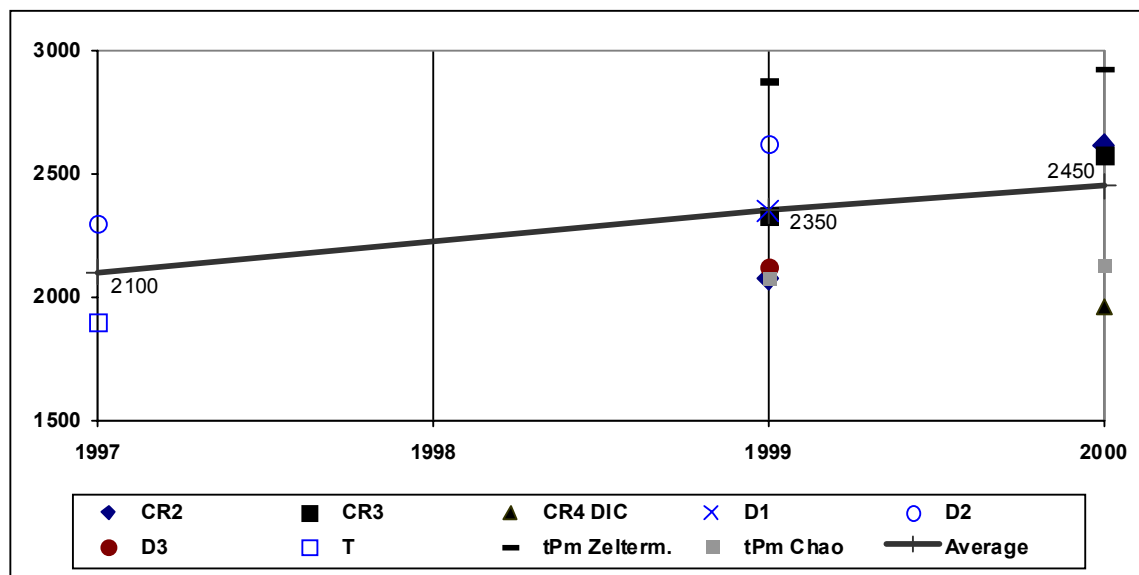
Data presented in the present chapter have been provided by the latest drug prevalence study on PDUs aged between 15 and 64 years (hereinafter referred to "2001 study") conducted by the focal point between 1999 and 2001 (Origer 2001)²⁶ and refers to the years 1999 and 2000. Since there have been no national 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).

²⁵ Substances such as MBDB, 4-MTA, Ketamin, PMMA 2C-I, 2C-T-2, 2C-T-7, 2C-D, 2C-E, TMA-2, BZP, TFMPP, 5-MeO-DIPT, 5-MeO-DMT, AMT, ALEPH 7, DXM, DPT, mCPP.

²⁶ Downloadable at <http://www.relis.lu>

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



Source: Origer 2001

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

	1997	1999	2000
GENERAL POPULATION			
National population on 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: MAIN DRUG – HEROIN			
Prevalence heroin	1,680	1,975	2,010
Total prevalence rate – heroin	4 / ¹⁰⁰⁰	4.57 / ¹⁰⁰⁰	4.58 / ¹⁰⁰⁰
Total prevalence rate – heroin – age: 15-54	7 / ¹⁰⁰⁰	8.05 / ¹⁰⁰⁰	8.09 / ¹⁰⁰⁰
INTRAVENOUS DRUG USE (IVDU)			
Prevalence IVDU	1.370	1.780	1.715
Total prevalence rate – IVDU	3.25 / ¹⁰⁰⁰	4.12 / ¹⁰⁰⁰	3.91 / ¹⁰⁰⁰
Total prevalence rate – IVDU – age: 15-54	5.71 / ¹⁰⁰⁰	7.26 / ¹⁰⁰⁰	6.90 / ¹⁰⁰⁰

Source: Origer 2001

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

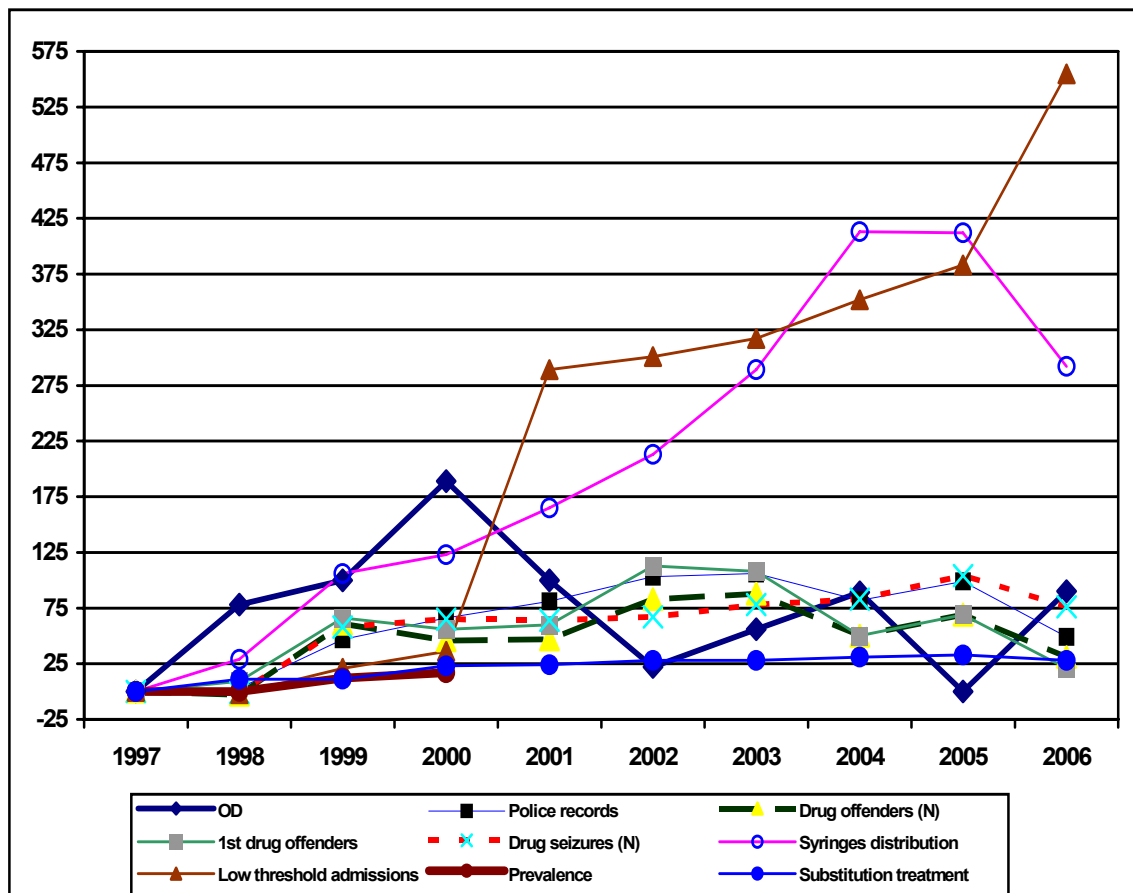
As can be seen in graph 4.2., all indirect indicators, except number of acute drug deaths and low threshold contacts, have been showing a significant downward trend. The fact that the number of ODs has increased in 2006 mismatches the evolution of all other indirect indicators. A special expert group currently studies this phenomenon which may be due more to changes in consume patterns than it indicates an increase in PDUs. Number of low threshold admission have known an increase primarily because low threshold offers have been diversified and opening hours enlarged and thus do not allow

to state an increase in the drug population prevalence. Substitution treatment demands are on the decrease for the first time since the creation of the substitution programme.

Taking into account the previous comments, one may state that **PDU prevalence tends to stabilise, or maybe even to decrease** at the national level. A second national drug prevalence study, which is foreseen for year 2009, in the framework of a final evaluation of the drugs action plan will provide more 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 careers than males). Currently the main drug to be found on the drug market is low quality cocaine.
- The exclusive '**cocaine scene**' is described as a fairly dispersed one and difficult to access since cocaine consume mainly takes place in privacy. Typical cocaine users/abusers are middle age men of upper classes. Recently, however, cocaine use has largely spread within the street PDU population.

CHARACTERISTICS OF INDEXED PDUs

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

The **number of problem PDUs** indexed by national institutions in 2006 figures 4.580(2002: 4,701) (in this figure double counting is included meaning that a given person could have been indexed twice and more by different institutions. It is thus not representing the actual prevalence, which has to be assessed by other methods). For comparison, 2,383 users have been indexed by national specialised drug demand reduction agencies and 2,318 drug law offenders by supply reduction agencies in 2002. In 2006 the same agencies have indexed 2,764 and 1,816 persons respectively. As the frequency of multiple contacts did not change over recent years, these figures suggest that in total and since 2002 fewer persons have come in contact with drug agencies and even more positive is the fact that an increasing proportion of PDUs seek contact with treatment services and less show contacts with law enforcement agencies.

10% (5%) of respondents are first treatment demanders, all treatment centres included. More recently, one has observed a stabilization 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. Although the proportion stabilised since then, it is still consistently higher than the one observed in general population. Notably, one observes a remarkable increase of PDUs of French origin (22%). This trend is confirmed by last 6-years data on drug law offenders.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 30 years and 11 months in 2006. 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 88% and 43% of current PDUs have tried cannabis and heroin (i.v.) while being minor of age. In 1995 the same proportions figured 71% and 23%. Most interestingly evolution of drug use patterns tend to accelerate in terms of shorter time spans separating first non-iv use from first iv-use. This acceleration is also observed as far as first treatment demands are concerned. PDUs tend to contact drug treatment facilities at an earlier stage, which may be due to a more diversified offer currently available.

The mean age of native and non-native problem drug users tends to balance. **Average age at first use of illicit HRC drugs** has decreased approximately 3 years from 1995 to 2004 and increased again in 2006 (2004:12Y8M; 2006:15Y3M). In 2006 age of first use of cocaine (iv/non-iv) 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.

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** 88% has reached stabilisation after a record level in 2004 (92%). As already indicated, the switch to intravenous drug use occurs earlier. The ratio of **intravenous** opiates consume to the **inhalation** mode 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: 25%, 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 and stabilised in 2005/2006. **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 (41,8%) and the centre region (38,3%) are the most representative. The northern region (13,7%), 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 2006 (72%). 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.

- TREATMENT DEMAND INDICATOR
 - 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 80% (60% iv / 20% non iv). In 2006, an increase of 10% in preference for intravenous heroin use was noted compared to 2005. The heroin inhalation **mode** has stabilised for several years. Polydrug use is the most observed consume pattern (88%). The i.v. heroin sub-population shows the highest mean age (32Y6M) of all treatment groups. 6% of the latter are **first treatment** demanders compared to 8% of non-iv heroin users.

Cocaine use as main reason of treatment demand showed a significant increase in 2004 and 2005 (20%) and decreased again in 2006 (14%), which is consistent with current supply indicators. Mean age of preferential cocaine using treatment demanders is 27 years and 1 month. With 7% (5%) 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 39% in 2006. **Crack** is never 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 and tends to decrease since 2004. Treatment demands related to **ecstasy use** are rare (1-3%) and have shown a fair stability over the last years. The same comments apply to **ATS use**.

By centre types

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

The proportion of **first treatment demanders** observed in 2006 was 10% (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 **decreasing admission rates and first treatment rates** between 2004 and 2006. Gender distribution shows a **weak upward trend in female treatment demanders** (2006: 42% / 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 57% (2005: 58%) has sensibly increased, during recent years. The proportion of **underage treatment demanders** (4.8%) 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 3 years now (2006: 51% / 2005: 47% / 1997: 72%). **Cannabis-related demands** have shown a clear upward trend since 2000 (2003: 15% / 1997: 1%) and stabilised after 2003 (2006: 13%), which may also be due to the development of specialised treatment offers for minors. The prevalence of **problem cocaine use** has stabilised.

➤ Outpatient, underage

Specialised drug care agencies for minors only exist in the centre of the country. The **rate of new treatment demanders** has discontinuously increased since the implementation of the referred agencies. Gender distribution in minor treatment demanders has been showing a slow decrease over recent years (2006: 30%). The proportion of clients aged below 15 (33.7%) has decreased since 2002. Cannabis use is the main reason of treatment demands (73.3%, stable), followed by heroin and polydrug use.

➤ Inpatient, drug therapy

The proportion of **new clients** has increased in inpatient therapy settings in past years. The proportion of **male treatment demanders** has increased during recent years and stabilised in 2006 (74%) as well as the observed mean age (2006: 30Y7M / 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. +/- 600 patients in 2006). **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 (105) 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 (32% 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** tends to stabilise [(939 patients in 2006 multiple counts excluded (2005: 970))].

➤ Low threshold services

The **number of contacts** indexed by low threshold agencies has increased dramatically over the last ten years (2006: 63,129 / 2005: 47,739 / 1996: 6,456), and so has the number of syringes distributed by the same agencies, although the number of syringes distributed in 2005 has stabilised for the first time since the existence of the national NEP and even decreased in 2006 (see Fig. 4.2.). The proportion of **new clients** within low threshold settings is on the increase. The number of **female clients** has been showing a weak but constant decrease (currently stable at 21%). Approximately 65% of clients are aged between 19 and 34 years, and a higher proportion of clients aged 35 and more is observed.

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'.²⁷

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 measures²⁸:** 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

²⁷ **SOURCE:** Classification of drug treatment in EU member states and Norway, Expert meeting, 8-9 February 2002

²⁸ 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.

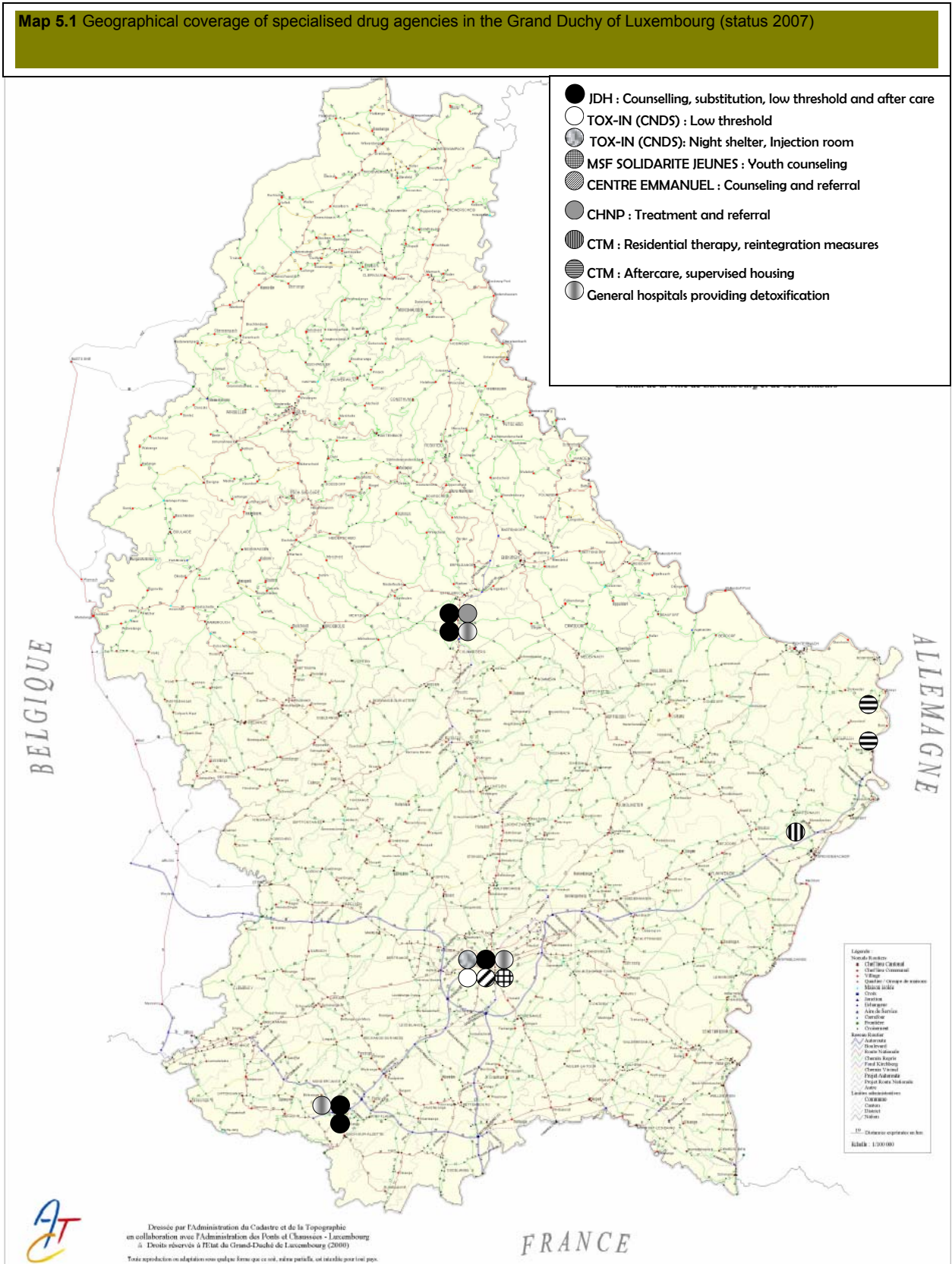
demanders. In general, a continuous yet **decelerating** increase of the number of drug treatment demanders is observed.

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.

As can be seen on map 5.1 drug treatment facilities are regionalised showing however a high concentration and diversity within the area of Luxembourg City. All listed services are specialised with the exception of regional general hospitals providing detoxification treatment. In June 2005, the first ‘consumption room’ has been opened in Luxembourg City, 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.

- TREATMENT SYSTEMS

Map 5.1 Geographical coverage of specialised drug agencies in the Grand Duchy of Luxembourg (status 2007)



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)²⁹ and the subsequent grand ducal decree of 10 December 1998³⁰, 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. Drug treatment agencies have developed proper **evaluation strategies** mostly in collaboration with external evaluators. Recent examples are the evaluation of current offers in the field of socio-professional integration, which future development has been promoted by the national drugs action plan, the implementation of a computer based evaluation procedure by the national substitution programme and prevention interventions in schools by CePT.

Also, the **RELIS database** on problem drug users provides relevant data for evaluation purposes since it includes detailed data on drug consume patterns, socio-economic situation, risk behaviour and treatment or law enforcement contacts, etc. In the long run, drug 'careers' can be analysed by means of the RELIS indexing system, which allows following up treatment demands and law enforcement contacts of indexed drug users. These data can be used to assess the impact and the performance of specific treatment approaches. A practical example of the application of evaluation results is to be seen in the conceptualisation of the national drug action plan 2000-2004, which did greatly rely on RELIS data and ad hoc evaluation initiatives from field institutions. Table 5.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 2006. **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.

²⁹ 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)

³⁰ Règlement grand-ducal du 10 décembre 1998 concernant l'agrément à accorder aux gestionnaires de services dans les domaines médico-social et thérapeutique (entry in force 18/12/1998)

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

SETTING	NUMBER OF ADMISSIONS (A) AND/ OR CONSULTATIONS (C) AND/OR CONTACTS (CO)						NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)					
	98	2000	2002	2004	2005	2006	98	2000	2002	2004	2005	2006
DEMAND REDUCTION: SPECIALISED DRUG TREATMENT												
OUTPATIENT												
- Drug Free	1,089	2,185	3,412	4,312	4,682	4,597	535	636	828	916	876	928
- Substitution	/	/	/	/	/	/	986	1,002	1,040	1,065	1,084	1,044
INPATIENT												
- Drug free	39	43	57	53	35	44	127	158	153	182	176	183
- Detoxification	/	/	/	/	/	/	243	316	289	382	568	600 ³¹
LOW THRESHOLD AGENCIES	9,499	13,083	29,536	39,526	47,730	63,129						
SUB TOTAL A: Number of drug treatment demanders (Multiple counts not excluded) (Multiple counts excluded)							1,891 n.a.	2,112 637	2,310 n.a.	2,545 n.a.	2,704 n.a.	2,755 n.a.
SUPPLY REDUCTION: LAW ENFORCEMENT INSTITUTIONS												
National prisons							167	161	101	92	247	243
Police - Judicial Police - Customs							1,170	1,758	2,217	1,808	2,034	1,573
SUB TOTAL B: Number of drug law offenders (Multiple counts not excluded)							1,337	1,919	2,318	1,900	2,281	1,816
TOTAL NUMBER OF PERSON SHOWING DRUG RELATED INSTITUTIONAL CONTACTS (Multiple counts not excluded)							3,228	4,031	4,628	4,445	4,985	4,571

Source: RELIS 2006

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

As far as drug treatment demanders are concerned one observes a fairly stable situation for the last 3 years. Substitution treatment demands are remarkably stable and Outpatient counselling have even been showing a decreasing trend during the same period.

If treatment demands and drug law offences are added to serve as an indicator it is reasonable to presume that the national PDU prevalence has stabilised since 2002.

³¹ Estimated since ICD-10 episodes' data were not yet available at the time of editing

- DRUG FREE TREATMENT

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

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

For the 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 stay varies from 3 months to 1 year.

In addition to individual and group therapies, the centre offers the opportunity to follow training activities in several professional domains and post therapeutic accommodation facilities. The final objective is the psychological, professional and social reintegration of treated clients. The latter is highly facilitated by the quality of provided professional training to patients. The collaboration with several employers willing to employ ex-drug addicts and the active involvement of social services 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 map 5.1) 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 (1996-2006)

AGE GROUP	1996	1998	2000	2002	2004	2005	2006	Males (2006)		Females (2006)	
	N	N	N	N	N	N	N	N	%	N	%
< 20 years			3	5	3	3	1	1	1.2	0	0
20 à 25 years			33	33	37	29	41	25	29.4	16	51.6
> 25 years			66	63	72	89	74	59	30.6	15	48.4
TOTAL	55	71	102	101	112	121	116	85	100	31	100
Mean age			27Y9M	28Y	28Y5M	30Y7M	30Y	31		27	

Source : Administration du Contrôle Médical : Cures de désintoxication (drogues dures et polytoxicomanie) à l'étranger - Exercices 1996-2006

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 referred case management programme has filled a current gap in the care system for minors.

- PHARMACOLOGICALLY 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. The 'Hôpital du Kirchberg' 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)
- Centre Hospitalier Emile Mayrisch – HVEA (South)
- Centre Hospitalier de Luxembourg – CHL (Centre)
- Clinique Ste. Thérèse (Centre)

Hôpital du Kirchberg (Centre)

- Substitution Treatment, Out-Patient

RELEVANT TRENDS: Continuous decrease in number of patients in structured programme and for the first time overall decrease (including low threshold substitution) of national substitution treatment demand - stabilisation of gender ratio (2 males/1female) - Increase of substitution treatment demanders 35 years+.

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 2002³² 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 prescribing MDs and adequate control mechanisms of **multiple prescriptions** (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a **structured substitution treatment programme** (JDH - mainly liquid oral methadone – 105 patients in 2006) provided by specialised agencies (JDH) and a **lower threshold substitution treatment** offer provided by freelance state licensed MDs (MEPHENON ®, METHADICT ® and SUBUTEX ®).

Until 2001 methadone and buprenorphine have been prescribed as part of a long-term treatment with a medium or long-term abstinence goal. There are, however, a series of cases in which substitution treatment has to be considered rather as a harm reduction or maintenance measure than 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.

³² The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>

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, a **central substitution register** is about to be implemented jointly by the ‘Surveillance Commission on Substitution Treatment’³³, the national drug coordinator and involved specialised treatment centres. The permission for its creation has been granted by the national data protection commission in June 2006 and it should be operational by the end 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	2006
Number of indexed patients (double counting controlled)	745	844	849	820	913	/	970	939
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	121

Source : Union des Caisses de Maladie 2006

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

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

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

³³ 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.

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'.

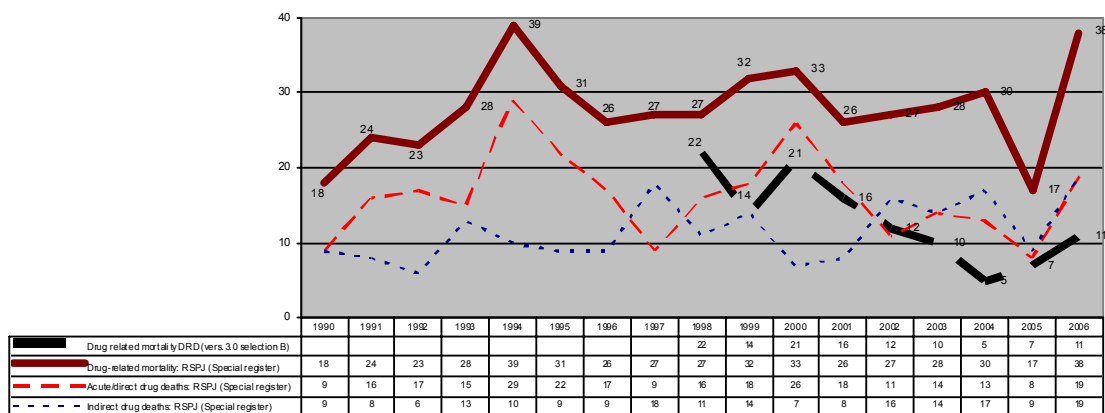
2. **The statistical department of the Directorate of Health maintains the General Mortality Register (GMR)** indexing all deaths that occurred on the national territory by means of death certificates provided by GPs. Since 1998 the GMR applies the 10th revision of the International Classification of 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 (2007) study on infectious diseased in PDUs applying serological test results to assess current prevalence rates and apply vaccination schemes if medically indicated.

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

Based on the outcome of the study: 'Epidemiological study on drug-related deaths and on the 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.

Figure 6.1 Evolution of drug-related death cases (direct - indirect - total mortality) from 1990 to 2006 (Origer 2007)



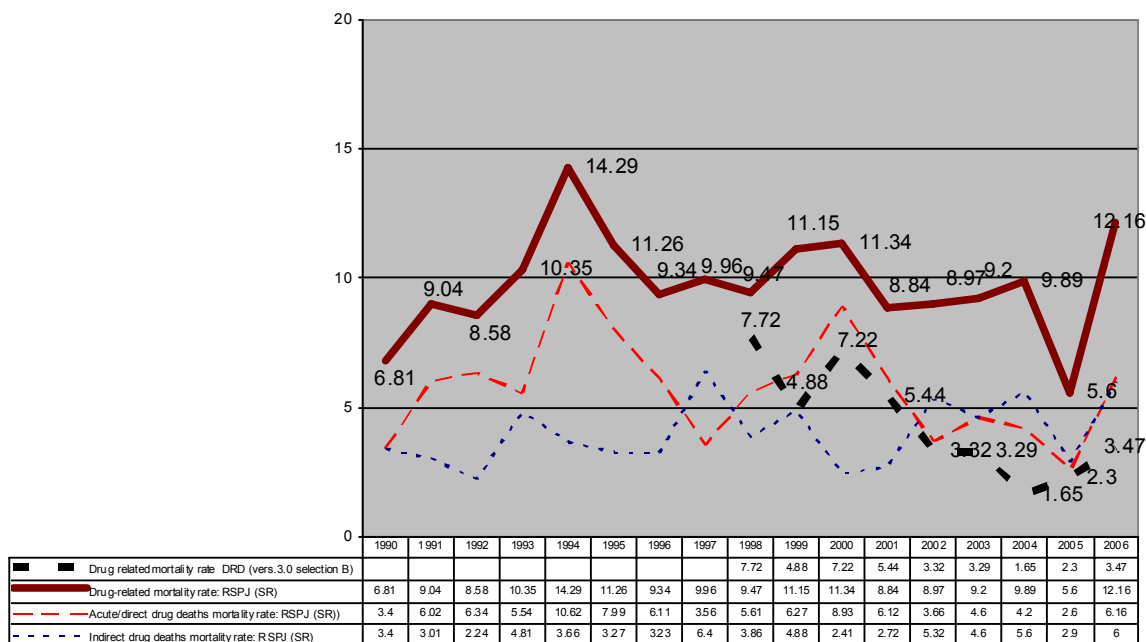
As can be seen in figure 6.1 the DRD v. 3.0 standard (selection B) appears to be a fair proxy of direct/acute drug deaths as indexed nationally by the RSPJ. Overall drug related mortality, however, should not be assessed by the same standard as far as Luxembourg is concerned.

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. A new upward trend is observed in 2006 and will probably be confirmed by 2007 data. This trend is unfortunately consistent with latest developments in most other EU Member states.

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

The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants³⁴ 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 2006 overdose rates of 4.13 and 6.16 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed.

Figure 6.2 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2006 (Origer 2007)



The overall discontinuous decrease of acute overdose cases from 1994 onwards has been associated to the regionalisation and extension of the methadone substitution programme as well as to the further development of low threshold facilities. Whether the latest **upward trend in acute drug deaths** is due to increasing drug user prevalence, a changing drug market profile and use patterns, remains uncertain. A national expert group, jointly with the national drug coordinator is analysing potential risk factors and contexts and will report their conclusion and recommendations to the minister of Health.

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). The positive evolution of direct drug deaths is to be associated to the implementation of a drug consumption room in 2005. Considering that since the opening in 2005 of the drugs injection room more than 80 overdose victims could be assisted and reanimated in this same facility, the life-saving effectiveness of such an offer is proven. This said, the actual increase of overdose cases

³⁴ All age groups

in 2006 would be much more important and is associated to other factors that most other Member States seem to be confronted to, to a similar extent.

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

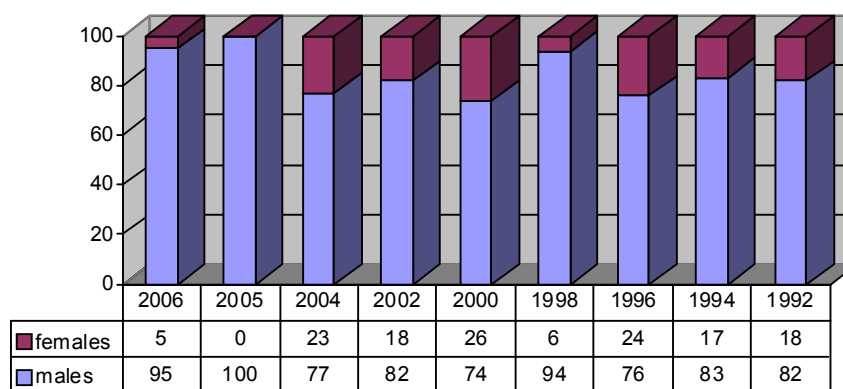
Forensic data by the department of National Toxicology Laboratory on Health³⁵ show that the most frequently involved substance in overdose cases is heroin, followed by methadone and cocaine. To stress that since 2000, methadone presence in blood samples of overdose victims has been increasing.

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

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

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

Figure 6.3 Gender distribution of direct drug-related death cases (1992 - 2006) (%)



Source: RELIS 2006

³⁵ Département de Toxicologie du Laboratoire National de Santé

Table 6.1. Age distribution of direct drug death cases indexed from 1992 to 2006

	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	Total
< 20	1	1				2	1	1			1		3	3		12
20-24	4	2	1		4	2	8	3	2	2	5	6	6	6	6	55
25-29	4	1	4	2	1	5	6	6	5	5	5	10	13	2	6	73
30-34	2	1	3	4	3	2	6	3	2	2	4	5	6	3	3	46
35-39	5	1	2	3	1	5	4	3	4		1	2	1	1		28
40-44	2	1	2	3		2	1	1	3			2			1	16
45-49			1	2	2		1					1			1	7
> 50	1	1									1					2
Mean Age	32.5	31.48	32.17	36.64	31.18	31.5	29	29.35	32.3	26.7	28.5	29.85	26.8	24.6	28.4	239

○ Mortality and causes of deaths among drug users

In terms of **drug-related mortality** (direct and indirect deaths indexed by RSPJ), 38 cases have been indexed in 2006 (17 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)³⁶, 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 [38 in 2006 of which 19 direct/acute death cases (17 & 8 in 2005)].

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

Origer & Dellucci (2002) reported 38 drug-related death cases in 2000. Applied to the estimated number of problematic drug users in 2000 (2,450) (Origer 2001), one obtains a rough **mortality rate of 1.51%**. The difference might be explained by the fact that the cohort study only included IVDUs 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.

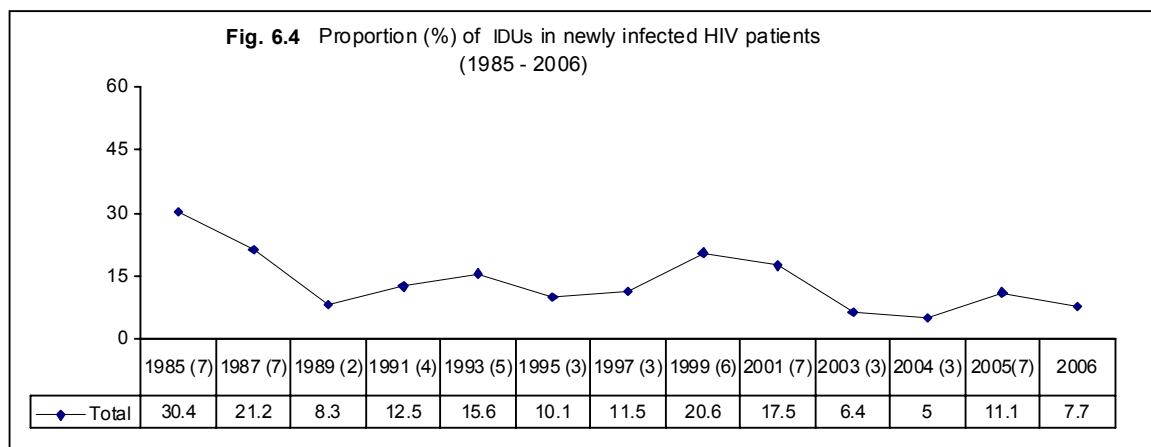
³⁶ A full text version of the study can be downloaded under: <http://www.relis.lu>

Main **causes of indirect deaths between 1996 and 2006** are, in order of importance: suicide (32)³⁷, 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 IVDUs in HIV infected patients**. Between 1984 and 2006, 767 HIV infected persons have been registered at the national level; 103 of the former were reported IVDUs, which leads to an average proportion of IVDUs in the national HIV population of 13.43 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 and figured 52 in 2006.



Source : Laboratoire de Retrovirologie – CRP-Santé. 2007 (data formatting NFP)

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IVDU and treatment status. In 2006, 83% 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 2.76% in 2006. Treatment demanders** show the highest HIV prevalence rate (3.49%).

³⁷ Valid percentage

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

A recent study by Origer and Removille (2007)³⁸ assessed the national prevalence via serological test results HIV, HCV, HAV and HBV in the population of problematic users of illicitly acquired drugs. Furthermore the authors performed a cross sectional analysis of the relation between the studied infections and selected observable factors, to increase the national vaccination coverage and to refer infected persons towards appropriated medical treatment centres. (See ST 9)

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

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 situates around 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 hepatitis B vaccination.

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 26.7% report syringes' exchange in prison. The study also refers to a series of determinants such as, inefficient disinfection methods such as cleaning injection paraphernalia with water or urine, inadequate

³⁸ Downloadable at: <http://www.relis.lu>

syringe elimination, a high proportion of PDUs not using condoms during sexual intercourse, especially with new partners or irregular partners, the lack of or false knowledge of serological status and finally, protection strategies based on subjective criteria rather than on established knowledge.

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

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

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

YEAR	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
HIV rate in problem drug users (RELIS self-report)	3	2.9	2.9	4.3	4.07	4.49	3.88	3.98	3.31	2.9
HIV rate in problem drug users (Origer & Removille, 2007)									2.90	/
HIV rate in drug treatment demanders (RELIS self-report)	3.8	2.6	3.4	4.87	4.78	4.32	3.88	4.93	3.84	3.49
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	2.76
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	3.33
HIV rate in life-time IVDUs (Origer & Removille, 2007)									2.50	/
HIV rate in current IVDUs prisoners (Schlink 1998)	/	4.4	/	/	/	/	/	/	/	/

Source: RELIS 2006

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

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

Source: RELIS 2006

The prevalence of **HBV** infection in problem drug users has been showing a decreasing tendency during recent years based on self-reported data. The results provided by Origer and Removille (2007) study based on blood sample provide slightly higher yet consistent rates in PDUs. The **significant increase of the HCV infection rate** during the same period is particularly marked in 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	2006
HBV rate in drug users (RELIS self-report)	29	30	30	28	25	22	20.51	21.34	18.67	17.21
HBV rate in PDUs (Origer & Removille)									21.6	
HBV rate in drug treatment demanders (RELIS self-report)	/	27	32	27	24	20	19.79	22.69	18.58	16.46
HBV rate in IVDUs (RELIS self-reports)	/	33	35	30	30	25	22.76	23.93	20.08	18.32
HBV rate in ever-injectors (Origer & Removille)									24.7	

Source: RELIS 2006

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

YEAR	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Self-reported HCV rate in drug users (RELIS)	26	25	32	46	50	49	59.92	64.55	64.94	64.95
HCV rate in PDUs (Origer & Removille)									71.40	
Self-reported HCV rate in drug treatment demanders	/	29	41	53	54	54	60.49	66.16	66.22	63.23
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	69.58
HBV rate in ever-injectors (Origer & Removille)									81	

Source: RELIS 2006 (Origer 2007)

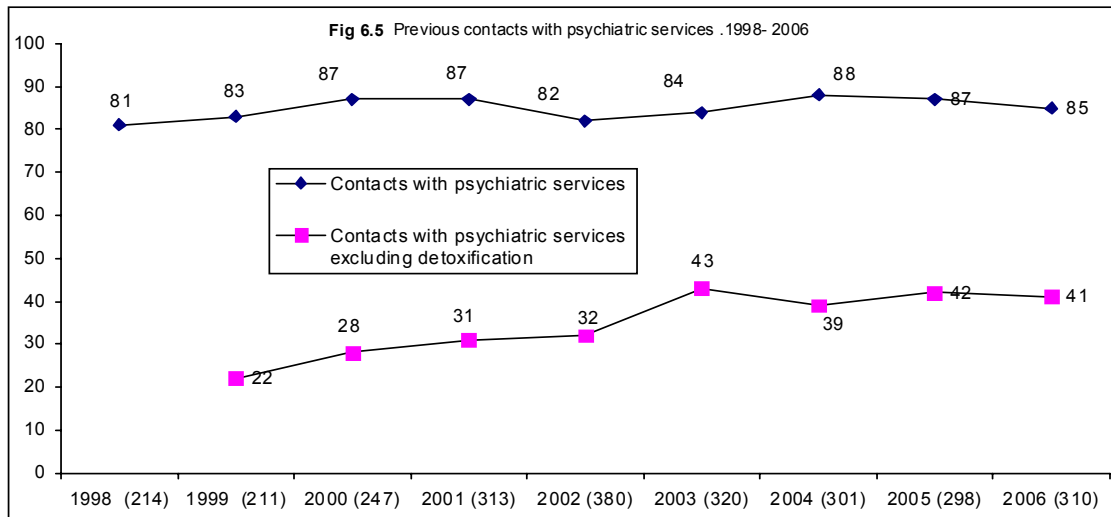
Summarily, HBV infection prevalence in PDUs and in drug treatment demanders is fairly stable while HCV prevalence in PDUs has significantly increased during the last 5 years. HIV infection rates show a decrease especially referred to IVDUs.

- PSYCHIATRIC CO-MORBIDITY (DUAL DIAGNOSIS)
 - Personality disorders, depression, anxiety, affective disorders

To date any genuine study on co-morbidity patterns in PDUs has been performed at the national level. Data presented in the present chapter have been provided by specialised drug agencies and the RELIS drug monitoring system and thus reflect 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 2006

SOURCE: RELIS 2006

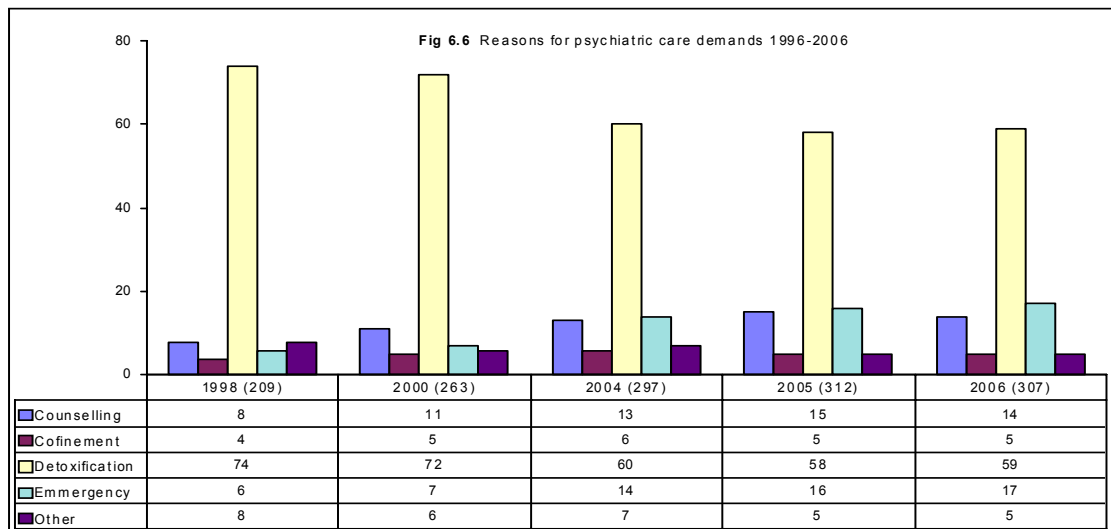


Figure 6.5 differentiates between contacts with psychiatric services and psychiatric contacts excluding detoxification. This distinction is necessary since, at the national level, most of detoxification treatments are provided by psychiatric departments of general hospitals.

Data from 1996 to 2006 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 a therapeutic process. It is therefore most difficult to integrate DD patients in traditional drug care settings also in terms of consistency of rules to be respected by all drug treatment demanders. This specificity has 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.

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

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

Compulsory treatment or confinement does only occur if there is a proved offence against the law by which the offender is declared irresponsible of his/her own behaviour.

This only occurs following a legal psychiatric expertise. Due to the lack of specialised infrastructures, the NFP disposes of no data on DD treatment and outcomes.

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

The above quoted priority areas result from professional experience sharing. As the implementation of drug treatment and prevention strategies are traditionally 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 2006, 84 per cent of problem drug users reported a self-perceived satisfying general health condition against 53 per cent in 1997. Half of indexed PDUs report single or multiple suicide attempt(s) during lifetime. No significant changes have been observed during the last 5 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 specialised drug care agencies as well as by the general health care system. No reliable data and drug treatment demands from general healthcare providers are currently available with the exception of detoxification treatments provided exclusively by psychiatric departments of general hospitals and ambulatory substitution treatment prescribed by authorized 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
 - Overdose prevention

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 reintegration 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 endocarditis.

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 3 pm to 10 pm from Monday to Friday and Sunday.

According to the first two-years' evaluation of the injection room (June 2007), 381 injectors had signed the mandatory user contract and proceeded to 14,330 injections supervised by trained staff. In September 2007 over 450 were already registered. The

facility were mostly used by men (79%); the most commonly used drugs were heroin (81%), cocaine (12%) or both of them (6%); age category 25-34 is most represented (56%). No fatal overdose has occurred thus far but over 80 overdoses have occurred and due to the immediate intervention of ad hoc staff all victims could be assisted, reanimated and saved. No drug scene concentration and no disturbances or nuisance in the neighbourhood have been observed. Over 600 safer use counselling sessions have been provided to clients. 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 in the latter city. The aim is to further decentralise low threshold offers and enhance local city authorities' commitment in the management of regional and urban drug problems. Involved national and local authorities have recently found an agreement on the geographical location of this facility although the concept has still to be agreed on.

- PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES
 - Prevention

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

The objective of these interventions is straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Traditionally harm reduction (HR) measures have been focusing on 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'³⁹ 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, 2007).

The most relevant measure in the field of prevention of infectious diseases in drug users is the **national needle exchange programme** established in 1993 and co-ordinated by JDH. In addition to free of charge needle provision by specialised drug and AIDS agencies, automatic syringes dispensers/collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy. Regarding the quantity of distributed syringes, table 7.1 shows an **increase of 470 per cent during the period 1996 to 2005**. However, for the first time since the setup of the NSP, the number of distributed syringes stabilised in 2005 and significantly decreased in 2006. The reasons for this trend are yet unknown.

³⁹ 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.

Syringes return rates witness a steady upward trend reaching up to 93% in 2006 (88% in 2005). Obviously automatic dispensers show lowest return rates.

Table 7.1 National needle exchange programme 1996-2006												
	Distributed syringes						Collected used syringes					
	1996	1998	2000	2002	2004	2006	1996	1998	2000	2002	2004	2006
TOTAL	76,259	109,743	189,413	254,596	435,078	332,347	28,646 (38%)	58,886 (46%)	112,625 (59%)	211,621 (83%)	376,491 (87%)	282,909 (93%)

Source: RELIS 2006

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, 2007).

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

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 experienced users
- Insure availability and free access to the whole range of injection paraphernalia (e.g. spoons, stericups, filters) in order to neutralise a maximum of infection vectors
- Inform on ineffective disinfection and syringe elimination techniques. Often drug users think they do the right thing but their 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 final report has been published in September 2007 and may be downloadable at <http://www.relis.lu>.

- 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.

A new project foreseen by the national HIV/Aids action plan 2006-2010 focuses on outreach measures in order to better reach target populations and in particular vulnerable groups. DIM (Mobile Intervention Facility) aims to access difficult to reach sub-populations and provide prevention counselling and infectious disease testing on site to various populations. The project is under preparation and should be operational by mid 2008.

- Infectious disease treatment

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

- INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY (NNIA)
- INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

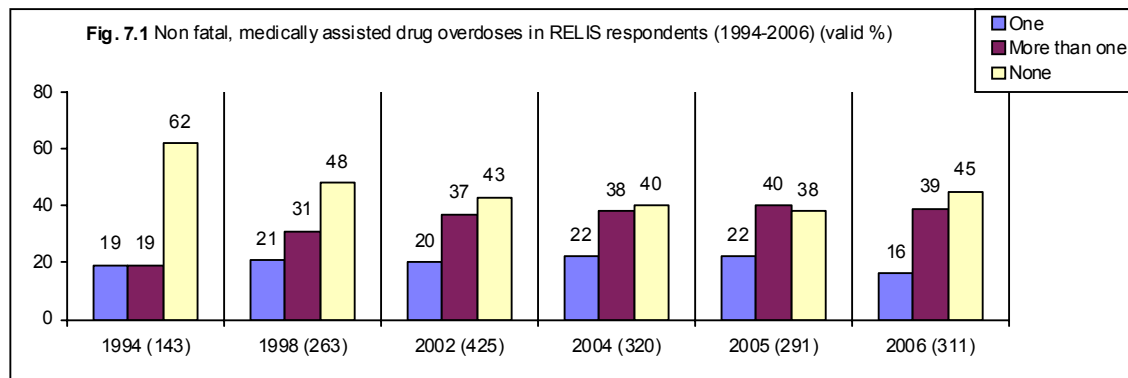
- Somatic co-morbidity

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 has been 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) (16%) during lifetime has slowly decreased during the last six years.



Source: RELIS 2006

- Prevention and reduction of driving accidents related to drug use

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

- 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. As far as the latter is concerned the Inter-ministerial Group on Drugs agreed on the opportunity of a national heroin distribution programme in September 2007 and the national drugs coordinator has been mandated by the Minister of Health to finalise the operational concept by March 2007.

- Interventions concerning pregnancies and children born to drug users

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

In order to meet specific needs of children and parents at risk, especially children from drug addicted parents, the Ministry of Family and Integration has implemented a project of "out-of-hospital nursery" (Maison Françoise Dolto) targeting children aged 0 to 3 years

whose parents are temporarily not able to ensure child care and education. The centre aims to provide temporary admission to these children and helps to compensate the lack of parents' involvement in child care. Besides, the structure offers therapy options, diagnostic testing and functions as a resource centre for parents. The project has a capacity for approximately 20 children and started in spring 2007.

8. Social Correlates and Consequences

Overview

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

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

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

Intervention of law enforcement agents based on reasonable suspicion. The *'interpellated' person* is heard and a police 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.

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

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

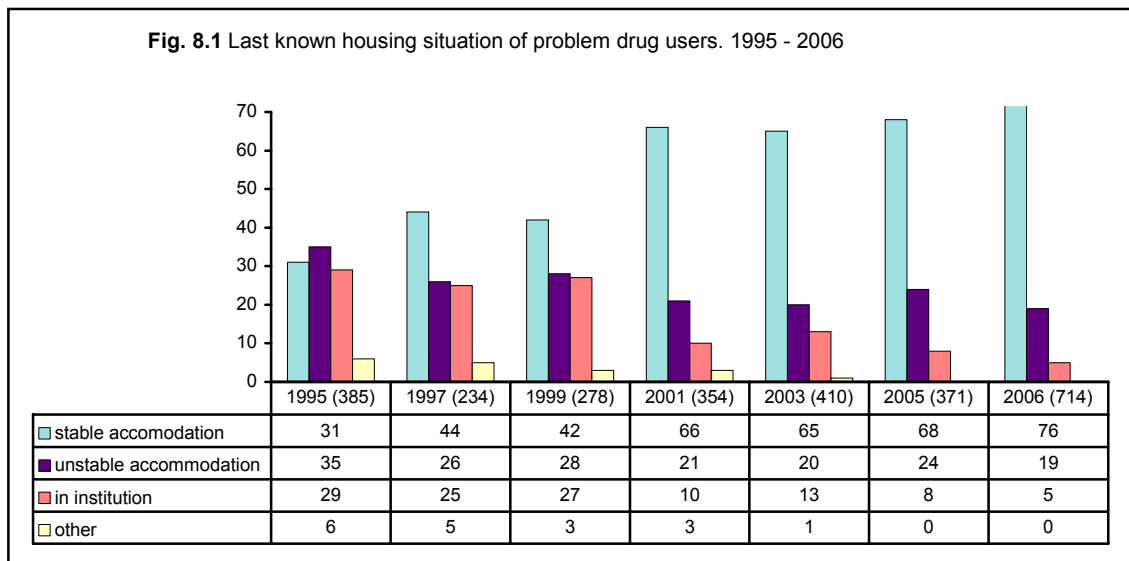
- SOCIAL EXCLUSION (AMONG DRUG USERS AND DRUG USE AMONG SOCIALLY EXCLUDED GROUPS)

- Social exclusion

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

- Homelessness

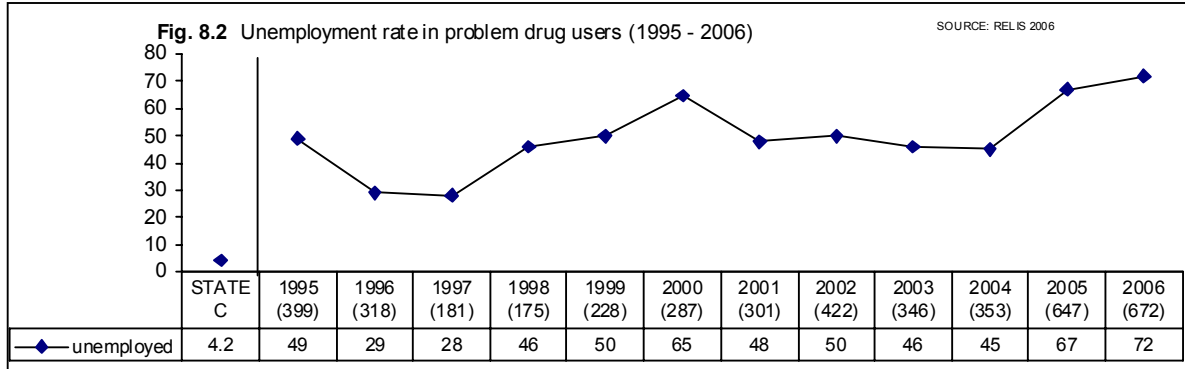
Housing status of registered drug users has markedly improved during recent years and tends to stabilise. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Currently 76 percent (68%) of PDUs report a stable housing situation. This positive evolution may 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.



Source: RELIS 2006

○ Unemployment

Recent data suggest that the **employment status** of respondents tend to worsen. Also the **unemployment rate** has increased in 2006 (72%).

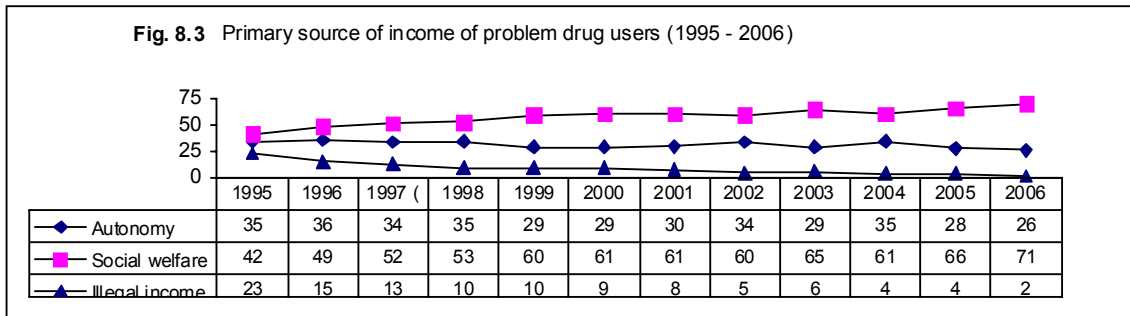


Source: RELIS 2006

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

Data on revenues confirm observed trends in occupational status:

- increase of social dependence associated to a stable **financial autonomy**. The Guaranteed Minimum Income constitutes the primary source of revenue of PDUs;
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 1995;
- a high proportion of respondents reporting **major debts** ($\geq 2,500$ EURO) (36%).

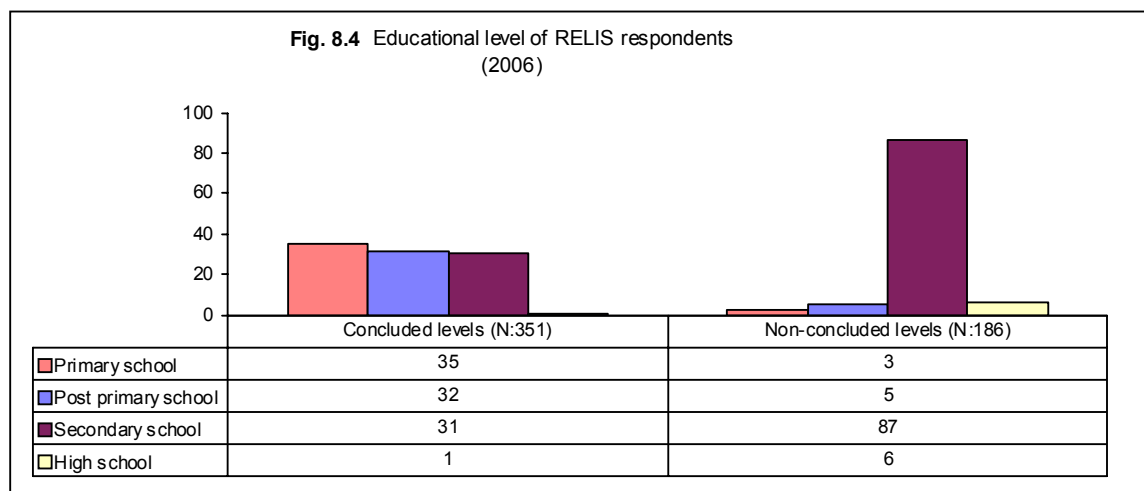


Source: RELIS 2006

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

- 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 2006

- Financial problems (See below)
- Social network (NNIA)
- Sex workers (See Chapter 9: DIM Project)

- DRUG-RELATED CRIME

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

- Drug offences

As can be seen in tables 8.1 and 8.2, the total number of arrests (225) has increased discontinuously during the last 10 years. Traditionally heroin was the most frequent substance involved in drug-related arrests. In 2004 cocaine has turned to be the main substance involved in those arrests (confirmed by 2005 data), followed by heroin and cannabis. Since 2004, charges on drug traffic have known an important increase.

Table 8.1 Arrests broken down by type reporting institution (1995-2006)

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

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

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

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

b. Prosecution data

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP), stable between 1996 and 1998, showed an important increase from 1998 to 2003 (825 to 1,660) to stabilise from then on. (2006: 1,200 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 significant decrease (1,575) in 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 (2006: 225 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 2006.

Table 8.3 Number of national law enforcement interventions (1995-2006)

Year	DRUG LAW ENFORCEMENT RECORDS							PREVENUS (Offenders)						
	95	97	99	2001	2003	2004	2006	95	97	99	2001	2003	2004	2006
S.P.J.	123	137	343	216	239	267	190	152	182	434	321	369	336	248
Gendarmerie	198	255	782	1,126	1,326	1,072	824	319	335	916	1,272	1,753	1,268	1,007
Police ⁴⁰	199	177	189					371	280	283				
Customs ⁴¹	244	236	173	113	95	129	186	421	408	306	182	148	204	320
Total	764	805	1,187	1,455	1,660	1,468	1,200	1,263	1,205	1,939	1,776	2,270	1,808	1,575

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 2005/2006 data reporting a decrease from 808 in 2003 to 471 in 2006. Also the **percentage of minors** (< 18 years) among drug law offenders having increased between 1994 (4.9%) to 2000 (6.7%) shows a clear decrease in 2004 (8.7%) and in 2006 (6.9%). Cocaine and heroin are the main drugs involved in first drug offences.

Table 8.4 Socio demographic data on 'prévenus' (1986-2006)

YEAR	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004	2005	2006
AGE															
0-14	9		7	6	1	3	7	27	21	11	15	41	24	9	8
15-19	121	212	179	320	169	270	249	415	413	399	647	602	334	436	279
20-24	264	569	383	527	403	447	321	519	497	566	650	557	510	617	415
25-29	119	220	278	371	309	304	220	448	354	299	388	375	278	345	323
30-34	49	67	124	159	186	191	187	269	208	194	219	254	250	230	188
35-39	17	29	27	52	65	80	76	131	113	139	177	162	190	174	136
≥40	17	19	43	46	21	42	78	84	108	113	82	174	126	153	181
unknown	27	21	30	50	20	31	32	46	44	55	40	106	99	70	43
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	1,575
Male	503	970	851	1,248	938	1,138	958	1,658	1,415	1,546	1,905	1,935	1,581	1,751	1,319
Female	120	166	220	256	209	173	193	248	241	215	292	288	181	237	218
gender unknown	0	1	0	27	27	57	19	33	44	15	21	48	49	46	38

Source: Specialised Drug Department of the Judicial Police 2006.

Table 8.5 Distribution of 'prévenus' according to first offence and underage status (1992-2006)

	1992	1994	1996	1998	2000	2002	2004	2005	2006
First offenders	697	382	508	422	608	828	585	657	471
Offenders underage	96	57	102	79	154	145	103	86	72
TOTAL ('Prévenus')	1,531	1,174	1,368	1,170	1,758	2,217	1,808	2,034	1,575

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

⁴⁰ The general activity report of the Government Grand-Duchy of Luxembourg can be downloaded from: http://www.gouvernement.lu/publications/informations_gouvernementales/rapports_activite/index.html

⁴¹ A summary of the general activity report of the "Anti-Drugs and Sensible Products" division of Customs can be found in annex H. The original report can be downloaded from: http://www.gouvernement.lu/publications/informations_gouvernementales/rapports_activite/index.html

Table 8.6 Distribution of first offenders (use and use/traffic) according to substance involved ad minima (1992-2006)

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

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

o Other drug-related crime

The data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results are worth to be retained for 2006:

- 94% of drug users indexed⁴² by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime. 77% (stable) of the total PDU population show multiple law enforcement contacts.
- The proportion of 'interpellations' for other reasons than presumed offences against the drug law (e.g. **petty crime**) has been decreasing since 1997 (38%) and has been fairly stable in recent years (2006:34%). The extension of substitution treatment and the intensification of socio-economic reintegration measures appear to have contributed to the currently observed situation.
- 69% (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 (36% stable) is still on the increase. Compared with 2005, an improvement of the penal situation of indexed drug users must be stressed; associated to a decrease of the duration of served prison sentences.

• DRUG USE IN PRISON

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

<p><u>MAIN RESULTS:</u></p> <p>Drug use in prison</p> <ul style="list-style-type: none"> - 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; <p>Risk behaviour</p> <ul style="list-style-type: none"> - 58% of current IVDU prisoners report life-time needle sharing in prison; - 8% of current IVDU prisoners report last month needle sharing in prison; - 70% of IVDU prisoners only use water to clean up syringes, 22% do not clean syringes at all; - 90% of prisoners reporting sexual intercourse in prison did not use condoms. <p>Miscellaneous</p> <ul style="list-style-type: none"> - 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
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Source: Schlink, 1999

⁴² 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, 2007) 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). An update of the Origer 2002 study has been performed according to data requirements for 2007 selected issues. Between 1999 and 2005, total public drug-related expenditures went up from 23,345,000 to 35,345,000, which equals to an increase rate of 51%. More specifically, the budget allocated by the Ministry of Health to drug related services and programmes, as foreseen by the national drug action plan, has known an increase rate of 217 % between 2000 and 2006. Concerning the 2006 budget 6,584,000.- EUR have been granted to involved services representing a progression rate of 6.27% compared to 2005. Further results of the referred study can be found in chapter 11.

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

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

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

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

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

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

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

9. Responses to Social Correlates and Consequences

Overview

- SOCIAL REINTEGRATION

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

In the framework of the 2000-2004 action plan, the Ministry of Health, jointly with the City of Luxembourg opened a **night shelter (called Nuetsel) for drug addicts** in December 2003 which has evolved in an integrated low threshold care centre for drug addicts (TOX-IN) including day and night shelter offers, accommodation and a supervised drug injection facility.

A project called 'Les Niches' functions as a social real estate agency for drug addicts. Approximately 30 flats and apartments are rented by a drug-counselling centre and provided to drug addicts in need by means of tailor made renting contracts. One of the medium term aims of the project is to allow demanding drug addicts to take over the renting contract on basis of their own financial means and thus dispose autonomously of a stable accommodation. The project is jointly financed by the National Fund against drug trafficking and the Ministry of Health.

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

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

“D’Stëmm vun der Strooss” association (Street voice association) primarily takes care of homeless people in providing them with low threshold facilities and in offering social and professional reintegration activities. The **editing, printing, publication and distribution of an in house magazine** addressing social matters is supposed to help 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 2009 and will provide approximately 30 addicts daily job opportunities adapted to their respective skills and physical and mental resources without imposing restrictive contractual requirements on them. The geographical site of the Centre has been agreed on, information sessions with residents of the concerned village have been organised and the budget made available allowing the start of the construction process in 2008.

- PREVENTION OF DRUG-RELATED CRIME
 - Assistance to drug users in prisons

The Grand Duchy of Luxembourg counts two state prisons at the national level; the CPL situated in the vicinity of Luxembourg City and the CPG implemented in the East of the country. Figure 8.5 (see above) provides the number of general admissions and number of admissions according to drug-related convictions in both prisons from 1989 to 2006.

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 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 specialised 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 2007, the external evaluation report⁴³ has been published that recommended the continuation of the action.

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

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

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

⁴³ TREPOS, J.-Y. (2007) Evaluation du projet global de prise en charge des personnes toxicodépendantes en milieu pénitentiaire au Grand-Duché de Luxembourg, Université Paul-Verlaine, Metz.

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.

- Urban security policies in the prevention of drug related crime
- Collaboration between national and municipal levels

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

- Measures for young drug law offenders

In 1996 a separate mechanism has been put in place with regard to underage and juvenile drug use offenders. The **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 9.1 Clients core statistics MSF SOLIDARITE-JEUNES 1997 – 2006											
		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Number of clients		27	46	99	132	195	208	231	267	249	322
Referral from the criminal Justice system			26.1%	26.3%	41.4%	44.1%	44.2%	37.2%	179	136	46.2%
Gender distribution	Female	26%	28%	26.3%	34.1%	32.3%	34.1%	31.6%	31.9%	31.3%	30.1%
	Male	74%	72%	73.7%	65.9%	67.7%	65.9%	68.4%	68.1%	68.7%	69.9%
Age distribution	< 15	7%	11%	16.1%	12.6%	13.8%	17.8%	23.8%	17.7%	25.7%	33.7%
	15-17	82%	81%	73.8%	74.2%	80.9%	71.6%	63.6%	64.1%	48.6%	49.3%
	≥ 18	11%	8%	10.1%	12.9%	11.3%	10.6%	12.6%	18.6%	25.7%	17%
Main substance involved	Cannabis	45%	49%	65.7%	78%	72.3%	82.2%	83.1%	72.4%	71.5%	73.3%
	Heroin	33%	22%	21.2%	12.9%	7.2%	2.4%	3.5%	4.5%	5.6%	3.7%
	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%	1.6%
	Cocaine		3%	1%		2.6%	1%	0.4%	1.1%		1.6%
Other	11%	3%	4%	3.1%	13.8%	12.9%	12.2	20.5%	22%		

Source: Solidarité Jeunes (MSF). 2006

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.

2006 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 **cocaine and cannabis**. Seizures of all substances have increased compared to 2005 as far as quantity is

concerned although the number of seizures is stable and the number of offenders involved in seizures has been showing an overall decreasing trend. This may suggest that greater quantities of drugs are trafficked by smaller groups of traffickers.

In general, quality of cannabis, ecstasy, STA and heroine show a mid term decrease but cocaine purity is fairly stable while prices show broad ranges for heroin and cocaine, and a still ongoing decrease for ecstasy like products. Cannabis and derivatives however have known a fair stability during the last 5 years as far as street prices are concerned. More concerning is the fact that maximum THC concentrations in cannabis are still raising (2006: over 25%).

Asylum demanders implicated in illicit cocaine trafficking mainly originate from West African countries, particularly from the Ivory Coast. Currently also Albanian citizens are of particular concern to law enforcement authorities. 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.

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.

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

- AVAILABILITY AND SUPPLY
 - Availability of drugs

Law enforcement sources⁴⁴ indicate that currently the majority of illicit drugs consumed in the G. D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). Till the beginning of the nineties, most of the persons involved in illicit drug distribution were consumers who supplied themselves in the Netherlands or acquired limited extra quantities of drugs in order to sell them within restricted local networks. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market.

The **expansion of more structured distribution networks** by organised criminal associations has been reported. The proportion of non-natives implicated in drug trafficking has been increasing over the last four years and may be stabilising according to 2006 data. Typically, involved dealers carry small quantities of drugs hidden in their mouth ready to be swallowed promptly in case of police controls. Initially drugs of high quality have been sold at low prices. Progressively however the quality and diversity of sold drugs have been decreasing. Recently, the national **drug market has been flooded with low quality injection drugs**, which has induced major changes in consume patterns of national drug users.

Little, however, is known on the provision sources of the referred dealer networks. They seem to rely on important stocks of cocaine. They are highly organised and have

⁴⁴ Non published information from the Specialised Drug Unit of the judicial Police

managed to significantly increase the supply and availability of drugs at the national level. In 2005 it was estimated that **0.5 kg of cocaine are daily sold** to drug users within the Luxembourg City drugs scene.

In 2006 no **clandestine drug-manufacturing laboratory** has been dismantled at the national level. Local cultures of cannabis remain rather insignificant in terms of quantity.

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

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

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

The results among the population of young people in Luxembourg lie within the scope of the European average. However the perception of ease of acquisition of drugs near schools and the immediate vicinity of 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.

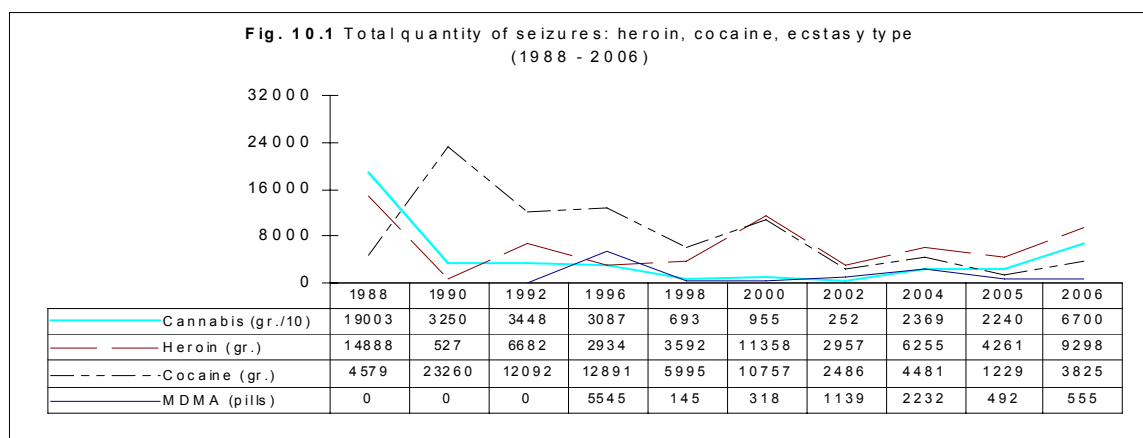
- Production, sources of supply and trafficking patterns
- SEIZURES
 - Quantities and numbers of drug seizures

Striking variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analyses indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002⁴⁵. 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.

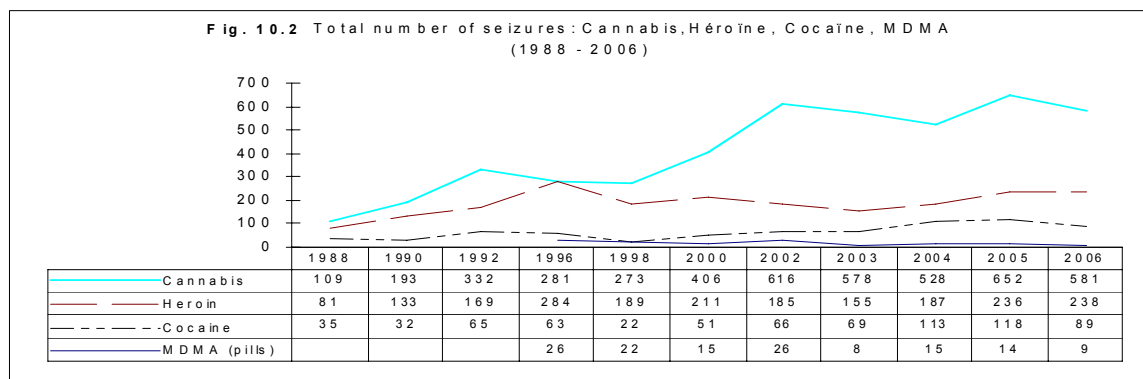
Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. Since 2000 the number of cannabis and cocaine seizures has clearly increased and the number of heroin seizures tends to stabilise. Markedly, the number of cannabis seizures has risen from 167 to 581 between 1994 and 2006. The total **number of persons** involved in traffic has followed a constant upward trend until 2002 and is showing a recent decrease. A confirmed majority of offenders are involved in cannabis traffic and are non-natives. For detailed information, see standard table 13.

⁴⁵ Non –transit drugs destined to the national market

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

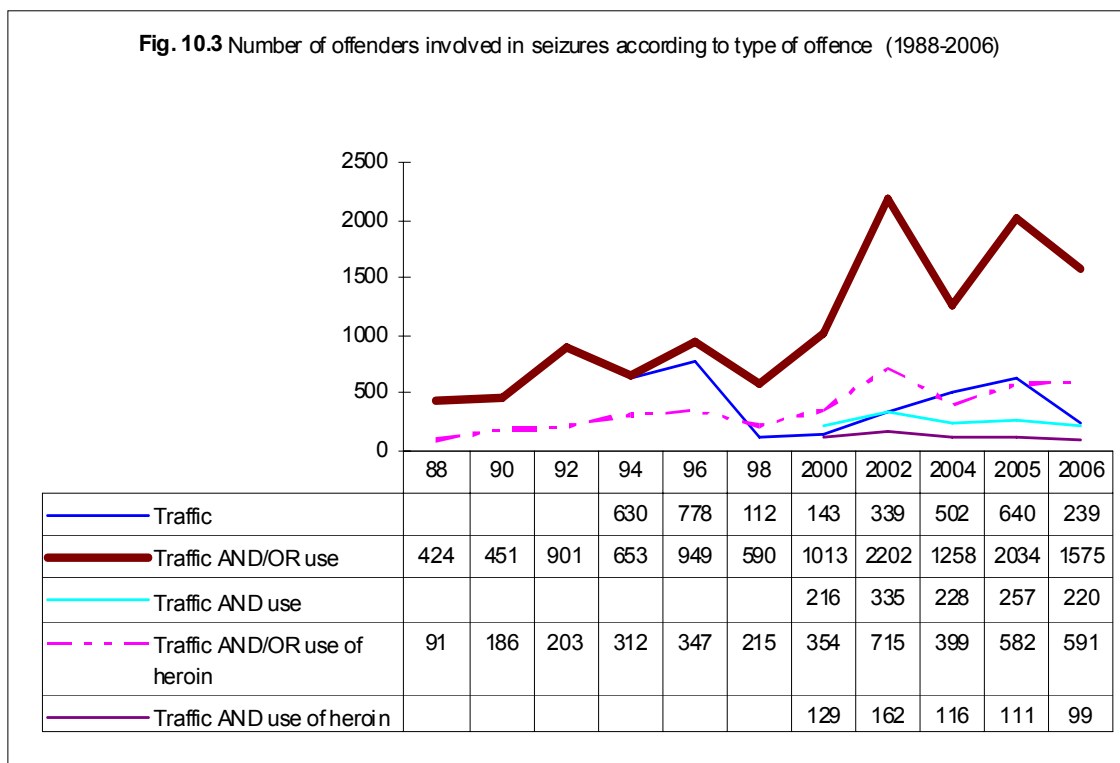


Source: Specialised Drug Department of the Judicial Police 2006



Source: Specialised Drug Department of the Judicial Police 2006

Fig. 10.3 Number of offenders involved in seizures according to type of offence (1988-2006)



Source: Specialised Drug Department of the Judicial Police 2006

- PRICE/PURITY
 - Price of drugs at street level

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 2005/2006. Cannabis and derivatives however have known a fair stability during the last 6 years. Heroin is frequently sold as 'boule' 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 (1994-2006)

	1994	1998	2000	2002	2003	2004	2005	2006
Cannabis								
Haschisch	5-6	5 - 6	7.4	7	8.3	7.3	7.3	8
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	30-100
Heroin (brown)	65-150	90 -150	74.4	50	40	82	80	50-90
STA		25-30	?	25	n.a.	n.a.	n.a.	5
Ecstasy		9 - 13	10.7	7	10	10	10	5
LSD	11-13	11 -13	?	n.a.	n.a.	10	10	n.a.

Source: Specialised Drug Department of the Judicial Police 2006

Price: expressed in EURO at street level.

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

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

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

○ Purity at street level and composition of drugs/tablets

Compared to the situation in 2003, purity of all reported substances is lower in 2006 except for cocaine that has been showing a fairly stable quality during the same period. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC in cannabis samples seized in Luxembourg.

Table 10.3 Purity of drugs at street level (1994-2006)

	1996	1998	2000	2002			2004			2005			2006		
	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)			Pur. (%)			Pur. (%)			Pur. (%)		
	AVERAGE	AVRG.	AVRG.	MIN.	MIN.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.
Cannabis (THC)			8,03	0.6	0.6	7.96	0.64	14.0	6.94	0.6	22.26	10.92	0.15	25.85	7.36
Cocaine	60-90	60-90	60,25	27.75	27.75	62.99	9.65	94.9	62.37	27.75	94.9	51.52	11.7	100	61.78
Heroin (brown)	15-23	20-25	17,59	4.85	4.85	9.97	5.0	41.55	17.07	4.85	57.65	28.18	3.6	40.9	14.48
STA				1.2	1.2	15.09	1.25	40.65	9.44	1.2	35.01	12.22	3.6	15.35	7.1
Ecstasy⁴⁶ (MDMA) (MDEA) (MDA)			35,5 6,8	1.75	1.75	71.11	22.35 6.25	39.5 6.25	29.77 6.25	1.75	38.33	15.82	1.2	43.98	26.44
Psilocybine				/	/	0.15	0.26	0.57	0.41	/	/	/	/	/	/

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2006.

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.

⁴⁶ Ecstasy : dose in mg/pill

Part B: Selected Issues

11. Public Expenditure

11.1 National estimates of labelled drug related expenditures

Preliminary remarks

The fight against drugs is multidisciplinary. Thus, in Luxembourg: 11 ministries and 13 departments are involved to a different extent in the enforcement of national drug policies. Although the programming and enforcement of the national drug strategy is centralised given the geographical size of the country.

A first study on direct economical public drug-related expenditures (Origer, 2002) published in 2002 allowed to assess the feasibility of such studies as well as the range of questions researchers are confronted to.

Following are some of the preliminary problems one may encounter in this type of studies:

- Budget lines may be generic (legal & illegal drugs), aggregated (addiction prevention), over inclusive (social solidarity) or unidentifiable (others),
- Apportionment of budgets may not be provided,
- Difference between provisional budget, voted budget and final expenditure (provisional budget often more detailed than voted budget),
- Expenditures may be annual, multiannual, unique, ordinary, extraordinary, etc. If they occur during the study reference year, they should be included even though they might give a biased picture of average or routine expenditures, especially when they are important (e.g. investments in real estate)⁴⁷.
- In terms of follow-up: budget lines may be restructured, integrated or divided over time,
- In the field of public health, expenditures may result from direct state financing or social security reimbursement,
- Lack of clarity due to National mixed (Multi-ministries) financing (e.g. Public research Centres – multi projects' financing) or National & EU & International shared financing,
- Eligibility of cooperation projects vs. variability of yearly contributions,
- Assessment of impact of general education and educational interventions (e.g.) on DDR impossible

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

⁴⁷ In order to highlight the different status/nature of budget lines, the following abbreviations have been used in the expenditure tables: S. : Standard budget (annual expenditure / budget line) ; I.: Investments (unique year dependant expenditure)

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

Examples are numerous. In the field of HIV/AIDS, for instance, the creation of a national surveillance commission on HIV/AIDS and the associated expenditures has to be considered in a different way than the costs of a home for PLWHIV/AIDS. The HIV/AIDS surveillance commission would exist even if there were no drug addicts, whereas the capacity of the home for PLWHIV/AIDS is dependant on the number of clients living in the referred home, of whom a certain proportion had been infected via IVDU. The capacities of such facilities have thus to be increased because people are infected through drug use and the related expenditures (proportion of clients in total clients) should be accounted for. Further examples will be discussed in sub-chapter 11.2 since they occur mainly when expenditures are not clearly and equivocally allocated to a given action or service.

Given the geographical size of Luxembourg and its political structure, listed expenses are of centralised and national nature. There are no significant regional or local drug related budgets to be considered in the present analysis. COFOG and REUTERS classification systems have been applied according to the requirements of the EMCDDA.

Methodology

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

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

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

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

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

The applied methodology refers to the concepts of the '**Cost of Illness**' (C.O.I.) theory in opposition to "Cost-Benefit" approach.

The following techniques have been applied or combined according to referred contexts:

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

Main reference documents:

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

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

Ministère des Finances (2004). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.

Ministère des Finances (2005). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.

Ministère des Finances (2006). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.

Ministère de la Santé (2006). Rapport d'activités 2005, Ministère de la Santé, Luxembourg.

Ministère de la Santé (2005). Stratégie et plan d'action national en matière de lutte contre les drogues et les toxicomanies 2005 – 2009. Ministère de la Santé. Luxembourg.

Origer, A. (2002b). Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies. Séries de recherche n°4, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

Tab. 11.1 National estimates of labelled drug related expenditures

Ministry / Department	Budget /Title	Budget / Expense (EUR)	COFOG	REUTERS
01 Ministry of Foreign Affairs and Immigration	S 01.2 / 35.031 35.40 International Relations: Contribution to the UN Fund against Drug Abuse (FNULAD)	50,000.-	01.2.2.	/
	S 01.7 / 35.030/35.40/01.53 Cooperation and development: Contribution to PNUCID	9,500.-	01.2.2.	/
04 Ministry of Finances	S. 04.3 /12.310 03.20 Staff and operational cost of the Special Drugs Division of Customs	3,430,239.-	01.1.2. (03.6.0)	3
05 Ministry of Finances Treasure and Budget	S. Operational costs and 2005 national investments of the National Fund against Drug Trafficking	350,028.-	01.1.2.	1,2,3,4
	I 34.3 74.300 01.22 Acquisition of drug detection equipment for Customs Administration	57,762.-	03.6.0	3
07 Ministry of Justice	S.07.0 35.060 03.10 International Relations: Contribution to EUROPOL DRUG UNIT	6,000.-	01.2.2.	3
10 / 11 Ministry of Education of Professional Training and Sports	S.10.0 12.223 04.01 Drug prevention in primary and post primary schools	64,997.-	07.4.0	1
	S11.4 12.301 08.30 Drug prevention and Sport	3,938.-	07.4.0	1
12 Ministry of Family, Social Solidarity/Youth	S 12.8 / 12.252 06.32 Drug Prevention in retention centres for minors	13.545	03.4.0	1
14 Ministry of Health	S14.0 12.000.05.00 Fees for National Drug Substitution treatment commission	1,500.-	07.4.0.	2
	S14.1 12.343 05.00 Control of national enforcement of UN drug conventions	5,000.-	01.2.2.	3
	S14.1 33.002 05.00 Co-financing of staff and operational coast of the national EMCDDA focal point	122,345.-	07.5.0.	/
	S 14.1 / 33.013 05.23 -	4,555,482.-	07.2.0	1,2,3,4

	33.014 05.23 Staff and operational cost of specialized drug agencies conventionned by state	318,151.-	07.1.2.	4
	S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	1 61,950.-	07.4.0	/
	S 14.2 12.301 05.20 / 12.801 05.20 Toxicological surveillance of drug addicts	371,664.-	07.2.0	2
	I 44.7 52.000 05.22 05.23 / 52.002 05.22 Construction works and acquisition of equipment for conventionned specialized drug agencies			
22 Ministry of Public Buildings	I .52.4 72.022 05.20 05.22 / 74.092 74.22 Construction works and acquisition of equipment for conventionned specialized drug agencies	300,000.-	07.2.0	2
TOTAL A	Labelled Public drug-related expenditures	9,822,101,-		

11.2 Non labelled drug-related expenditures and definitions of attributable proportions

The assessment of non-labelled expenditures requires both analysis of budgetary documents and the conceptualization of reliable and reproducible apportionment keys (Attributable proportion). It refers to situations that range from expenses that are not explicitly referred to in accessible financial documents to the complexity of Health Insurance expenses. Indeed, as Health insurance is mostly mandatory and state financed, any reimbursement of medical interventions due to the consequences of drug use represents a share of resources that cannot be spent for other purposes (COI). It is a variable reality researchers are confronted with and harmonization of methodologies is crucial if the aim is to produce comparable results.

Table 11.2 provides an exhaustive overview of non labelled drug-related public expenditures as well as information on proportion calculations. In case the attributable proportion keys are complex, a more detailed description is provided below.

Tab. 11.2 National estimates of non labelled drug related expenditures (attributable proportions)

Ministry / Department	Budget /Title	Budget / Expense (EUR)	Attributable proportion	COFOG	REUTERS
01 Ministry of Foreign Affairs and Immigration	S. 01.7 Staff ,operational and mission cost related to drug related issues	18,847.-	Estimation by MFA based on analysis of work and mission reports and career of involved agents	01.2.2.	/
05 Ministry of Finances Treasure and Budget	S. 05 Renting of real estate for specialized drug agencies	260,531.-	Standard rent prices according to location and surface	0.1.1.2	2
07 Ministry of Justice	S. 07.0 Staff ,operational and mission cost of MJ related to drug related issues	6,000.-	Estimation by MJ based on analysis of work / mission / career	03.6.0	3
	S. 07.1. 0 Staff ,operational and mission cost of judiciary services (courts, etc) related to drug related issues	987,588.-	Estimation of total cost of judicial services x proportion of drug offences affairs (based on ad hoc register)	03.3.0	3
	S. 07.2 Prison drug related expenditures	13,885,166	Total prison budget x proportion of drug law offenders in total prison population	03.4.0	3

	S.07.4 Police drug related expenditures	1,056,692,-	Dedicated staff, operational and mission costs (Special drug units 100%)	03.1.0	3
		3,356,003.-	+ Assessment by Police Directorate based on analysis of job descriptions and related operational costs	03.1.0	3
12/13 Ministry of Family, Social Solidarity and Youth	S. 13.1 / 12,140 06. 32 Information campaigns on drugs	14,960.-	Internal budget breakdown	07.4.0	1
	S. 13.1 / 11.000 11.00 Staff ,operational and mission cost of MF related to drug related issues	17,674.-	Estimation by MF based on analysis of work / mission / career	07.4.0	1
14 Ministry of Health	S 14.0 Staff ,operational and mission cost of MH related to drug related issues	17,674.-	Estimation by MH based on analysis of work / mission / career	07.6.0	1,2,4
<i>14.1 Directorate of Health</i>	S 14.1 / 33.014 05.23 Staff and operational cost of National Aids counselling Centre	143,111.-	25% of total budget : average proportion of PLWHIV/AIDS infected via IVDU in clients	07.2	1
	S 14.1 / 11.000 05.00 / 12.010 05.00 Staff and mission costs of Directorate of Health allocated to drug related issues	159,940.-	Dedicated staff to drug issues + Estimation by MF based on analysis of work / mission / career	07.6.0	1,2,4
<i>14.2 Public Health Laboratory</i>	S 14.2 / 11.000 05.20 Staff ,operational and mission cost of Laboratory related to drug related issues	17,478.-	Estimation by Laboratory based on analysis of work / mission / career	07.4.0	2

17 Ministry of Social Security <i>Health / Social insurance</i>	S 17.2 Staff ,operational and mission cost for agents in charge of drug treatment referral abroad	70,694.-	Estimation by MSS based on analysis of work / mission / career	07.4.0	2
	<u>A. Substitution treatment</u>				
	- Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (Net, patient's contribution excluded)	138,517.-	Detailed breakdown by Union of Sickness Funds (UCM)	07.2.2	2
	- Reimbursement of medical counselling cost related to substitution prescriptions	184,000.-	Number of substitution prescriptions x prescription fees x % reimbursed by health insurance	07.2.2	2
	<u>B. Inpatient hospital drug treatment</u>				
	- Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification)	2,320,805.-	ICD-10: F11, F12, F14, F15, F16, F18 and F19 hospital episodes x cost per episode (provided by UCM)	07.3.2	2
	- Medical counselling costs associated to hospital treatment episodes	153,645.-	Number of medical consultations x reimbursed fees according to duration of stay	07.3.2	2
<u>C. Drug treatment abroad</u>					
- Reimbursement of drug treatment costs abroad/ e.g. residential therapy or therapeutic offer unavailable in Luxembourg	1,041,490.-	Breakdown provided by UCM	07.3.2	2	

	<u>D. Cost of HIV/AIDS treatment provided to patients infected via IVDU</u>	1.672.000.-	Number of HIV/AIDS patients infected via IVDU in treatment x yearly average cost of HIV/AIDS treatment (+/- 20,000.- EUR) x reimbursable proportion	07.2.2 07.3.2	2
TOTAL B	Non-Labelled Public drug-related expenditures	25,522,815			
TOTAL A+B	Labelled + Non-Labelled Public drug-related expenditures	35,344,916			

Tab. 11.3 Overall expenditure on fiscal year 2005 by 1st level COFOG functions

COFOG 1 st level function	Labelled expenditures	Non-labelled expenditures	TOTAL
3 (Public Order and Safety)	3,501,546.-	19,291,449.-	22,792,995.- (66%)
7 (Health)	5,900,027.-	5,630,070.-	11,819,381.- (34%)
		TOTAL	34,612,376.-

Tab. 11.4 Overall expenditure on fiscal year 2005 by 2nd level COFOG functions

COFOG 2 nd level function	Labelled expenditures	Non-labelled expenditures	TOTAL
3.1 (Police services)	3,488,001.-	4,412,695.-	7,900,696.-

3.3 (Law courts)	/	987,588.-	987,588.-
3.4 (Prisons)	/	13,898,711.-	13,898,711.-
7.1 (Medical Products, appliances and equipment)	318,151.-	/	318,151.-
7.2 (Outpatient services)	5,227,146.-	1,301,628.-	6,528,774.-
7.3 (Hospital services)	/	4,351,940.-	4,351,940.-
7.4 (Public Health services)	232,385.-	120,806.-	353,191.-
TOTAL			34,339,051.-

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

05 Ministry of Finances Treasure and Budget

05 FLTS: (Eligibility? / Revenue - Expenditure). Confiscated assets re-invested in the fight against drugs. Only financial means invested in national projects have been retained as these would have to be financed by public money if the FLTS did not exist.

07 Ministry of Justice

07.2 State prisons.

Distinction between new entries and stock of prisoners per year. Prison administration provided proportion of 'drug offenders' in prison (prevalence: 25%) (Incidence:21% new entries): A) Calculation of total costs B) 25% of total costs

But: Estimation bias: Prevalence based estimation does not take into account duration of prison stays.

A more accurate method if data available is the following:

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

17 Ministry of Social Security (Health expenditures)

II.1 HIV/AIDS treatment (IVDU related infections and health costs)

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

- **A** : Total number of registered PLW HIV/AIDS infected via IVDU (diagnosis reporting) (status: alive)

(If not available: Total number of PLWHIV/AIDS infected via IVDU x mortality rate of target population)

(Higher precision (if available): Total number of PLW HIV/AIDS IVDU in treatment during year X that might be provided directly by central social security department)

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

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

01 Ministry of Foreign Affairs and Immigration

II.1 National Contribution to the EU ‘drugs budget’

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

a) Assessment of the EU “drugs budget” (x EUR)

= difficult since EU drug budget lines are scattered, affected to internal and external programmes and there are multiannual budget lines. At the time of study only an inventory of drugs related EU budget lines did exist (COM (2001) 301 final). Methodology: Sum of annual EU drugs budget lines + proportional share of multiannual EU drugs budget lines for year of study

b) Determination of the national contribution share to the total EU budget (y%)

c) Estimation of national contribution: X x Y

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

• Relevant or pertinent expenditure breakdowns:

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

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

11.3 National studies on drug-related public expenditures

The first study on drug-related public expenditures has been published in 2002 and refers to fiscal year 1999:

Origer, A. (2002). Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies. Séries de recherche n°4, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg

Abstract: The 'Origer 2002 study' focuses on the estimation of direct economic costs of policies and interventions in the field of illicit drug use. The estimation applies to budgetary year 1999. The study exclusively refers to direct economic costs, thus excluding 'costs of indirect consequences' and 'non quantifiable costs' as well as expenditures related to the acquisition of illicit drugs by the consumer him- or herself. The applied methodology refers to the concepts of the 'Cost of Illness' (C.O.I.) theory. In 1999, the direct economic costs of national policies related to illicit drug use reached approximately 23.345 million euros, which represents an annual per capita expenditure of 54.- €. Based on the results of the latest national drug prevalence study (Origer 2000), the author calculated an average annual cost per problem drug user of 9,934.- €. 39% of estimated expenditures are related to supply reduction measures against 59% that are devoted to demand reduction interventions. Annually 1% of public resources are invested in drug research and international cooperation respectively. The total annual costs the collectivity has to stand for annually represents 0.13% of the gross national product and 0.5 of the total state budget in 1999.

12. Vulnerable Groups of Young People

12.1 Profile of main vulnerable groups

- **Children living in government care institutions**

The activity report 2006 of the Ministry of Family and Integration shows the evolution of minors placed from 2001 to 2006 in government care institutions or care families.

Tab. 12.1 Minors placed from 2001 to 2006 in government care institutions or care families

Type of placement	2001	2002	2003	2004	2005	2006	Total 2006
Conventioned children centres	305	309	318	321	320	344	37.23%
Conventioned day and temporary admission homes	47	47	36	39	38	38	4.11%
State children homes	60	64	60	60	60	69	7.47%
Socio-educative state centres	64	73	79	68	82	65	7.03%
Abroad placement	78	83	103	114	123	149	16.13%
Family placement	227	224	227	233	249	259	28.03%
Total	781	800	823	835	872	924	100%

SOURCE: Activity report 2006, Ministry of Family and Integration

- **Early school leavers/ academic failure**

The study of “School leave in Luxembourg”⁴⁸ (2006) surveyed a population of 37,347 secondary school students. During a period from 1st November 2004 and 30 April 2006, a total of 2.422 students have been leaving school without a professional certification (temporary stay offs from school have also been taken into consideration). The study refers to a proportion of 6.5% of “school leavers”. This proportion figures 3.6% if one is considering the total number of students having been reached but who have not reintegrated a school in Luxembourg. Concerning this category of school leavers, composed of students attending courses abroad, being employed, following professional insertion measures and those without occupation (N=1,357), the situation was as follows: 41.2% of students who dropped school have integrated the job market (work or professional insertion measure), 39.8% didn’t work nor went to school and 19% attended school courses abroad. In general boys, youngsters from abroad and aged more than 15 years (age of school obligation) are more vulnerable to the risk of early school leave.

Tab.12.2 Early school leavers in native population 2006

	School leavers			
	Total	%	Total	%
School attendance in Luxembourg	345	14.2%		
School attendance abroad	258	10.7%	258	19.0%
With employment	250	10.3%	250	18.4%
Insertion measure	309	12.8%	309	22.8%
Without occupation	540	22.3%	540	39.8%
Not reachable/without information/left country	720	29.7%		
Total	2422	100%	1357	100%

Source: Ministère de l’Education nationale et de la Formation professionnelle (2006). Le décrochage scolaire au Luxembourg. Luxembourg

- **Youth in families with drug and/or alcohol use**

No studies have been performed on youth in families with drug and/or alcohol use. Concerning the item “drug consumption within the family of origin”, the national monitoring system on drugs and drug addiction RELIS reported in 2006 a proportion of 62% of regular, sustained or problematic substance use among at least one member belonging to the family of origin of PDUs (illegal psychotropic substances and/or alcohol and/or medicaments). As additional information, one may add the age of RELIS respondents. Data from 2006 suggest a total of 6% of RELIS respondents aged 15 to 19 years. 1% of youngsters aged less than 15 years have been indexed by RELIS.

- **Homeless youth**

According to latest estimations 715 persons are currently estimated to be homeless in the Grand-Duchy of Luxembourg⁴⁹. The study reported a proportion of 54% males and 46% females and a relatively young age of homeless population. Half of the population of homeless people is aged 18 to 34 years and only 9% are aged more than 55 years. Youngsters aged less than 25 and living on the street is referred to as a quite new phenomenon and linked to the societal evolution. Societal changes as the increase of mono parental families, an increase number of divorces, the decrease of married

⁴⁸Ministère de l’Education nationale et de la Formation professionnelle (2006). Le décrochage scolaire au Luxembourg. Luxembourg

⁴⁹ Centre d’Etudes de Populations, de Pauvreté et de Politiques Socio-Economiques (2007). L’exclusion liée au logement des personnes prises en charge par les centres de jour, les foyers de nuit, les centres d’accueil et les logements encadrés. Luxembourg

couples and the necessity of work of women obliged to work for economical reasons are likely to have negative impacts on youngster's psychological development and education.

- **Young offenders**

A specialized drug counselling agency for minors, **MSF Youth-Solidarity**, provides psycho-social support to youngsters in breach with drug laws by including family and institutions. In 2006, MSF counted a total of 1,579 (2005: 1,289) structured interviews. Concerning age groups, 4.9 % of youngsters were aged less than 14 years, 28.8% were aged 14 to 15, 49.3% were aged 16 to 17 and 17% aged more than 17 years. The psychoactive substance primarily involved was cannabis (73.3%) followed by heroine (3.7%) and legal drugs (3.1%). Poly-consumption was reported in 3.7% of cases.

The 2006 annual report of the Grand-Ducal Police shows that 11.5% of all law offenders are minors (youngsters aged less than 18 years).

Tab.12.3 Minor law offenders 2006

Categories	Total offenders	Adults				Minors (less than 18 years)			
		male	female	total	%	male	female	total	%
Offences against property	4,059	2,531	708	3,239	79.8%	640	180	820	20.2%
Offences against the person act	5,338	3,726	1,078	4,804	90%	437	97	534	10%
Others whereof drug offences	5,403	4,016	1,040	5,056	93.6%	261	86	347	6.4%
	1,732	1,288	234	1,522	87.9%	166	44	210	12.1%
TOTAL	14,800	10,273	2,826	13,099	88.5%	1,338	363	1,701	11.5%

SOURCE: Activity report 2006, Grand-Ducal Police

- **Youth in deprived places/ neighbourhoods and/or with drug availability**

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

- **Ethnic minorities**

The national drug monitoring system RELIS reported in 2006 a proportion of 53% of native PDU respondents (n=769). Since 1994 the proportion of non-natives in PDUs has been showing a discontinuous upward trend. National drug agencies had to adapt their programmes and concepts to this situation. Persons of Portuguese nationality are the most represented. The neighbouring countries (France, Germany and Belgium) showed in 2006 a remarkable upward trend (34%). The number of PDUs originating from non EU countries has been showing an upward trend until 2003 but decreased since then.

An NFP study called "Comparative study on the drug population of Portugal and a representative sample of Portuguese drug addicts residents of the Grand Duchy of

Luxembourg⁵⁰ was published in 1999. The most important group of foreign drug addicts treated within national health care institutions have been of Portuguese origin (50% of foreign drug treatment demanders).

- **Party goers**

No national studies have been performed on party goers. However, to combat the sustained consumption of legal drugs in youngsters, new laws concerning the prohibition of selling alcohol to youngsters aged less than 16, as well as a restriction of the tobacco law have both entered in force in 2006. Taxes on the so called “alcopops” have been raised in January 2006 in order to make designer drinks less attractive for youngsters.

- **Youth from vulnerable families**

The national action plan against drugs and drug addiction (2005-2009) foresees among other prevention projects the development of concepts of prevention in homes, admission centres and socio-educative centres for children and youngsters as this target population constitutes a risk group. The national prevention centre CePT is in charge of these measures and will evaluate this project.

12.2 Drug use and problematic drug use among vulnerable groups

Given the “low” national drug prevalence as far as the absolute number of PDUs is concerned, only few studies exist on specific sub-groups, as for instance vulnerable groups.

- **Prevalence, patterns of drug use, social and geographical profiles**

The before mentioned comparative study on the drug population of Portugal and a representative sample of Portuguese drug addicts residents of the Grand Duchy of Luxembourg (Origer, 1999) showed that 82% of Portuguese addicts treated in Luxembourg and 98% of Portuguese living in Portugal used opiates as primary drug. Concerning the route of administration, it seems that far more Portuguese drug addicts treated in specialized national institutions injected drugs than Portuguese native treatment demanders. Cocaine abuse was more frequently observed among Portuguese addicts living in Luxembourg, while inhaling seemed to be a far more common practice in Portugal. Portuguese drug addicts treated in Luxembourg have been far younger than native addicts. The mean age of opiate drug addicts entering treatment in Luxembourg tended to increase.

- **Trends in the last 10 years**

Over ten years of RELIS data confirmed a predominance of Portuguese citizens among PDUs varying from 50% to 58%. Data from 2005 however suggest a slight decrease (39%) of Portuguese population among PDUs and an increase of France citizens (2004:11%; 2005: 23%).

⁵⁰ Origer A. (1999). Comparative study on the drug population of Portugal and a representative sample of Portuguese drug addicts residents of the Grand Duchy of Luxembourg. EMCDDA National Focal Point, Ministry of Health, Luxembourg.

- **ESPAD**

Luxembourg is not a participating country of ESPAD studies.

12.3 Vulnerable groups among the treated population (See chapter 1 and 2)

12.4 Correlates and consequences of substance use among vulnerable groups

- **Psycho-social and health problems related to substance use**

No special studies on correlates and consequences of substance use among vulnerable groups have been conducted so far. (See comment under 2.)

- **Criminal behaviours**

In 2006 1,575 drug law offences have been registered at the national level. 0.5% of offenders were younger than 15, in 6.7% they were minors of age and in 18.2% they were younger than 20 years. 64% of the drug offenders were non-natives.

12.5 Policy and legal development

- **National and legal development**

In line with the EU commitments, Luxembourg set up a national action programme against poverty and social exclusion (NAP 2006-2008). Concerned ministries in collaboration with social partners elaborated measures against social exclusion.

The national action plan against drugs and drugs addiction (2005-2009) includes measures specifically addressing youngsters to prevent social exclusion by reason of substance abuse and addiction. These measures primarily include prevention projects in school environment and children homes as also selected prevention programmes addressing first time consumers (CHOICE).

- **Strategies and policies for social exclusion**

To better respond to the situation of homeless people, the Government charged the International Network for Studies in Technology, Environment, Alternatives, Development (CEPS/INSTEAD) to study the population of homeless persons in the Grand-Duchy of Luxembourg.

In the context of the reform of psychiatry in Luxembourg, new youth care structures are implemented to better respond to the situation of drug dependent youngsters. In the framework of the 2005-2009 drugs action plan, the Neuro-Psychiatric Hospital Centre (CHNP) implemented in 2006 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.

- **Definitions and concepts of vulnerability in the national context**

As stated above, the national action plan against drugs and drug addiction defined measures for vulnerable populations. Primary prevention projects target very young children in post primary and primary schools, children and youngsters in admission homes and drug-dependent parents.

12.6 Prevention and Treatment

- **Specific treatment options for vulnerable groups**

National drug treatment agencies take into account specificities of the national context (geographical size of the country, multi nationalities - cultural context...). Prevention and treatment are not substance specific but take into account the individual and his environment.

- **Institutional responses/ responses in the area of social inclusion**

In the area of social exclusion special attention is paid to professional/occupational reintegration structures for drug dependant persons. The national drugs action plan 2005-2009 foresees the implementation of a day structure offering further education and daily occupation to persons with drug related problems.

- **Responses to public nuisance**

By means of round-tables, all actors concerned (citizens, ONG, drug dependant persons, ministries, City of Luxembourg...) discuss solutions regarding public nuisance. One may note that the City of Luxembourg regularly organizes prevention committees discussing public nuisance issues in collaboration with concerned NGOs. The implementation of the first drug consumption room in Luxembourg City in July 2005 required regular meetings between the Ministry of Health and all actors concerned. The latter are ongoing and of routine nature in order to solve, among others, public nuisance related problems as soon as they occur.

- **Trends and changes in recent years**

In recent years, a restructuring of the "Interministerial Group of Drugs" (GIT), an advisory platform of ministries involved in drug related issues, discusses and approves measures of the national drugs action plan (2005-2009). New trends and changes are also directly reported by field workers from NGO's.

- **Early intervention strategies**

The national prevention centre CePT assures primary prevention sessions for children in kindergarten and primary schools in order to reach the very youngsters.

- **Selective prevention for families at risk**

Since 2003 the Youth-and Drughelp foundation (JDH) is running a parental project with the aim to provide psycho-social aid to drug-dependant parents and their children. The

primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative abilities. This long term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. In 2006, 69 different family situations have been treated, 62% of them being mono parental situations involving in all 50 children. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

13. Drug-Related research in Luxembourg

13.1. Research structures

13.1.1 Drug related research in national policy

The EMCDDA National Focal Point implemented in the Public Research Centre of Health is the main national research centre for drug related epidemiological research. The laboratory of toxicology associated to the National Health Laboratory is the State's reference laboratory in the context of toxicological analyses and related drug research.

The national drug action plan 2005-2009 elaborated by the Ministry of Health explicitly refers to research and information as an integrated part of the transversal axes of demand and supply reduction and stresses that research and information constitute a primary need for all anti-drugs policy. The research domains include: fundamental, epidemiological, sociological research, elaboration, harmonization and standardization of methodological applications, evaluation and exchange of knowledge. The objective of national policy in regard to research is to develop infrastructures and research means, to build up a national and international research network, to optimize the transfer of knowledge between research actors and the decisional level, to rationalize the diffusion of information to different target audiences, to put special attention on the evaluation of planned actions, to contribute to need assessments (e.g. treatment, infrastructures) and the conceptualization of strategies/policies. Investment into research constitutes a necessity even if results are often only visible in the long term.

13.1.2 Relationship research-policy

As stated above, the EMCDDA National Focal Point is the centre of reference for epidemiological drug research at national level. National policy and practice are highly interlinked with the RELIS national monitoring system, Luxembourg information network on drugs and drug addiction. The national drugs action plan is based upon the findings of the RELIS drug monitoring system. Besides, NGO's working in the drug field and financed by the State's budget, can call for research activities in the field of sociological research and often participate in European projects funded by the European Commission. In regard to Public Health, the Ministry of Health in close collaboration with NGO's, define national research needs.

13.1.3 Main national structures for drug-related research

- **Coordination bodies for drug-related research**

Since 2000, the Ministry of Health entrusted a national drug coordinator to assure drug coordination between ministerial and NGO level. In 2006, the national drug coordinator was appointed chair of the interministerial group on drugs and drug addiction (“GIT” Groupe Interministériel Toxicomanie) and ensures the set up of the national drugs action plans, which is to be approved and followed up by the GIT.

The main coordination bodies involved in drug related research are the Ministry of Health and the Public Research Centre of Health, run under the supervision of the Ministry of Culture, Higher Education and Research and the Ministry of Health.

- **Main research institutions and organizations**

The Public Research Health Centre (CRP-Santé) and more precisely the EMCDDA National Focal Point is the national reference centre for drug related research.

The National Prevention Centre for Drug Addiction (CePT), partly financed by the State budget in close collaboration with the NFP, ensures research in the field of drug prevention. Several other research actors (University departments of the University of Luxembourg, external experts...) operate as subcontractants to the NFP or the CePT.

The Central Service of Statistics and Economic Studies (STATEC), national statistical centre of the Ministry of Economic Affairs and External Trade, has published in 2006 a socio-economical study in regard to drugs called “Illegal activities related to drugs: estimation of economic impact in Luxembourg”⁵¹. The respective method was mainly based on RELIS data provided by the NFP.

- **Main funding frameworks and size of funding**

The CRP-Santé disposes of different budgetary resources. Financial contributions can originate from the state’s budget, from financial participation from third institutions, national or international, for contractual research projects or by donations and legacy contracts or other resources originating for example from the cession of property rights.

The Ministry of Culture, Higher Education and Research assures the Interministerial, European and International coordination of research.

Since 1999 the National Research Fund managed by the Ministry of Culture, Higher Education and Research aims to promote research activities at national level, attributes awards to researchers and scientists, allocates subsidies to individuals and associations and promotes programmes of the European Commission and international organizations.

The National Fund against Drug Trafficking manages assets and capital confiscated in the framework of drug law offences by virtue of the law of 19 February 1973 and co-

⁵¹ Service Central de la Statistique et des Etudes Economiques (2006), Les activités illégales liées à la drogue: estimation de leur impact économique au Luxembourg, Statnews n°35/2006 et Bulletin du Statec n°2-2006, Luxembourg.

ordinates, among other tasks, the allocation of respective financial resources to drug-related prevention, care or research projects at national and international level.

According to Origer (2002 b)⁵² *the proportion of the national budget invested in the fight against drugs dedicated to drug research amounts approximately 1%.*

13.2 Main recent studies and publications

13.2.1 Main recent studies since 2000

- **Prevalence and spreading of viral hepatitis A, B ,C and HIV among problematic users of illicitly acquired drugs⁵³ (Origer & Removille 2007)**

The study “Prevalence and spreading of viral hepatitis A,B ,C and HIV among problematic users of illicitly acquired drugs” was conducted by the NFP of the EMCDDA. The National Fund against Drug Trafficking ensured the funding of the study.

The objective of the “action-research” was to assess the national prevalence of blood borne viruses HIV, HCV, HAV and HBV in the population of problematic users of illicitly acquired drugs, to perform 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.

Eight month data collection in 2005 have allowed to establish 1167 contacts , of which 397 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 self reported rates provided by the national drug monitoring system (RELIS) provide a satisfactory proxy of diagnostic based prevalence. The HCV prevalence rate of the total study sample was 71.4% and reached 81% for the ever injectors⁵⁴. The highest prevalence rate (86.3%) was observed in in-prison respondents, followed by those in in-patient treatment centres (75.4%) and those in out-patient treatment centres (58.2%). The study has not allowed to determine the proportion of active chronic hepatitis⁵⁵.

The HBV prevalence (comprising acute/chronic infection and past cured infection) in the G.-D. of Luxemburg among PDUs is 21.6% and figures 24.7% in ever injectors. HBV prevalence in out-patient treatment centres is 16.4%, 15.1% in the in-patient treatment centres and 31.8% in prison. 32% of the PDUs could benefit from the vaccination against hepatitis B and 46% are immune due to vaccination.

⁵² Origer, A. (2002b). Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies. Séries de recherche n°4, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

⁵³ Origer, A., Removille, N. (2006). Prevalence and spreading of viral hepatitis A, B, C and HIV among problematic users of illicitly acquired drugs. CRP-Santé, EMCDDA, NFP Luxembourg

⁵⁴ Ever injector: injection of drug for non therapeutic reasons at least once.

⁵⁵ Active chronic hepatitis: Infection for more than six months with liver inflammation.

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 overall HIV prevalence among the PDUs provided by the study figures 2.9% and 2.5% when exclusively referred to ever injectors. The HIV prevalence rate is 1.9% in the out-patient treatment centres, 7.7% in the prison centres and is null in the in-patient treatment 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 prison population. This has to be confronted to the fact that half of the respondents declare having consumed illicit drugs in prison whereof half report intravenous use during their prison stay.

The study also refers to a series of associated factors such as, inefficient disinfection methods, inadequate syringe elimination, a high proportion of Problematic Drug Users (PDUs) not using condoms during sexual intercourse, especially with new 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 points out 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 by 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 recommendations that may contribute to reduce incidence of infectious diseases and related risks in drug users.

- **Illegal activities related to drugs: estimation of economic impact in Luxembourg (STATEC, 2006)**

The study “Illegal activities related to drugs: estimation of economic impact in Luxembourg”, conducted between 1999 and 2004, was published in July 2006 by the central service of statistics and economic studies STATEC. The study was realized in the framework of a European project aiming to improve comparability of national accounts.

One of the particularities of national accounts, the gross national income (GNI) is used as a part of contribution to the European budget. In principle, the concept of the European system of accounts (SEC95) also includes illegal activities. For methodological reasons and absence of accurate data, illegal activities have not yet been included into the EU accounts. As there exist numerous definitions of illegal activities in the different EU member states and to assure justice and equality of treatment, the European Commission requires including illegal activities into national accounts. Similar studies are running in different member states. By means of these studies the Commission may decide upon the future inclusion of illegal activities into national accounts of member states.

The Grand-Duchy of Luxembourg disposes high quality statistical data of problematic drug use. However data on occasional drug use are insufficient in reason of an absence of regular general population surveys. The economic and geographic position of

Luxembourg does not enable to make a statistical extrapolation of confiscation data on drug supply and demand of the Luxembourg drug market. Therefore the basis of data produced in this study is build upon the estimation of drug consumption. The drug expenditure from households are estimated between 37,8 million euros per annual mean in 1999 to 2004.

Information from experts helped to estimate the drugs supply for the Luxembourg market. However produced results are fragile and have to be interpreted only as data ranges.

Results of the study situate the impact of illegal activities related to drugs for 2004 at 0.11% GNI and to 0.08% GNR. The impact is limited, however it agrees to data ranges of studies conducted in several EU member states.

- **Benzodiazepine prescribing in the Grand-Duchy of Luxembourg (1995-2004)**

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Objective: The chronic use of benzodiazepines is of limited therapeutic benefit and increases the risk of adverse events. The purpose of the study was to examine benzodiazepine prescription routines of physicians in domiciliary practice in the Grand-Duchy of Luxembourg and to obtain reliable results on the prevalence of benzodiazepine use within the country (411,600 inhabitants in 1995 vs. 455,000 inhabitants in 2004).

Study design: The survey is retrospective, population-based and covers a ten year period (1995-2004). The authors used a database available at the National Social Security that includes all the national insurance contributors (with the exception of the employees working for the European Union).

Methods: The authors calculated the number of annual prescriptions, the annual prescription by drug (converted in equivalent diazepam dosage), the number of patients receiving a prescription by year and draw a profile of the consumers (age and sex). The authors estimated the mean daily dose and the duration of the prescription (discontinuous/continuous intake). The authors finally gave a profile of the chronic consumers and reviewed the number of prescription containing more than one benzodiazepine.

Results: In Luxembourg, 23 different benzodiazepines are approved for medical usage (Table 13.1, with equivalent dose of 10 mg of diazepam):

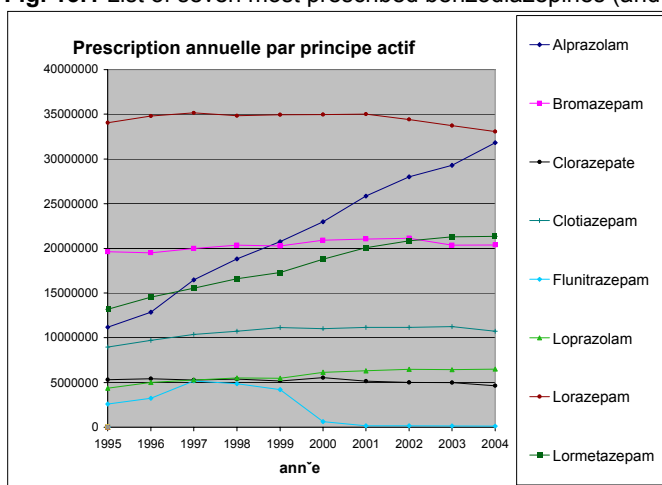
Tab. 13.1 Benzodiazepines approved for medical usage with equivalent dose of 10mg of diazepam

Chemical denomination	Dose eq.	Cloazolam	1	Lormetazepam	2
Alprazolam	0.5	Diazepam	10	Midazolam	5
Bromazepam	6	Flunitrazepam	1	Nitrazepam	5
Brotizolam	0.5	Flurazepam	30	Nordazepam	20
Clobazam	20	Ketazolam	30	Oxazepam	50
Clonazepam	2	Loflazepate	1.33	Prazepam	20
Clorazepate	20	Loprazolam	1.33	Tetrazepam	50
Clotiazepam	5	Lorazepam	2.5	Triazolam	0.5

They are reimbursed at 40% by the national health insurance. The number of annual prescriptions showed a slight decrease within the study period (228,188 prescriptions in

1995 vs. 198,547 prescriptions in 2004), thus not informing about the length of the prescription (which may be up to 6 months).

Fig. 13.1 List of seven most prescribed benzodiazepines (and flunitrazepam):



The annual prescribed volume of alprazolam nearly tripled during the study period. The classification of flunitrazepam as a stupefiant in 2000 decreased its prescriptions drastically (2,609,100 mg eq. dose in 1995 vs. 104,560 mg in 2004). The number of insured having received at least one benzodiazepine prescription per year passed from 14.3% (n=58,753) in 1995 to 12.8% (n=58,338) in 2004, with a total number of 166,781 different persons during the 10-year study period. 2/3 of the all the subjects are older than 50 and nearly 2/3 are female (Table 13.2):

Tab. 13.2 Male and Female aged ≤ 49 and ≥ 50

Total	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
≤ 49	19,209	19,671	19,648	19,990	19,711	19,493	19,277	19,310	18,622	18,584
≥ 50	39,544	40,401	40,507	40,943	41,037	40,524	40,180	40,357	40,020	39,754
Men	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
≤ 49	7,499	7,620	7,541	7,766	7,716	7,615	7,481	7,448	7,205	7,239
≥ 50	13,398	13,622	13,723	14,016	14,075	13,723	13,698	13,795	13,712	13,628
Women	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
≤ 49	11,710	12,051	12,107	12,224	11,995	11,878	11,796	11,862	11,417	11,345
≥ 50	26,146	26,779	26,784	26,927	26,962	26,801	26,482	26,562	26,308	26,126

The estimated mean daily dose calculated in the next table (Table 13.3) is a daily average of the yearly delivered dosage per subject and therefore does not necessarily reflect the real daily consumption:

Tab. 13.3 Estimated average daily dose

Eq. dose	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
0-20 mg	56.247	57.314	57.043	57.658	57.409	56.595	55.913	56.035	54.968	54.646
21-50 mg	2.154	2.345	2.597	2.738	2.800	2.855	2.881	2.938	2.974	2.953
51-100 mg	290	338	415	426	438	445	510	541	541	556
≥ 101 mg	62	73	100	109	101	122	153	153	159	183

The number of high dosage consumers (≥ 51 mg/day) doubled within ten years. The authors divided all the subjects into 3 subgroups, to study the consumption profile:

1) A group of "short term delivery": the benzodiazepine prescribing for these subjects was either unique or no longer than three months (n=58,161).

2) A group of “discontinuous delivery”: around one third of all the subjects (n=51,396) had several prescriptions but with at least a one year break between the prescriptions. The authors calculated the total annual dose prescribed for these subjects in the years they were on benzodiazepines and considered a yearly average dose of the equivalence of 900 mg of diazepam as not being problematic (n=38,554). The rest of the subgroup (n=12,842) consumed more.

3) A group of “continuous delivery”: these subjects (n=57,224) never stopped with the benzodiazepines, once prescribed, and represented 34.3% of all the subjects (i.e. 12.6% of the general population). Their profile is given in Table 13.4:

Tab. 13.4 “Continuous delivery” profile

Length	≤ 10 mg	11-30 mg	31-100mg	≥ 100 mg	Total (n)
4-12 months	9,287	1,484	130	5	10,906
1-3 months	14,433	2,331	228	13	17,005
4-5 months	3,838	1,159	137	11	5,145
≥ 6 months	14,948	7,893	1,259	68	24,168
Total (n)	42,506	12,867	1,754	97	57,224

Nearly three quarters (n=42,506) of the “continuous delivery” subgroup are low dose consumers. The daily dose seems to be average (10-30 mg of diazepam equivalence) for another 22.5% (n=12,867). High dosage consumption is found in 3.2% (n=1,851) of the chronic consumers (i.e., 0.4% of the general population).

40 of the 68 highest consumers (> 100 mg eq. dose since more than 6 years) were 50 years or older, and 45 of them were female (30 older than 50). The top 2 benzodiazepines consumed were bromazepam (n=42) and alprazolam (n=52). The authors finally examined the number of benzodiazepines per prescription and the profile of the prescribers: of all the prescriptions (n=2,189,078), nearly 10% contained 2 different benzodiazepines (n=211,055), 0.5% of them (n=10,805) listed 3 substances, and there was a small number with more than 4 (n=632). The 3 top prescribing specialist groups were the neuropsychiatrists, the general practitioners and the psychiatrists.

Conclusions: Benzodiazepine prescriptions in Luxembourg were appropriate for nearly two third of the patients and prescribed according to current treatment guidelines. However, up to 40% of the consumers had long term prescriptions, most of them at a low dosage. The literature estimates a dependency in half of these subjects, thus representing around 5% of the general population. High dose dependency and abuse remains more rare and is to be suspected in 3.7% of the consumers (i.e., 0,4% of the general population).

Implications: The study was presented as a thesis at the University of Strasbourg (France). It was published by the national association of physicians and sent to every member. It was discussed in an open session by the national government and in the press. It has lead to a general awareness of the problem within the country and to several concrete measures.

Bibliography: “Les benzodiazépines au Grand-duché de Luxembourg”. Association des Médecins et Médecins-Dentistes du Grand-duché de Luxembourg (AMMD): Le Corps Médical (nr. 3/2007: part 1, pp. 4-39, nr. 4/2007: part 2, pp. 3-29).

- **The direct economical cost of policies and public interventions to fight illegal drug use in the Grand-Duchy of Luxembourg⁵⁶ (Origer, 2000)**

The study was conducted by the NFP of the EMCDDA and focuses on the estimation of direct economic costs of policies and interventions in the field of illicit drug use. The estimation applies to budgetary year 1999.

The study exclusively refers to direct economic costs, thus excluding “costs of indirect consequences” and “non quantifiable costs” as well as expenditures related to the acquisition of illicit drugs by the consumer him- or herself. The applied methodology refers to the concepts of the “Cost of Illness” (C.O.I.) theory.

In 1999, the direct economic costs of national policies related to illicit drug use reached approximately 23.345 million euros, which represents an annual per capita expenditure of 54.-euros. Based on the results of the latest national drug prevalence study (Origer 2000), the author calculated an average annual cost per problem drug user of 9,934.-euros.

39% of estimated expenditures are related to supply reduction measures against 59% that are devoted to demand reduction interventions. Annually 1% of public resources are invested in drug research and international cooperation respectively.

The total annual costs the collectivity has to stand for annually represents 0.13% of the gross national product and 0.5 % of the total state budget in 1999.

- **Epidemiological study on drug-related deaths and analysis of methodological aspects of indexing procedures applied in the Grand-Duchy of Luxembourg (1992 – 2000)⁵⁷ (Origer and Delucci, 2002)**

The consequences of drug misuse are manifold. A drug-related death often materializes the final outcome of an entanglement whose components are difficult to analyse a posteriori. The concept of drug-related mortality embraces both, acute fatal intoxications (overdose) and deaths that are not a direct consequence of an adverse somatic reaction following substance intake but in which drug use has to be considered as a contributing cause. Those scenarios represent two different epidemiological complexities, which the present study intends to explore. The first part of the study analyses factors that may influence the transition from experimental drug use to a fatal drug-related incident. The second part focuses on methodological aspects with regard to the production and collection of reliable prevalence and incidence data on drug related mortality.

The number of fatal 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). Afterwards, the prevalence has increased anew to reach 26 cases in 2000. In terms of drug-related mortality (direct and indirect deaths), 23 cases have been indexed in 1992; prevalence has stabilized since 1995 figuring roughly 40 cases per year.

⁵⁶ Origer A. (2002), Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies. Séries de recherche n°4, Point Focal OEDT Luxembourg – CRP-Santé, Luxembourg.

⁵⁷ Origer A., Dellucci H. (2002), Etude épidémiologique et méthodologique des cas de décès liés à l’usage de drogues (1992-2000), Séries de recherche n°3, Point Focal OEDT Luxembourg – CRP-Santé, Luxembourg.

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 represents 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.

The overdose rate in the national general population figures 6.43 overdose deaths per 100,000 inhabitants in 2000 (3.95 o.d. cases in 1999 and 2.09 in 1997). An international comparison shows that the overdose rate of the G.D. of Luxembourg is among the highest within EU Member states, even though it has known a significant decrease in 2001.

Two action strategies emerge from the epidemiological outcome of the study. Firstly, the need of a specialized care network allowing for rapid and active contact making with high risk users as profiled by the study and secondly, the set-up of re-integration programmes designed to fill the psychosocial gap often observed after a prolonged institutional journey (Hospital, prison, therapeutic community). Those programmes have to start before clients are released from respective institutions. A proactive approach in terms of risk reduction, multidisciplinary networking and an early perception of high risk factors appear to be valuable means towards the reduction of drug-related morbidity and mortality in drug using populations.

- **Estimation of national prevalence of problematic use of illicitly acquired drugs. Multi-methods comparative study 1997-2000⁵⁸ (Origer, 2001)**

The research focuses on two primary objectives. It is the first comparative multi-methods drug prevalence study conducted at the national level.

The research strategy relies on the methodological framework of the Luxembourgish Information System of Drugs and drugs addiction (RELIS), set up in 1994 by the national focal point of the EMCDDA. The study specifically aims at the prevalence estimation of problem use of illicitly acquired high risk drugs (HRC) in the national population aged 15 and 54 years. The chosen terminology defines the target population with regard to the observable consequences of drug use, the nature of consumed substances as well as the context (legal or illegal) of their acquisition.

Data from 1999 and 2000 have been considered in comparison with the 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).

Absolute prevalence and prevalence rates of problem HRC drug use have shown a growing tendency over the past four years. The increase curve observed between 1999 and 2000 is less ascending than the one observed during the period 1997 to 1999. The observed figures comply with the stability of heroin use and intravenous drug use

⁵⁸ Origer A., (2001), Estimation de la prévalence nationale de l'usage problématique de drogues à risque élevé et d'acquisition illicite – Etude comparative multi-méthodes 1997-2000, Séries de recherche n°2, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

prevalence between 1999 and 2000. Although the total drug use prevalence shows an upwards tendency, heroin use does not contribute significantly to the referred progression. Intravenous drug use prevalence has even shown a slight decrease in 2000.

The average prevalence of problem HRC drugs use (2,350) and the related prevalence rate of 5.59/1000 (9.58/1000 in national population aged between 15 and 54), in 1999 are deemed to show good validity according to the non-contradicting estimates obtained by the multi-methods approach and the evolution of indirect indicators such as the number of fatal overdose cases, the number of distributed syringes through the national needle exchange programme, the number of HRC drug law offences, drug seizures and admission data of low threshold agencies. Prevalence figures calculated for 2000 (N: 2,450, total rate: 5.59/1000, rate 15-54: 9.58/1000) also fit the curve of indirect indicators. Since the 2000 figures have been obtained by a limited number of estimation methods, observed tendencies should be confirmed by further research based on the evaluation outcome of multi-source methodologies in the light of national specificity. According to experience gathered in the framework of the present research project, the application of a routine set of methods including CR3, tPm and D1, currently appears to be a highly valuable option.

13.2.2 Peer-reviewed scientific journals

There exist few national researchers publishing in international peer-reviewed scientific journals.

A recent article published in 2005 of the "Forensic Science International" can be cited : 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", whereas Wennig R. represents a national researcher of the Public Health Research Centre, National Laboratory of Health, Toxicological Department, University of Luxembourg.

13.3 Collection and dissemination of research results

13.3.1 Information flow

- **Description National Focal Point**

The National Focal Point can be considered as a national excellence centre in drug-related research. It also plays a major role in drug-related policy decision process at national level. Implemented in the Public Research Centre of Health (CRP-Santé) and more particularly in the department of health studies (CES), the NFP depends on the State's and EMCDDA budgetary means. Since 1994 the national drug monitoring system RELIS aims to situate prevalence and incidence of problematic drug use. RELIS stands for both, a human and technical network. Information is gathered annually by means of standardized questionnaires covering all national drug treatment agencies. The NFP disseminates research information by publishing research studies on its internet platform www.relis.lu, and introduces new research studies to the national press.

13.3.2 National scientific journals

No national scientific journals on drugs and drug addiction exist.

13.3.3 Other means of dissemination

- **Websites dedicated to research**

The NFP internet page www.relis.lu includes all drug related research studies performed by the NFP. The bulletin of the society of medical sciences invites researchers to publish articles from different scientific specialities (www.ssm.lu).

A governmental public internet page is dedicated exclusively for innovation and research www.innovation.public.lu without however being specialised on drug related issues.

- **National drug conferences**

In May 2007 the national FP organized a REITOX academy on public expenditure analysis in the field of drugs.

Part C

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- Alphanumeric list of all bibliographic references

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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 (attributers) namely: gender (i.e. 01/02), date of birth (i.e., 10051967), and country of birth into a code - calculator developed by the NFP in collaboration with the CRP-Henri Tudor. The solution found is time and cost effective because it relies on a simple HP calculator that runs an attributor-to-code transcription programme based on a multiple-step algorithm.

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

One of the main benefits of the described procedure is that no personal data can be inferred directly from the identification code. The indating and encoding procedures are carried out at the very level of the field institutions. Thus, NFP is provided with individualised data (reporting protocols) without any reference to identifying information or attributers 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 EMCCDA 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 IVDUs 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://eddra.eu.int/>
- <http://eldd.emcdda.eu.int/>
- <http://www.emcdda.eu.int/>
- <http://www.etat.lu/>
- <http://www.etat.lu/MS/>
- <http://www.gouvernement.lu/>
- <http://www.ilres.com/>
- <http://www.jdh.lu/>
- <http://www.legilux.public.lu/>
- <http://www.msf.lu/>
- <http://www.msr.lu/>
- <http://www.police.public.lu/PoliceGrandDucale>
- <http://www.relis.lu/>
- <http://www.statec.lu/>
- <http://www.unodc.org/>
- <http://www.who.int/>

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