

2009 National Drug Report (2008 data)

Grand Duchy of Luxembourg

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



2009 NATIONAL DRUG REPORT (2008 DATA)

"GRAND DUCHY OF LUXEMBOURG"

**NEW DEVELOPMENTS, TRENDS AND IN-DEPTH
INFORMATION ON SELECTED ISSUES**

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ABBREVIATIONS

AST	Service d'Action Socio-Thérapeutique
CATF	Chemical Action Task Force
CePT	Centre de Prévention des Toxicomanies
CAS	Commission d'admission et de surveillance (CHDP)
CFSP	Common Foreign and Security Policy
CHDP	Controlled Heroin Distribution Program
CHNP	Centre Hospitalier Neuro-Psychiatrique
CICAD	Inter-American Drug Abuse Control Commission
CMO	Comprehensive Multidisciplinary Outline (UN)
CND	Commission on Narcotic Drug
CNDS	Comité National de Défense Sociale
CNER	Comité National d'Ethique de Recherche
CNPD	Commission Nationale de Protection des Données
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
CPOS	Centre de Psychologie et d'Orientation Scolaire
CRP-HT	Centre de Recherche Public - Henri Tudor
CRP-Santé	Centre de Recherche Public - Santé
CTM	Centre Thérapeutique de Manternach
DEA	Drug Enforcement Administration (United States)
EWS	Early Warning System on New Synthetic Drugs
GID	Groupe Interservices Drogue (de la Commission européenne)
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMA	European Medicines Agency
EUROPOL	European Police Office
FBI	Federal Bureau of Investigation (United States)
FED	Fond Européen de Développement
FATF	Financial Action Task Force on Money Laundering
FEDER	Fond Européen de Développement Régional
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
HDG	Horizontal Working Party on Drugs
Honlea	Heads of National Drug Law Enforcement Agencies
ICD	Interministerial Commission on Drugs
ICPO/Interpol	International Criminal Police Organization
ILO	International Labour Organization
INCB	International Narcotic Control Board
JDH	Fondation Jugend- an Drogenhëllef
LNS	Laboratoire National de Santé
NDLEA	National Drug Law Enforcement Administration (Nigeria)
NFP	National Focal Point of the EMCDDA

NIDA	National Institute on Drug Abuse (United States)
OAS	Organization of American States
OCDE	Organisation de Coopération et de Développement Economiques
OGD	Observatoire Géopolitique des Drogues
OLAF	European Anti-Fraud Office
ONDCP	Office of National Drug Control Policy of the White House (United States)
PECO	Pays d'Europe Centrale et Orientale
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
REITOX	European Information Network on Drugs and Drug Addiction
SADC	Southern African Development Community
SEPT	Semaine Européenne de Prévention des Toxicomanies
SID	Système d'Information Douanier
SIS	Système d'Information Schengen
SNJ	Service National de la Jeunesse
SPG	Système de Préférences Généralisées
SPJ	Service des Stupéfiants de la Police Judiciaire
SSJ	Service Solidarité Jeunes (Jongenheem a.s.b.l.)
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organization
WHO	World Health Organization
ZePF	Zentrum für Empirische Pädagogische Forschung – Universität Landau



FOREWORD

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

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SUMMARY

ANNUAL NATIONAL REPORT ON THE DRUG SITUATION (EDITION 2009)

The report on the Drug Situation in the G. D. of Luxembourg 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.

Drug policy: legislation, strategies and economic analysis

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

The 2009 governmental programme has introduced no changes concerning competences and attributions in the drugs field and constitutes the framework for the elaboration of the third national strategy and action plan (2010-2014) for the fight against drugs and addictions. **The national strategy and action plan 2010-2014** relies upon the priorities of the Ministry of Health and a sustained collaboration with field actors and civil society. In order to optimize its impact, the new action plan has taken into account relevant issues from EU and EC treaties, **the EU anti drugs strategy 2005-2012** and the **EU drugs action plan 2009-2012**. The general aim of the national strategy and action plan is to contribute to a high level of protection in terms of public health, public security and social cohesion.

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

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 2008 budget figures 7,288,000.- EUR. In regard to the 2009 budget, 7,991,583.- EUR have been allocated to drug care services representing an increase of almost 40% referred to the implementation period of the 2005-2009 drugs action plan. Human resources dedicated to specialised state financed drug agencies have known a significant increase from 30.75 full time posts in 2000 to 83.75 in 2009. The 2005-2009 action plan targeted the creation of 26 new full time posts; 24 new posts were eventually created.



Epidemiological Indicators

Referred to most recent prevalence data from 2007 (UNODC 2009), between 172 and 250 million persons aged 15-64 yearly use illicit drugs at least once, worldwide. The same estimates suggest that there were between 18 and 38 million problem drug users in 2007, 11 to 21 million being injection drug users.

Cannabis remains by far the most widely used drug (173 to 190 million people), followed by amphetamine-type stimulants (16 to 51 million), which include amphetamines and ecstasy (12 to 24 million). The number of opiate abusers is estimated at between 15 and 21 million persons. The number of cocaine users, as defined, range between 16 and 21 million users.

In the last decade, the markets have been showing signs of stabilisation or regression for opiates, cocaine and cannabis and an increasing trend for ATS. A similar evolution is observed within the EU and the micro-geographical level of the Grand Duchy of Luxembourg, however, accompanied by more or less sustained local variations in prevalence.

NATIONAL DRUG PREVALENCE IN THE GENERAL POPULATION

Drug prevalence in school population and in general population

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

New data available from the serial HBSC study (2005/2006) show a recent decrease of last 12 months prevalence of cannabis use in youngsters aged 13 to 17 years. Last 12 months heroin and cocaine use have been showing a fair overall stagnation between 2002 and 2006 whereas ATS, LSD and magic mushrooms consumption in youngsters has sensibly decreased over the same period. A more detail analysis reveals that the age category of 15 years old youngsters is the only to show increasing use specifically for XTC and cocaine. Also, a higher proportion of 15 years old students report repeated lifetime drunkenness when compared to the data from 2002 (HBSC, 2002).

NATIONAL PREVALENCE OF PROBLEM DRUG USE (PDU)

Data on institutional contacts and drug treatment demands

The **number of PDUs contacts** indexed by national institutions in 2008 figured 4,655¹ (2002: 4,701)

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 2008 the same agencies have indexed 2,836 and 1,819 persons respectively. Overall the number of persons showing drug related contacts with DR or SR agencies has reached a plateau since 2002. During the referred period a sensible increase in drug treatment demands has been observed whereas contacts with law enforcement agencies have been decreasing. Referred to the general population aged 15-64, the proportion of persons in contact with DR or SR agencies for drug related matters, likewise PDU prevalence rates in particular, has clearly been decreasing since 2002 (1,385/100,000 inhabitants in 2008 and 1,598/100,000 inhabitants). The same applies to SR contacts taken separately knowing that DR contact rates remained stable over the last 7 years.

¹ 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.

The **male/female ratio** of the PDU population has stabilised at 3:1. The last nine years the proportion of indexed non-native PDUs has shown strong variations but a clearly increasing tendency since 2003, confirmed by 2008 data. The population of non-native drug users largely consists of Portuguese nationals, a proportion constantly increasing until 2004 but decreasing remarkably since, although it is still consistently higher than the one observed in general population. Notably, one observes a strong and continuous increase of PDUs of French origin (28%). This trend is confirmed by last 8-years data on drug law offenders.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 31 years and 8 months in 2008. Mean age of male PDUs has been increasing faster than for females. The gap between youngest and oldest PDUs continues to grow. The mean age of native and non-native problem drug users tends to balance. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to "new" PDUs. Worth mentioning is also the significant increase of the average age of overdose victims during the last years and an important but currently decreasing proportion of minors among drug law offenders until 2006, having stabilised since around 4.5%. **Rates of first cannabis use, in 11-13 years** old youngsters levelled off at 35% in 2008. Respectively 90% and 46% 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 developed over recent years.

Problem drug use prevalence and consume trends

National data are provided by serial prevalence studies on PDUs aged between 15 and 64 years performed in 1997, 1999, 2000 and most recently on 2007 data (Origer 2009)². The estimation performed on 2007 data provides an absolute prevalence of problem HRC drug users (PDU-HRC) of 2,470 persons (C.I. (95%): 2,089 to 3,199). In terms of prevalence rates estimates for the same age categories, 7.67 out of 1,000 habitants aged between 15 and 64 years show problem drug use. According to available serial data for the period 1997 to 2007, absolute prevalence and prevalence rates of PDU-HRC have been showing an increasing trend until 2000. After a brief plateau, a decrease has been observed from 2003 onwards. A similar evolution occurred also for problem heroin use (2007: 1,900 PDUs: 5,90/1000). Although absolute prevalence of intravenous drug use (IDU)³ has slightly increased compared with the situation observed at the end of the 20th century, IDUs prevalence rate in the national population aged 15 to 64 years shows an obvious decreasing trend over the referred period.

Intravenous heroin use associated to **poly-drug use** has been reported being 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 3:2. The prevalence of the use of cocaine as primary drug increased until 2006 and from there on tends to stabilise.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use had known a sensitive increase at the beginning of the 21st century but decreased again to stabilise between 2006 and 2008. **Amphetamine** type substances and ecstasy related treatment demands are only weakly represented, which, however, does not inform on their prevalence in general population as RELIS data refer to PDUs and not to the overall population of recreational drug users.

² Downloadable at <http://www.relis.lu>

³ IDU prevalence rates have been processed on basis of proportion of IDU in PDUs by means of representative RELIS data sets for respective years



The proportion of **poly drug use** (89% in 2008) stabilised at high level after a record level of 92% in 2004. The average ages at **first time consumption** of a preferred drug and illicit drugs in general, show a slow but continuous decrease for the last 9 years with a tendency to stabilise. In 2008, age of first use of cocaine (iv/non-iv) and heroin (iv) shows a weak decrease.

Drug-related treatment

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

In 2008, 2,836 drug treatment demands were recorded nationwide (multiple counts included). Since 2002 a sensible increase in drug treatment demands has been observed until 2007. The number of substitution treatment demands, however, begun to plateau around 2002. Outpatient counselling demand started to level off (1,050) in 2007 in contrast to the number of contacts in low threshold services, having increased and reached almost 68.000 in 2008. 4.6% of respondents are first treatment demanders, all treatment centres included.

Health correlates and responses to consequences

HBV (hepatitis B) and the HIV/AIDS prevalence in PDUs have not been increasing in recent years while the **infection of HCV (hepatitis C)** showed a clear progression. Data from the Laboratory of Retrovirology of the CRP-Santé suggest a long term and discontinuous decreasing tendency of average proportion of IDUs in newly diagnosed HIV cases until 2004. From 2004 to 2008 this proportion has been varying between 7 and 14 %. HIV infection rates in IDUs situate around 4 percent and are witnessing a currently stable trend. A recent study (Origer and Removille, 2007) based on serological testing, confirmed a significant increase in HCV prevalence in PDUs and IDUs during recent years, especially in prison settings.

The implementation of the 2000-2004 and 2005-2009 action plans has been accompanied by a significant yet discontinuous decrease of **overdose cases** in the Grand-Duchy of Luxembourg (2008: 10 cases). This decrease was mainly observed in male victims, the number of female overdose victims has remained fairly stable for the last 7 years.

In terms of number of overdose cases in the general population of the Grand-Duchy of Luxembourg, this proportion figured 1.76 overdose deaths per 100,000 inhabitants aged 15 to 64 years in 2005 (2000: 5.9 cases per 100,000 inhabitants). In 2008, however, 3.04 (2007: 5.67) acute OD cases per 100,000 inhabitants were registered, which represents a decreasing tendency likely to be confirmed by 2009 figures. An expert working group analysed possible reasons for this evolution and stressed the impact of high purity variation of street drugs currently on the market and generalized polydrug use including a series of prescription drugs with potentially dangerous interactions patterns with illegal drugs. **Forensic data** from 1992 to 2008 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 were male (83%) and their mean age at the moment of death shows an important increase over the past 15 years (in 1992: 28.4 years and in 2008: 33.16 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years remained relatively unchanged and the proportion of those older than 35 has been increasing during the retained observation period. No underage victims were reported in 2008.

Considering the nationality of overdose victims, 80% were natives while 20% had foreign nationalities. 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 decreasing number of victims of Portuguese origin, which is consistent with nationality trends in the general PDU population.

A confirmed majority of acute drug death victims are known by law enforcement agencies for their drug user "career", with average durations of 10 years. Half of the latter report 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 places.

In 2008, 10 **indirect drug death cases** have been indexed. Main causes of indirect deaths between 1996 and 2008 are, in order of importance: suicide, traffic accidents, undefined intoxication, associated cardiovascular 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 1998 and 2008 figuring roughly 20 to 38 cases per year. In 2008, 20 drug-related deaths have been reported (10 direct and 10 indirect drug related death cases).

Social correlates and social reintegration

Social correlates of problem drug use are manifold and touch upon family, professional, financial and legal areas. For instance, according to RELIS data, the use of illegal drugs or abuse of alcohol or psychotropic pharmaceuticals **in the family of origin** of indexed PDUs is highly prevalent (63%). The educational levels of PDUs are low and mostly incomplete. The average age at the end of studies shows a global decreasing tendency and currently situates at 16 years and 8 months. 39% of the population of PDUs have major debts (1997: 54%).

The **residential status** of indexed respondents has improved over the last years. In 1995, 31% of the users reported stable accommodation; in 2008 the same proportion figured 77%. This improvement is partly due to various accommodation and housing offers for addicted people set up in the framework of the drug action plan.

All indicators included, **employment status** of PDUs suggest a stabilised situation since 2007, as the rate of PDUs set around 47%. After a high level plateau (46-50%) over several years a new increase is reported between 2006 and 2008 (63%).

Law enforcement indicators ⁴

Seizures of illicit substances at the national level

Great variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002⁵. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. Cocaine seizures (quantity) are highly variable since the beginning of the nineties. Compared to 2007 data, the quantity of seizures of nearly all listed substances went up in 2008 (except for heroin). This observation particularly applies to cannabis and cocaine.

⁴ If not specified, data refer to 2008. Figures between brackets refer to 2007 if not otherwise specified.

⁵ Non-transit drugs destined to the national market.



The number of seizures did not show significant variations during the same period, with the exception of cannabis going up. Markedly, the number of cannabis seizures has indeed risen from 167 to 580 between 1994 and 2008. Also, the number of offenders involved in seizures has been showing an overall decreasing trend. This may suggest that greater quantities of drugs are distributed by smaller groups of traffickers. The total **number of persons** involved in traffic has followed a constant upward trend until 2000 and stabilised afterwards (2008: 1,487 (1,072) persons). A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

Crack (cocaine-base) seizures have not been reported to date by national authorities. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. The availability of ecstasy appeared to soar between 1994 and 1996 however stabilization at low level occurred over the last decade.

Drug law offenders and prison sentences

The **number of police records** for presumed offences against the modified drug law of 1973 went from 764 in 1995 to 1,219 in 2008. A similar evolution has been observed with regard to the **number of drug law offenders**. In 2008, 188 (225 in 2006) arrests for presumed offences against the modified 1973 drug law have been reported. Overall, in recent years, the number of police records, the number of drug law offenders and the number of persons arrested for the same charge have discontinuously decreased.

The population of drug law offenders is composed of 88% **males**; a proportion that has been varying between 79% and 89% during the past decade. The spectacular increase in 2002-2003 of the proportion of **first drug law offenders** is not confirmed by 2007/2008 data reporting a decrease from 808 in 2003 to 546 in 2008. Also the percentage of **minors** (< 18 years) among drug law offenders having increased between 1994 (4.9%) to 2000 (8.7%) shows a clear decrease in 2004 (5.7%) and tended to stabilize from there on (2008: 5.5%). Heroin and cocaine are the main drugs involved in registered first drug offences.

Since 1998, **non-natives** (58.7% in 2008) have been representing the majority of drug law offenders (52-68%). 36% (32%) of the registered cases were **first drug law offenders**; the percentage of **minors** in drug law offenders has decreased from 13.8% in 2003 to 6.7% in 2008. National prison data of 2007 refer to 990 (1,030) new admissions of which 332 (33.5%) were related to drug law offences; a proportion having represented 42.6% in 1996.

Profile of the national drug market

The national production of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2008 no clandestine drug-manufacturing laboratory has been dismantled at the national level. According to observational data provided by the Judicial Police and all decentralised national police units, a majority of illicit drugs consumed in the G. D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). 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.

For several years, the **expansion of more structured distribution networks** by organised criminal associations has been observed. More recently different ethnic groups have started to create synergies in drug distribution and traffic, whereas previously these groups have been operating separately. Moreover, it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible for police as for instance private flats or bars. The proportion of non-natives involved in drug trafficking has been increasing until 2005 and has since then been decreasing quite sensibly although non-natives drug traffickers represent 74% (60% in 2007).

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.

Over the last 5 years, **purity** of heroin has remained fairly stable whereas average potency of cocaine has been on the decrease for the last 2 years. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (over 30%) in herbal cannabis samples seized in Luxembourg in recent years. **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 6 years as far as street prices are concerned.

Harm reduction activities

The **number of contacts** indexed by low threshold agencies has increased dramatically over the last ten years (2008: 67,494 / 2005: 47,739), and so has the number of syringes distributed by the same agencies, although the number of syringes distributed has stabilised in 2005 and subsequently even decreased. The proportion of **new clients** within low threshold settings is on the increase. Approximately 42% of clients are aged between 25 and 34 years, and an increasing proportion (36%) of clients aged 35 and more is observed. 56% (56%) of clients are natives.

The number of **distributed syringes** distributed in the framework of the national needle exchange program, stabilised in 2005 and has been significantly decreasing from 2006 onwards (2008: 259,607 / 1996: 76,259) although the return rates continue to increase. An increasing majority of injectors (32%) procure their syringes in specialised agencies followed by pharmacies and automatic dispensers.

Most Relevant Trends

All indicators included, a decrease in PDU prevalence rates has been observed over recent years. An increasing number of PDUs enter treatment or use low threshold offers and less come in contact with law enforcement agencies.

Intravenous opiate use, combined with polyuse, still is the predominant PDU pattern. However, overall quality of street drugs went down, which had as a side effect an overall spread of polydrug use. The number of drug-related deaths reached 20 cases (10 acute, 10 indirect) in 2008 which represents a first decrease after two years of increase. However, the drug mortality indicator has to be considered with caution since a series of external factors such as the overall aging of heroin users, high variations in the purity of street drugs, generalised polydrug use including non therapeutic use of prescription drugs, presenting dangerous interaction effects with illicit substances' use, may strongly influence its evolution.

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



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

The national drug market is led by more aggressive selling techniques and distribution strategies due to improved collaboration between criminal groups of different ethnic origins previously operating independently. A tendency to move selling points to locations or settings less visible for police as for instance private flats or bars is also observed in this context. Attention has finally to be paid to the striking differences in maximum and minimum purities of street drugs as well as to a historically high maximum concentration of THC (over 30%) in herbal cannabis samples seized over the last 3 years. Heroin purity has remained fairly stable, but cocaine and MDMA purity in XTC-like products has been decreasing over the last 10 years.

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

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

Consistency between Indicators

Demand reduction indicators are highly consistent with supply reduction data (see fig. 4.2). Indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies except for admission statistics in low threshold drug agencies from 2000 onwards and the number of fatal overdoses between 2005 and 2007. These trends are respectively to be linked to an increase in capacities of low threshold offers and better access to harm reduction measures at the national level and significant changes in supply and consume patterns.

Both indicators thus appear to be influenced by external factors not directly linked to a presumed increase of PDU prevalence and thus not in contradiction with a general stabilisation of the latter.

Selected Issue 1 : Market and production of cannabis

In the course of the 70s, heroin, cocaine and cannabis have been the most prevalent drugs of illicit use in the Grand Duchy of Luxembourg. Whereas other illegal substances than cannabis show more or less important variations in terms of appearance on the national market and in terms of users preferences, from the eighties onwards, cannabis use remained steadily prevalent and mainly in youngsters. Until the nineties, the majority of persons involved in cannabis related traffic were self-supplying consumers who acquired limited quantities of drugs mainly in the Netherlands in order to consume them and sell part of them within a restricted local network.

In recent years more organised distribution networks have been developing nationally. The expansion of these structured distribution networks by criminal associations thus contributing to a significant increase in drug availability, and particular in the supply of cocaine and cannabis. National production of cannabis is limited to small indoor cannabis cultivations mostly for personal use or for botanical interest and not primarily meant to procure economic profit.

Selected issue 2 : Problem amphetamine and methamphetamine use, related consequences and responses

At national level, 93% of PDUs reported polydrug use in 2008. A total of 79% of PDUs referred to opiates as main drug (i.v. and non i.v.). One percent of PDUs declared amphetamine type stimulants as main drug of use. This figure suggests a low degree of consumption of amphetamine type stimulants by national PDUs. However, little is known about out-of-treatment populations of (meth)amphetamine users.

In 2003, the first and until now only clandestine laboratory of amphetamines has been detected in the Grand-Duchy of Luxembourg. To date, no methamphetamine seizures have been registered. Thus far, no case of (meth)/amphetamine related death has been reported at the national level.



PART A:

NEW DEVELOPMENTS AND TRENDS

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

Introduction

Drug use is defined as a 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 has gained in importance and influences increasingly policy debates. This tendency is reflected by the recent enlargement of ICD (Interministerial Committee on Drugs) competences and its increased external visibility as well as the general framework set by the new national drugs strategy 2010-2014 still to be approved.

National parliamentary elections of June 2009 have confirmed the previous coalition government of social democrats (CSV) and labour socialists (LSAP) as well as the previous Minister of Health, Mr. Mars Di Bartolomeo. Competencies and ministerial attributions in the drugs field have not been modified. The governmental programme 2009⁶, foresees to further develop the national drugs action plan and specifically refers to the decentralisation of care and harm reduction structures, to a critical revision of drug substitution treatment, to the creation of a heroin assisted treatment programme and to the further development of post-therapeutic offers. More efforts should also be invested in effectiveness and efficiency evaluations of drug treatment offers and services.

By the end of 2009, the Minister of Health will present the new drug strategy and action plan 2010 – 2014, elaborated by the National Drug Coordinator who was also appointed chair of the ICD by the Minister of Health in 2006. The referred action plan is based on the evaluation outcome of previous action plans and the assessment of current and future needs. In this context a mid-term implementation review of the 2005-2009 drugs action has been published in April 2008 and for the first time a final external output and progress evaluation of the national drug strategy and action plan 2005-2009 has been performed by a specialised Dutch institute. The results of the latter, to be presented in November 2009, will thus be integrated in the elaboration of the new drugs strategy.

⁶ Gov. Declaration of 2009, <http://www.gouvernement.lu/gouvernement/programme-2009/programme-2009/index.html>

LEGAL FRAMEWORK

Drug legislation and recent drug related laws

The basic national drug law, namely: 'Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie'⁷ regulates both, the selling of controlled medicaments and the fight against drug addiction and dates back to the 19 February 1973. It has been last amended by the law of 27 April 2001.

- **law of 27 April 2001**⁸ modifying the basic drug law of 19 February 1973. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of harm reduction and maintenance measures, namely, drug substitution treatment, needle exchange and other state accredited means, which, in addition to article 13 of the grand ducal decree of 30 January 2002 (see below) could materialise in shooting galleries or medically controlled heroin distribution programmes.
- **law of 11 August 2006**⁹ on the fight against tobacco regulates advertising of tobacco and related products, the prohibition of smoking in certain areas and the prohibition of sale of oral tobacco. Main legal amendments concern an increase of the number of smoke free public areas, a prohibition of smoking in catering establishments, a general prohibition of advertising, the prohibition of tobacco sale to minors under 16 and the prohibition of import and sale of tobacco in forms of candy or toys. The prohibition of smoking in spaces where food is served can be compassed by the implementation of separate smoking rooms, not exceeding 25 % of the total area, with specifically installed smoke extraction systems. Access is denied to youngsters aged less than 16 years. Pubs and bars are only concerned during core hours as far as they serve meals. Hospitals are allowed to install one smoking room exclusively reserved to patients

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

- **law of 13 July 2007**¹⁰ referring to the markets of financial instruments and including the implementation of the : - directive 2004/39/CE of the European Parliament and of the Council from the 21 April 2004 concerning markets of financial instruments, modifying the directives 85/611/CEE and 93/6/CEE of the Council and the directive 2000/12/CE of the European Parliament and of the Council and abrogating the directive 93/22/CEE, - article 52 of the directive 2006/73/CE of the Commission of the 10 August 2006 executes the directive 2004/39/CE of the European Parliament and of the Council with regard to the organisational requirements and operational conditions applicable to investment companies and the definition of some terms of the aforesaid directive.
- **law of 18 September 2007**¹¹ 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:

⁷ Official gazette A 1973, p.319

⁸ Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001

⁹ Official gazette A 2006, p.2265 (Adoption: 13/07/2006, Entry in force: 05/09/2006)

¹⁰ Official gazette A 2007, p.2076 (Adoption: 13/07/2007, Entry in force: 01/11/2007)

¹¹ Official gazette A 2007, p. 33475 (Adoption: 18/09/2007, Entry in force: 01/10/2007)



- 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.

- **Law of 18 December 2007**¹² regarding the approbation of the United Nations Convention against the organised transnational criminality, adopted by the annual general meeting of the United Nations in New York, on the 15th of November 2000. The object of the Convention consists in the development of the cooperation in order to prevent and to fight the organised transnational criminality in a more efficient manner.

NEW!

- **Law of 17 July 2008**¹³ on the fight against money laundering and financing of terrorism. This law transposes the EC regulation 2005/60/CE of the European Parliament and of the European Council of 26 October 2005. It thereby modified laws related directly to the national drug legislation.

Grand Ducal Decrees (2004/2009)

- **The grand ducal decree of 30 January 2004**¹⁴ 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 1995¹⁵
- Grand ducal decree of 13 **February 2007** on the surveillance and commerce of drug precursors¹⁶

¹² Official gazette A 2007, p. 4410 (Adoption: 18/12/2007, Entry in force: 28/12/2007). See also ELDD

¹³ Official gazette A 2008, p. 1495 (Adoption: 17/07/2008, Entry in force: 23/07/2008). See also ELDD

¹⁴ Official gazette A 2004 (Adoption: 30/01/2004, Entry in force: 13/02/2004). See also ELDD
Règlement grand-ducal du 30 janvier 2004 modifiant le règlement grand-ducal modifié du 2 février 1995 relatif à la fabrication et à la mise sur le marché de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes.
<http://www.legilux.public.lu/leg/a/search/resultHighlight/index.php?linkId=1&SID=e0622007c5892b499e6269171b466eaf>

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

¹⁶ Official gazette A 2007 (Adoption: 30/01/2004, Entry in force: 13/02/2004). See also ELDD
Règlement grand-ducal du 30 janvier 2004 modifiant le règlement grand-ducal modifié du 2 février 1995 relatif à la fabrication et à la mise sur le marché de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes.

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>.

- The **grand ducal decree of 7 October 2004**¹⁷ 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 18 January 2005**¹⁸ 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 16 March 2006**¹⁹ defines maximum prescription periods for methylphenidate, oral morphine, transdermic fentanyl, buprenorphine, hydromorphone and methadone.

New!

- The **grand ducal decree of 14 April 2008**²⁰ modifies the annex of the grand ducal decree of 4 March 1974 on certain toxic substances by putting GHB (Gamma hydroxybutyric acid) under national control.
- The **grand ducal decree of 20 April 2009**²¹ put the following molecules and materials under national control:
 - a) BZP
 - b) CP-47,497, JWH-018, HU-210 and all other synthetic agonists of cannabinoid receptors.
 - c) Organisms or part of organisms containing a nationally controlled substance in its natural state or after human intervention.
 - d) Biological material²² capable of producing organisms referred to under c).

¹⁷ Official gazette A 2004 (Adoption: 07/10/2004, Entry in force: 21/10/2004). See also ELDD 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>

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

¹⁹ Official gazette A 2006, p.1156 (Adoption: 16/03/2006, Entry in force: 31/03/2006). See also ELDD

²⁰ Official gazette A 2008, p. 754 (Adoption: 14/04/2008, Entry in force: 28/04/2008). See also ELDD

²¹ Official gazette A 2009, p. 1077 (Adoption: 20/04/2009, Entry in force: 05/05/2009). See also ELDD

²² e.g. spores of magic mushrooms.



Laws implementation

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

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

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

In accordance with Article 23 of the 1973 law, cases involving personal use of drugs (individually or in a group) and/or cases involving offences against Article 8 of the 1973 law are dropped if the offender, before the illegal use was discovered, undertook treatment for drug addiction. Moreover, the public prosecutor can offer the offender the option of voluntary treatment for the addiction. If the offender successfully completes the treatment proposed by the prosecutor, the charges have to be dropped.

According to the terms of Article 24 of the 1973 law, when preliminary charges are brought for personal use of drugs and when it is established that the offender is the subject of medical treatment, the investigative judge may order treatment for drug addiction at the request of the prosecutor or the accused person.

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

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

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

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

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

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

The law of 27 April 2001²³ 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 2002²⁴ on substitution

²³ Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001) See also ELDD

²⁴ Official gazette A 2002, p.232 (Adoption: 30/01/2002, Entry in force: 12/02/2002) See also ELDD

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

The reaction to an offence committed by a drug user must be proportional to the harm it aims to prevent. All the legal experts of Luxembourg are in agreement with this statement, and the principle is applied in practice. In fact, as long as the drug addict remains a simple user, any damage caused is to himself/herself and the legal response remains minimal as long as public order is not greatly disturbed. However, if the drug addict causes harm to others, the response will become firmer according to the seriousness of the offence.

In line with the same principle and in a public health perspective, the law of 2001 has introduced a special article on prosecution of drug law offenders having called for medical aid in case they witness an overdose of another user. The law abolished prison sentences and fines for witnesses being simple users and reduced penalties for users having sold or delivered drugs to the overdose victim(s). In practice, however, the second category of users is generally not prosecuted in case they tried to assist another user by calling for specialised help.

Overall, the highest priority is given to trafficking of 'very dangerous' drugs. Such traffickers may be considered to be trafficking in death. Since the first objective of Luxembourg's drug policy is to prevent addiction and related risks, it is fundamentally important to pursue the dealers. As long as there are widely available 'dangerous' drugs on offer, the price will be relatively low. This situation will increase the temptation for consumers of other drugs (even the legal ones, such as alcohol and tobacco) and access to 'very dangerous' drugs will remain easy. Consequently, all efforts must be concentrated on fighting dealers in 'very dangerous' drugs, in order to limit the availability of such drugs. The penalties handed down to traffickers should have a deterrent effect. All the legal experts, the police and the social workers agree on this. It is not possible to tolerate any trafficking of hard drugs if an efficient fight is to be conducted against drug addiction.

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

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

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



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

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

Other drug policy developments: Initiatives in Parliament and civil society

Following a series of Parliamentary initiatives and debates on drug strategies and policy in 2006 and 2007, the national drug coordinator was invited twice during 2008 and 2009 to report the state of implementation of the national drugs action plan to the Parliamentary commission on Health and Social Security.

Parliamentary questions during the reporting period mainly addressed the state of play regarding the Spice phenomenon and progress made in implementing a permanent low threshold centre for drug addicts (TOXIN: injection room + day and night shelter). The geographical location of the referred centre also continued to be subject to sustained discussions between the Ministry of Health, the City of Luxembourg, civil society and local citizens' interest groups.

No projects or propositions of law in relation with drugs or drug addiction were introduced in 2008.

NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

Coordination mechanisms

The coordination of drug demand reduction, risk reduction and drug related research is a competence of Ministry of Health. Since 2000 a National Drug Coordinator, appointed by the Minister of Health, has been mandated with the overall coordination (including interministerial coordination) in the domains of drug-related demand and harm reduction and represents Luxembourg at the international level. Supply reduction and international cooperation aspects remain a competence of the Ministry of Justice and the Ministry of Foreign Affairs respectively.

At the national level, the coordination among the competent ministries takes place in the *Inter-ministerial Commission on Drugs (ICD)*. 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 constitutes the top decision level with respect to coordination and orientation of actions. Both, the ICD and the Ministry of Health are responsible for the implementation of national drugs strategies and action plans, supervise field activities and are bound to guarantee an effective consultation process with other involved ministries (e.g. Justice, Foreign Affairs). The ICD meets 4 to 6 times yearly. There are four permanent agenda items: the implementation of action plans, the early warning system on drugs, emerging trends and legal changes and international affairs. Outcomes of the ICD meeting are transmitted to all competent ministers and national media in order to ensure complete public visibility. Since 2006, the ICD has been granted an enlarged mandate and addresses currently issues ranging from illicit drug use to alcohol use and prescription drugs under the general heading of addictive behaviour and its consequences. In May 2008 the ICD issued its first press communication on alcohol misuse in youngsters, first to raise awareness and secondly in order to give increased visibility to the work and priorities of the ICD.

At the governmental level, there exists a Special Parliamentary Commission on Drugs as an advisory body to the government. Currently, however, the referred commission is not active.

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

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



National plan and strategies

The national drugs strategy and action plan 2005-2009 has been presented in detail in previous annual reports. Having taken into consideration the EU drugs strategy 2005-2012 endorsed under Luxembourg Presidency in June 2005 and the EU drugs action plan 2009-2012, the national strategy and drugs action plan are meant to contribute to a high level of health protection, public security and social cohesion and rely on two policy pillars, namely supply reduction and demand reduction.

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.

As the new governmental drugs strategy and action plan 2010-2014 will only be presented by the beginning of year 2010, a detailed presentation of their final and approved version will be provided in the annual report 2010.

Implementation of policies and strategies

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

In 2009, in order to best meet current needs in the elaboration of the 2010-2014 action plan, the national drug coordinator has launched a third multilateral consultation process involving ministerial departments, specialised NGOs and civil society. A special working group, chaired by the Ministry of Health, performed a needs assessment and elaborated national recommendations focusing on specialised drug care and rehabilitation offers. A more restricted group composed of representatives of the Ministry of Health and the National Addiction Prevention Centre drafted the action plan in the framework of primary prevention strategies. The priorities set by the Ministry of Health were discussed and, if necessary, complementary measures were added. A consensus on priority rankings of listed actions has been reached among involved parties. Finally all retained actions were structured in a clear, simple and output oriented way as follows: '1. Description/objective of action – 2. Responsibilities – 3. Budget – 4. Outcome – 5. Deadlines for outcome and evaluation'.

The active involvement of specialised NGOs and civil society from the very start of the conceptualisation work and consensus making prior to the implementation phase have shown to be a major criteria to guarantee an effective implementation process. Summarily, one should stress that the multilateral involvement of competent actors and the fact that most agencies involved in the implementation process are financed and controlled by the centrally coordinating Ministry of Health highly promote the effectiveness of the national strategic model.

Evaluation of policies and strategies

Implementation progress of the drugs action plan has been kept on the political agenda since its start in 2000 and consequently the pressure to perform was continuously high. Media also contributed to this enhanced awareness and activity boosting, especially since they have been able to identify a central personalised key actor in the person of the national drug coordinator. Another positive side effect of consecutive drugs action plans is an increased commitment of NGOs and civil society in the drug policies as they have been involved since the very beginning of the process. The general public has largely welcomed drug action plans since it enables them to follow up public efforts to fight a problem that is of great concern for them and to compare announced objectives with achieved actions.

Over the last 10 years the concept of implementation follow-up, evaluation and external evaluation strategies have gained in importance in the field of drugs and drug addiction.

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

Beside the efforts made by the totality of involved actors and networks, the positive outcome has also to be related to the considerable increase of the budgetary means allocated to the fight against drug addiction. An increase of 287% of the budget invested by the Ministry of Health in drug demand reduction occurred between 2000 and 2009.

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.

By the end of 2009, the Minister of Health will present the new drug strategy and action plan 2010 – 2014, elaborated by the National Drug Coordinator. The referred action plan is based on the evaluation outcome of previous action plans and the assessment of current and future needs. In this context and for the first time nationally, a final external output and progress evaluation of the national drug strategy and action plan 2005-2009 has been performed by the Dutch Trimbos instituut.

The contractual scope of the evaluation is a critical analysis of the implementation of the National Drug Action Plan 2005-2009. It builds upon the above mentioned mid-term evaluation of the Drug Action Plan. The aim is to serve policy relevant information to the stakeholders involved in making and implementing drug policy in Luxembourg. The following questions were addressed:



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

In implementing the evaluation the following guiding principles were applied:

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

The evaluation will result in a report answering the above mentioned questions resulting in a set of recommendations regarding the next National Drug Action Plan, the coordination structure and the policy-making process.

The final output of the external evaluation exercise (not yet available at the time of reporting) in addition to the recommendations of previously referred to working groups will and have been serving the national drug coordinator and the Interministerial Commission on Drugs to elaborate the new national drugs action plan 2010-2014.

Public expenditures

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

- Budget lines may be generic (legal & illegal drugs), aggregated (addiction prevention), over inclusive (social solidarity) or unidentifiable (others),
- Apportionment of budgets may not be provided,
- Difference between provisional budget, voted budget and final expenditure (provisional budget often more detailed than voted budget),
- Expenditures may be annual, multiannual, unique, ordinary, extraordinary, etc. If they occur during the study reference year, they should be included even though they might give a biased picture of average or routine expenditures, especially when they are important (e.g. investments in real estate)²⁶,
- In terms of follow-up: budget lines may be restructured, integrated or divided over time,
- In the field of public health, expenditures may result from direct state financing or social security reimbursement,
- Lack of clarity due to National mixed (Multi-ministries) financing (e.g. Public research Centres – multi projects' financing) or National & EU & International shared financing,
- Eligibility of cooperation projects vs. variability of yearly contributions,
- Assessment of impact of general education and educational interventions (e.g.) on DDR impossible.

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

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

In order to tailor and fine tune a methodology that fits the national context and in line with the work plan of the EMCDDA, a national study on direct economic costs of drug policies and interventions has been performed from 1999 to 2002 and refers to data from 1999 (Origer 2002 b). (*Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies*). The original research report can be accessed under: <http://www.relis.lu>. In the framework of 2006 EMCDDA contractual requirements an update of the Origer 2002 study has been performed. A detailed description of the methodology applied in 2002 can be consulted in the original study. The same methodology has been applied for the present and other yearly updates.

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

²⁵ See related chapter in Part B

²⁶ In order to highlight the different status/nature of budget lines, the following abbreviations have been used in the expenditure tables: S.: Standard budget (annual expenditure / budget line) I: Investments (unique year dependant expenditure)



METHODOLOGY

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

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

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

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

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

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

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

Main reference documents:

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

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

Ministère des Finances (2007). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.

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

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

Ministère de la Santé (2009). Rapport d'activités 2008, Ministère de la Santé, Luxembourg.

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

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

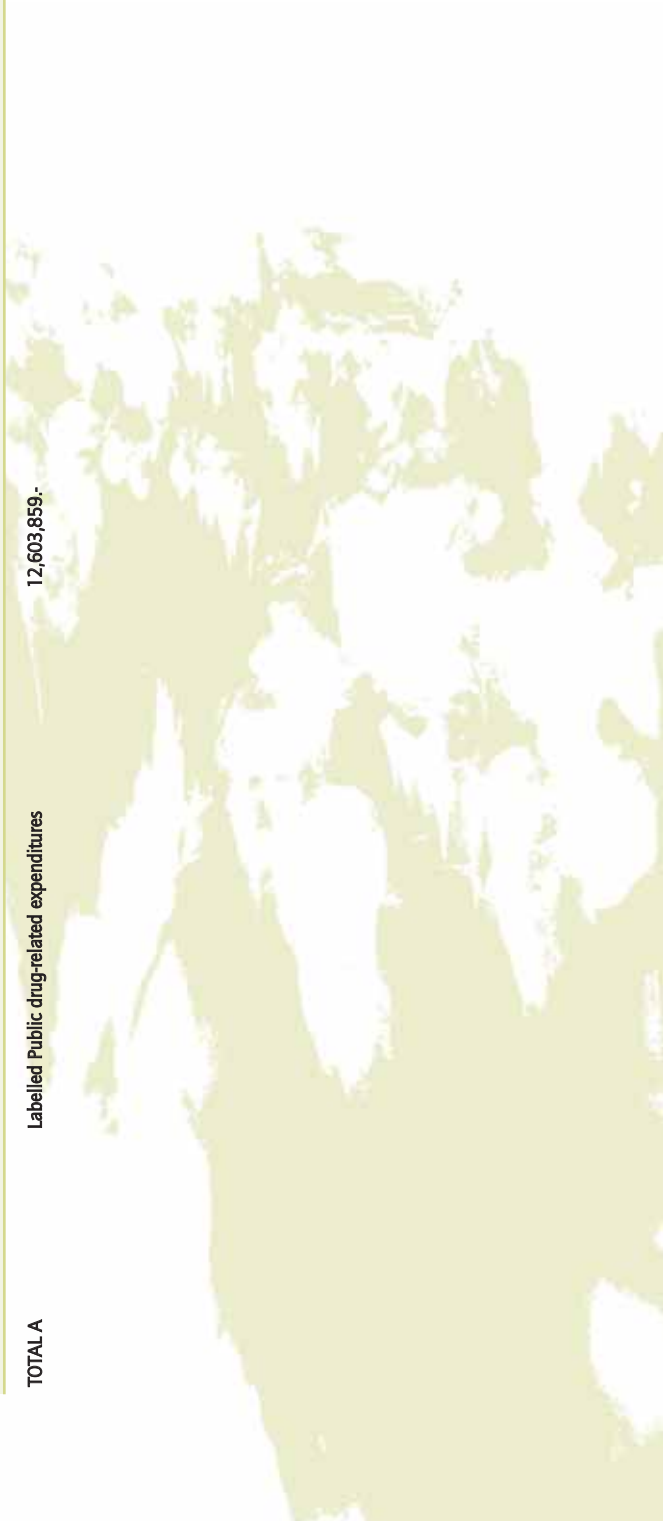
Origer, A. (2002b). Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies. Séries de recherche n°4, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

Tab. 1.1 National estimates of labelled drug related expenditures

Ministry/Department	Budget/Title	Budget/Expense (EUR)	COFOG	REUTERS
01 Ministry of Foreign Affairs and Immigration	S 01.7 / 35.031 Cooperation and Development: Voluntary contributions to international organisations Contribution to UNODC	100.000.-	01.2.2.	/
04 Ministry of Finances	S 04.3 / 12.310 Special Drugs Division of Customs Staff and operational costs of the Costs related to drug dogs brigade	3.886.000.- 45.000.-	01.1.2. (03.06.0)	3
05 Ministry of Finances Treasure and Budget	S 2008 national investments of the National Fund against Drug Trafficking	610.800.-	01.1.2 (03.06.0)	1,2,3,4
	I 34.3 74.300 Acquisition of drug detection equipment for Customs Administration	65.000.-	03.6.0	3
07 Ministry of Justice	S 07.0 35.060 International Relations: Contribution to EUROPOL DRUG UNIT	0.-	01.2.2.	3
	S 12.370 / 12.30 Care programme for drug addicts in prison	737.040.-	07.2.0.	
10/11 Ministry of Education of Professional Training	S 10.0 12.223 primary schools 04.01 Drug prevention in primary and post	0.-	07.4.0	1
	S 11.4 12.301 Drug prevention and Sport	2.000.-	07.4.0	1
12 Ministry of Family, Social Solidarity and Youth	S 12.8 / 12.252 Drug Prevention in retention centres for minors	13.000.-	03.4.0	1
14 Ministry of Health	S 14.0 12.000 Fees for National Drug Substitution treatment commission	0.-	07.4.0	2
	S 14.1 12.343 Control of national enforcement of UN drug conventions	2.000.-	01.2.2.	3
	S 14.1 33.002 Co-financing of staff and operational costs of the national EMCDDA focal point	161.220.-	07.5.0.	/
	S 14.1 / 33.013 Staff and operational cost of specialized drug agencies conventionned by state	6.451.228.-	07.2.0	1,2,3,4



S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	510,000.-	07.1.2.	4
S14.2 12.301 05.20 / 12.801 05.20 Toxicological surveillance of drug addicts	150,000.-	07.4.0	/
S 14.1 / 12.126 13.90 Costs of external evaluation of the national drugs action plan 2004-2009	15,000.-	?	
S 14.1 / 12.140 05.10 National Aids plan (25%)	17,000.-		
I 44.7 52.002 05.22 Construction works and acquisition of equipment for conventioned specialized drug agencies	130,000.-	07.2.0	2
22 Ministry of Public Buildings			
I 52.4 72.022 05.20 05.22 / 74.092 74.22 Construction works and acquisition of equipment for conventioned specialized drug agencies	30,000.-	07.2.0	2
TOTAL A	12,603,859.-		



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

Ministry/Department	Budget/Title	Budget/Expense (EUR)	Attributable proportion	COFOG	REUTERS
01 Ministry of Foreign Affairs and Immigration	S. 01.7 Staff, operational and mission cost related to drug related issues	20,400.-	Estimation by MFA based on analysis of work and mission reports and career of involved agents	01.2.2.	/
05 Ministry of Finances Treasury and Budget	S. 05 Renting of real estate for specialized drug agencies	285,000.-	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	6,700.-	Estimation by MJ based on analysis of work / mission / career	03.6.0	3
	S. 07.1. 0 Staff, operational and mission cost of judiciary services (courts, etc) related to drug related issues	1,120,000.-	Total cost of judicial services x proportion of drug offences affairs (based on ad hoc register)	03.3.0	3
	S. 07.2 Prison drug related expenditures	14,203,670.-	Total prison budget x proportion of drug law offenders in total prison population	03.4.0	3
12/13 Ministry of Family, Social Solidarity and Youth	S. 07.4 Police drug related expenditures	1,162,360.-	Dedicated staff, operational and mission costs (Special drug units 100%)	03.1.0	3
	S. 13.1 / 12,140 06. 32 Information campaigns on drugs	3,691,600.-	+ Assessment by Police Directorate based on analysis of job descriptions and related operational costs	03.1.0	3
	S. 13.1 / 11.000 11.00 Staff, operational and mission costs of MF related to drug related issues	14,960.-	Internal budget breakdown	07.4.0	1
		22,700.-	Estimation by MF based on analysis of work / mission / career	07.4.0	1



14 Ministry of Health	§ 14.0 Staff, operational and mission cost of MH related to drug related issues	22,700.-	Estimation by MH based on analysis of work / mission / career	07.6.0	1,2,4
14.1 Directorate of Health	§ 14.1 / 33.014 05.23 Staff and operational cost of National Aids counselling Centre	188,217.-	25% of total budget : average proportion of PIW/HIV/AIDS infected via IDU in clients	07.2	1
	§ 14.1 / 11.000 05.00 / 12.010 05.00 Staff and mission costs of Directorate of Health allocated to drug related issues	245,000.-	Dedicated staff to drug issues + Estimation by MH based on analysis of work / mission / career	07.6.0	1,2,4
14.2 Public Health Laboratory	§ 14.2 / 11.000 05.20 Staff, operational and mission costs of Laboratory related to drug related issues	22,700.-	Estimation by Laboratory based on analysis of work / mission / career	07.4.0	2
17 Ministry of Social Security	§ 17.2 Staff, operational and mission costs for agents in charge of drug treatment referral abroad	77,694.-	Estimation by MSS based on analysis of work / mission / career	07.4.0	2
<i>Health / Social insurance</i>	<u>A. Substitution treatment</u>				
	- Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (Net, patient's contribution excluded)	333,200.-	Detailed breakdown by National Health Fund (CNS)	07.2.2	2
	- Reimbursement of medical counselling costs related to substitution prescriptions	37,289.-	Detailed breakdown by National Health Fund (CNS)	07.3.2	2
	<u>B. Inpatient hospital drug treatment</u>				
	- Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification) (2007)	2,876,498.-	ICD-10: F11, F12, F14, F15, F16, F18 and F19 hospital episodes (provided by CNS)	07.3.2	2

C. Drug treatment abroad

- Reimbursement of drug treatment costs abroad (e.g. residential therapy or specialized therapeutic offers not available in Luxembourg)

1,220,000.- Adjusted breakdown provided by UCM in 2005 07.3.2 2

D. Cost of HIV/AIDS treatment provided to patients infected via IDU

1,830,000.- Number of HIV/AIDS patients infected via IDU in treatment x yearly average cost of HIV/AIDS treatment/patient (+/- 20,000.- EUR) x reimbursable proportion 07.2.2 07.3.2 2

TOTAL A

Non-labelled Public drug-related expenditures 27,380,688

TOTAL A+B

Labelled + Non-labelled Public drug-related expenditures 39,984,547



Tab. 1.3 Overall expenditure in fiscal year 2008 by 1st level COFOG functions

COFOG 1 st level function	Labelled expenditures	Non-labelled expenditures	TOTAL
3 (Public Order and Safety)	13,000.-	20,197,330.-	20,210,330.- (57%)
7 (Health)	8,171,488.-	6,890,958.-	15,062,446.- (43%)
TOTAL			35,272,776.-

Tab. 1.4 Overall expenditure in fiscal year 2008 by 2nd level COFOG functions

COFOG 2 nd level function	Labelled expenditures	Non-labelled expenditures	TOTAL
3.1 (Police services)	/	4,853,960.-	4,853,960.-
3.3 (Law courts)	/	1,120,000.-	1,120,000.-
3.4 (Prisons)	13,000.-	14,203,670.-	14,216,670.-
7.1 (Medical Products, appliances and equipment)	510,000.-	/	510,000.-
7.2 (Outpatient services)	7,348,268.-	558,706.-	7,906,974.-
7.3 (Hospital services)	/	5,926,498.-	5,926,498.-
7.4 (Public Health services)	152,000.-	138,054.-	290,054.-
TOTAL			34,824,156.-

ADDITIONAL EXPLANATORY NOTES ON ATTRIBUTABLE PROPORTION CALCULATION KEYS (NOT ADDRESSED IN TABLES)

05 Ministry of Finances Treasure and Budget

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

07 Ministry of Justice

07.2 State prisons.

Distinction between new entries and stock of prisoners/year is to be made.

Prison administration provided proportion of "drug offenders" in prison (prevalence: 25%) (Incidence: 21% new entries):

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

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

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

17 Ministry of Social Security (Health expenditures)

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

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

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

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

01 Ministry of Foreign Affairs and Immigration

II.1 National Contribution to the EU 'drugs budget'

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

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

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

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

c) Estimation of national contribution: X x Y.

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



Relevant or pertinent expenditure breakdowns:

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

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

BUDGET

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

Fig. 1.1 Annual budget of the Ministry of Health allocated to drug-related activities 2000 - 2009

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Budget (EUR)	2,066,00 0.-	3,210,000.-	4,294,000.-	4,862,000.-	5,771,000.-	6,196,000.-	6,584,000.-	6,689,000.-	7,288,455	7,991,583
Progression rate	Reference year	55%	108%	135%	180%	200%	217%	224%	253%	287%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2009. Volume 1. (Ministère des Finances 1999-2009)

Fig. 1.2 Annual progression of budget of the Ministry of Health and human resources allocated to drug-related activities 2004 - 2009

Budget Year	2004	2005	2006	2007	2008	2009
Budget (EUR)	5,771,000.-	6,196,000.-	6,584,000.-	6,689,000.-	7,288,000.-	7,991,583.-
Annual progression rate	Reference year	7.36%	6.27%	1.59%	8.97%	9.65%
Annual cumulative progression rate	Reference year	7.36%	14.09%	15.91%	26.29%	38.48%
Dedicated human resources Full Time Equivalent (FTE)	59.5	63.5	69.25	73.5	78.5	83.75
Annual progression rate	Reference year	6.72%	9.06%	6.14%	6.80%	6.70%
Annual cumulative progression rate	Reference year	6.72%	16.39%	23.53%	31.93%	40.76%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2006/2009. Volume 1. (Ministère des Finances 1999-2009)

Funding arrangements (NNIA)

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

National media coverage of drug-related issues

Relation with the media is an indispensable tool in communications strategies aiming at informing a broad public by providing up-to-date and reliable data on the numerous topics related to drugs and drug use. In 2008 the NFP performed an in-depth analysis of national written media base on an exhaustive press review and focusing on thematic areas touched upon and frequency of appearance. Of 425 articles on drug related matters, 90% were published by the most read national daily newspaper. Most represented topics in order of importance are: doping in sports, international short news, national short news and infectious diseases. Table 1.3 summarizes main results and covers the period from August 2008 to July 2009.

Fig. 1.3 National coverage of written media²⁷ regarding drug-related topics from August 2008 to July 2009

Paper/magazine Topic	1	2	3	4	5	6	7	8	9	10	11	12	TOT	%
SR, law enforcement													76	18
National short news item (arrests, seizures)	56				1		2						59	
Court news (convictions, sentences)	4												4	
National drug scene (perquisitions, etc)	9				1								10	
Prison related topics	3												3	
Research													0	0
Substances and addiction													147	35
Additions in general	2												2	
Cannabis	1						1						2	
Spice and analogues	2	1		1	2	1							7	
Alcohol / Alcopops	6												6	
Doping	135												135	
Campaigns, prevention, laws													58	13.65
Drugs in general	10	1		1	1		2					1	16	
Alcohol	6												6	
Tobacco	12												12	
Infectious diseases	23												23	
Others												1	1	
Specialised drug agencies													27	6
NGOs	18					1	3						22	
TOXIN / Drug injection room	3						1					1	5	
EMCDDA National Focal point													5	1.18
Activities and publications	2	1		1			1						5	
Ministry of Health , Government, Parliament													25	6
EU drugs strategy and action plans						1							1	
Health Commission, Questions to government, Interministerial Groups on Drugs	14				2	2	1						19	
Heroin Assisted Treatment					1	1	1	1				1	5	
External relations													85	20
Organised crime/ trans-border cooperation	4												4	
International Organisations	2					3	1						6	
Afghanistan	7												7	
The Netherlands	5												5	
International short news	63												63	
Miscellaneous													2	0.47
Readers letters	2												2	
TOTAL	384	3	0	6	12	5	11	0	0	2	2	/	425	100
PERCENTAGE	90	0.71	0	1	2.82	1.18	2.59	0	0	0.47	0.47	/	100	

²⁷ Daily newspapers : 1. Luxemburger Wort, 2. Woxx, 3. Zeitung vum Letzebuurger Vollek, 4. Journal, 5. Tageblatt, 6. La Voix, 7. Le Quotidien, Weekly magazines : 8. Revue, 9. Telecran, Weekly newspapers : 10. Letzebuurger Land, 11. Le Jeudi, 12. Contacto.



2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

Introduction

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

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

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

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

DRUG USE IN THE GENERAL POPULATION

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

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

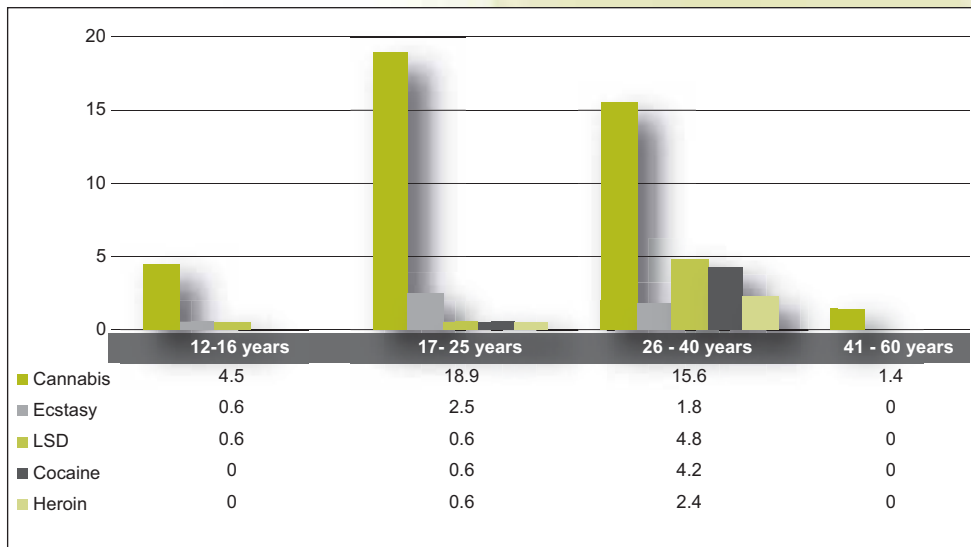
REFERENCE 1.

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

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

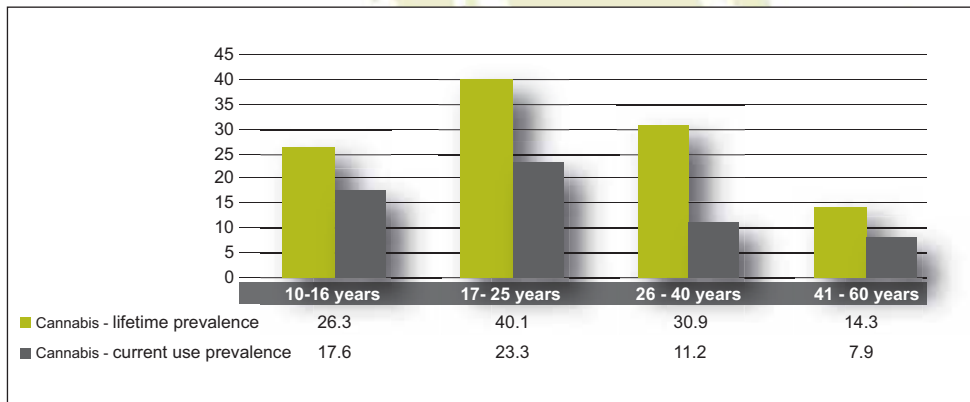


REFERENCE 2.1:

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

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 to 64 years
Data coll. Procedure	On-site interviews
Sample size	991 valid cases
Sampling procedure	Random sampling of cinema customers
Remark	Detailed results of both surveys are provided in EMCDDA standard tables

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

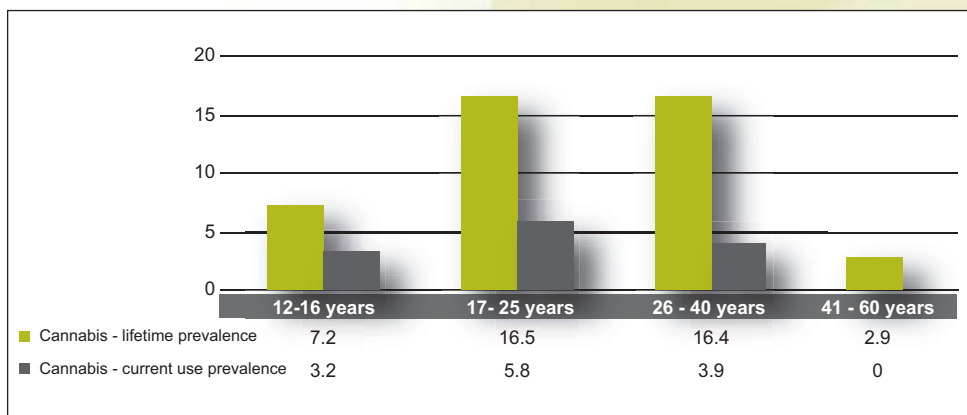


REFERENCE 2.2 :

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

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

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



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

Discussions are currently held with the CRP-Santé to collaborate in a general study on health behaviour in general population in order to include items on drug use. This study may be conducted in 2010 if necessary financial means are granted.



DRUG USE IN THE SCHOOL AND YOUTH POPULATION

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

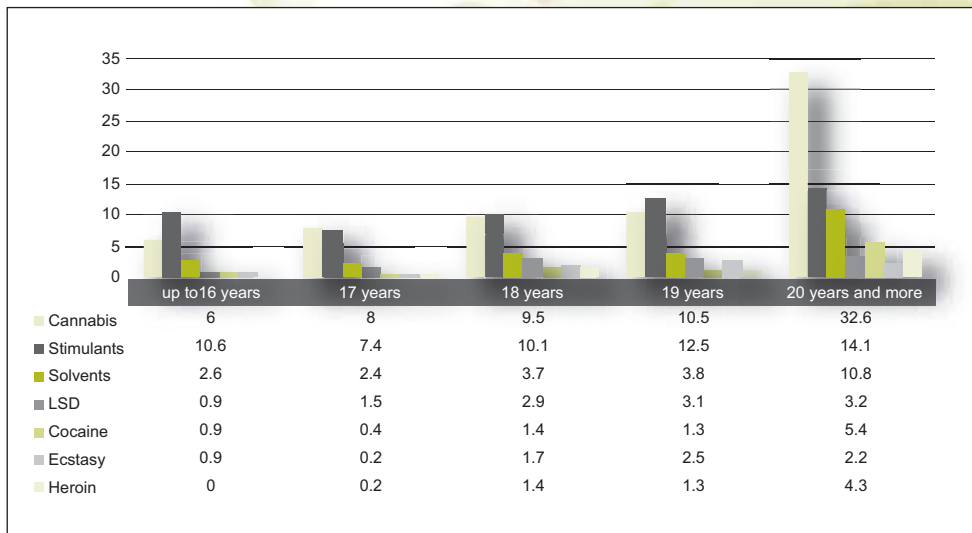
SURVEYS: CATEGORY 1

REFERENCE 1 :

Matheis J. et al. (1995) 'Schüler an Drogen', IEES, Luxembourg.
EN.: Students and Drugs.

Year of data collection	1992
Single/repeated study	Repeated study 1983 – 92
Context	Public Health
Area covered	Nation wide
Type of school	5 th years of all types of secondary school classes at the national level
Age range	16-20 years (AGE ENTERING 5 TH CLASS)
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	1,341
Response rate (M, F, T)	96% Matheis and Prussen (1985) have conducted a survey on 1983 data relying on the same methodological criteria than the 1995 survey. The referred study will be addressed in the comparative analysis part.

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



REFERENCE 2 :

Dickes P. et al. (1996), La consommation de drogues légales et illégales des élèves des 6^{ème} de l'enseignement secondaire et des 8^{ème} 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

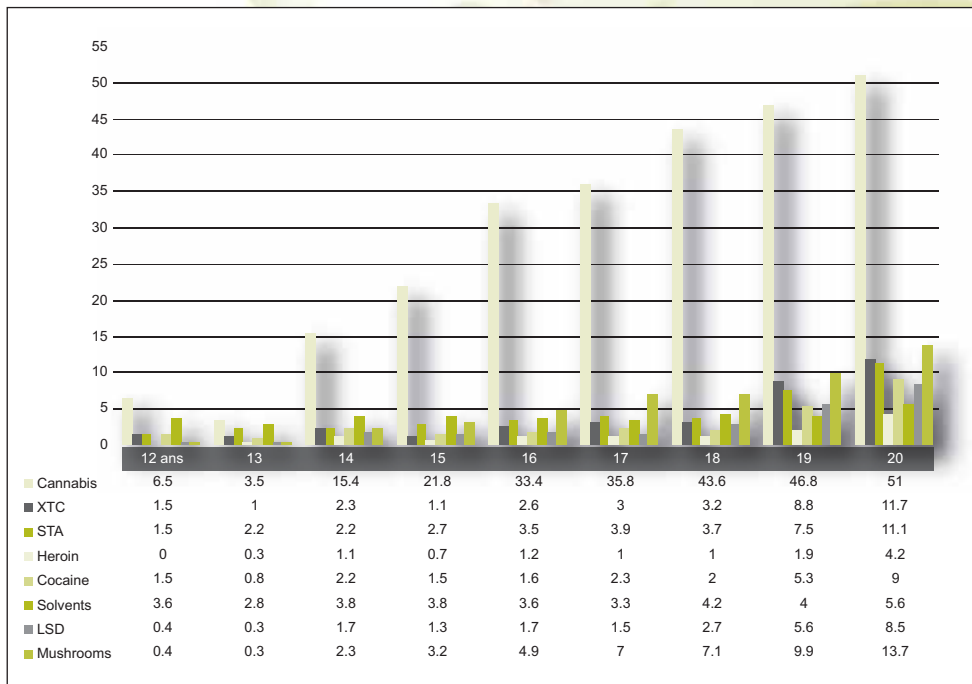
REFERENCE 3:

Das Wohlbefinden der Jugend – HBSC Studie (2000), Ministère de l'Education Nationale de la Jeunesse et des Sports, Direction de la Santé, Luxembourg.

EN.: Health and Health Behaviour of Young People

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

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



The consumption of illegal drugs has clearly increased the last years. A comparison of the Matheis 1992 study and the HBSC 2000 study reveals 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.

It should be stressed that a new HBSC study referring to 2005/2006 data has been presented in 2008 (Ministry of Health, in press). The section on drug use in youngsters thus allows to updating a series of former data.



Tab. 2.1 Comparative results from the serial HBSC 2002 and HBSC 2005/2006 surveys

	HBSC 2002						HBSC 2005/2006					
	age 11		age 13		age 15		age 11		age 13		age 15	
	BOY	GIRL	BOY	GIRL	BOY	GIRL	BOY	GIRL	BOY	GIRL	BOY	GIRL
TABACCO												
ever smoked tobacco	-	-	39.4%	38.8%	59.6%	57.9%	13%	8%	34%	29%	57%	60%
at least once a week	0.5%	0%	9.2%	8%	24.7%	26.1%	2%	1%	6%	6%	17%*	21%*
daily smoking	0.5%	0%	5%	5.5%	20%	21%	1%	0%	4%	5%	13%	16%
ALCOHOL												
Drunkenness (proportions that reported having been drunk at least twice)	2.3% (11 and 12 years)	1.4% (11 and 12 years)	6% (HBSC 2006: 5.5%)	21.9% (HBSC 2006: 23.5%)	2%	1%	6%	5%	27%	20%*		
weekly drinking (proportions that reported drinking any alcohol at least every week)	-	-	17.1%	13.4%	37.7%	22.9%	4%*	2%*	9%	6%	30%*	19%*
CANNABIS												
Lifetime use (at least once)	3.9%	0.2%	3.5%	21.8% (HBSC 2006: 23.9%)							25%	21%
Recent use – last 30 days – at least once											13%*	7%*
Cannabis use in the last 12 months	3.8% (11 and 12 years)	0.6% (11 and 12 years)	3.5%	21.8% (HBSC 2006: 18%)							21%	16%

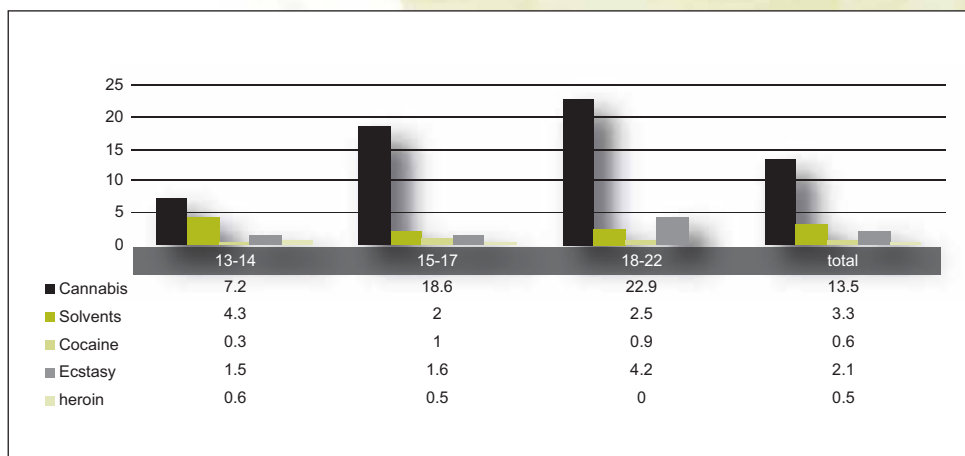
* indicates a significant gender difference (p <0.05)

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%

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

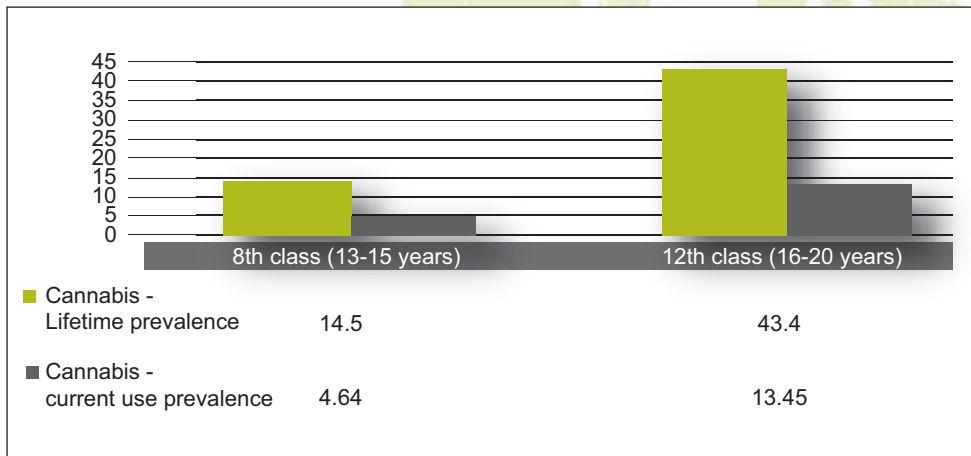




REFERENCE 5: Fischer U. CH. (2000), Cannabis – Eine Analyse der aktuellen Situation, CePT, Luxembourg. EN.: Cannabis – Rapid assessment of the current national situation.

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%

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



LIFETIME PREVALENCE: SCHOOL POPULATION:

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

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

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

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

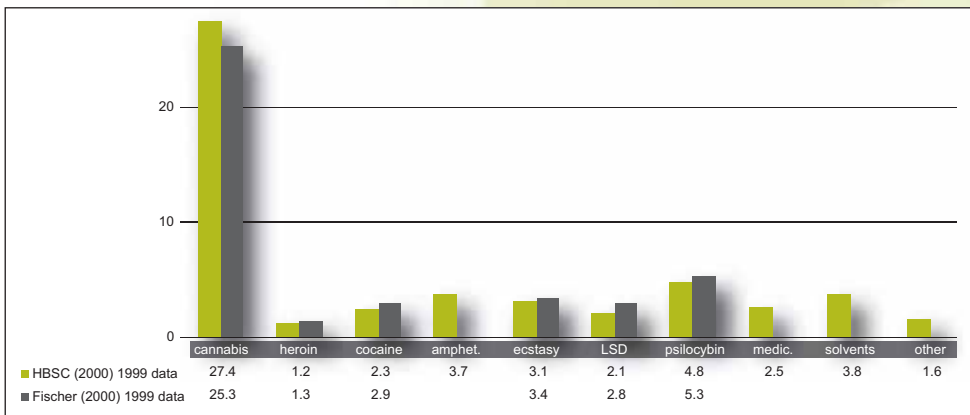


Fig. 2.9 LIFETIME PREVALENCE: SCHOOL POPULATION - 16-20 years

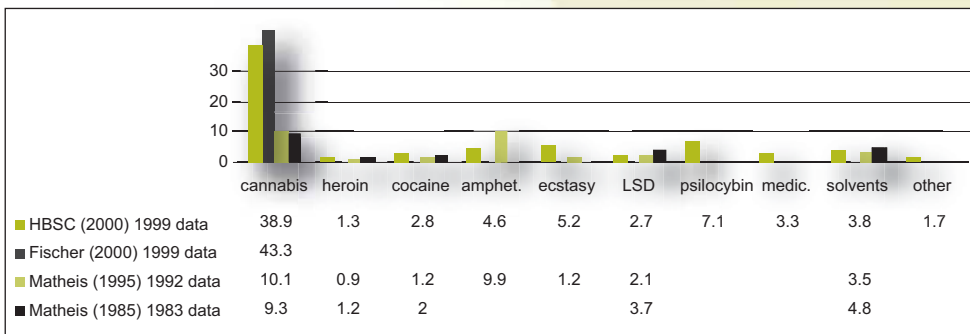




Fig. 2.10 LIFETIME PREVALENCE: SCHOOL POPULATION - 13-14 years

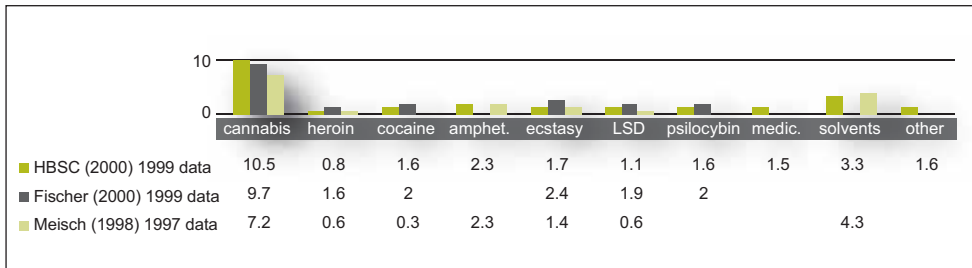
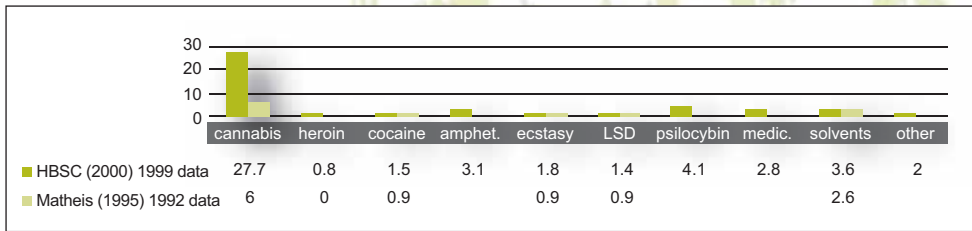


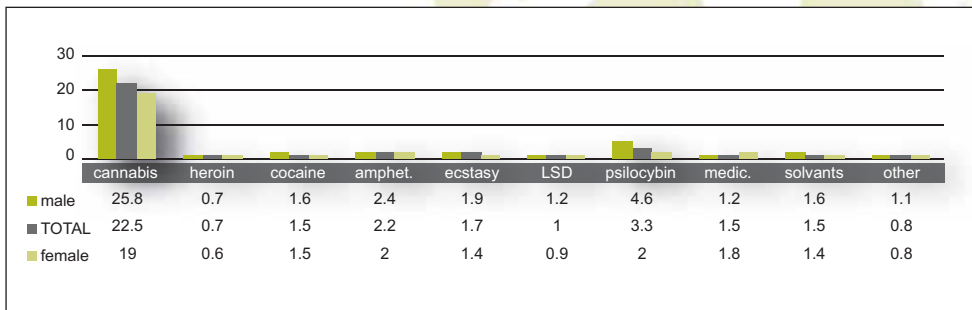
Fig. 2.11 LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years



LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

The HBSC surveys (2000, 2006) 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 is more prevalent than in males.

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



New data available from the serial HBSC studies (2002 and 2005/2006) show a recent decrease of last 12 months prevalence (tab.2.2) of cannabis use in youngsters aged 13 to 17 years. This observation is particularly obvious in youngsters aged 14, 16 and 17. Last 12 months heroin and cocaine use have been showing a certain overall stagnation between 2002 and 2006 whereas XTC, amphetamines, LSD and magic mushrooms consumption in youngsters has sensibly decreased over the same period. After a more detailed analysis, one notices that the age category of 15 years is the only to show increasing use specifically for XTC and cocaine. This age group should be monitored with greater attention in coming years.

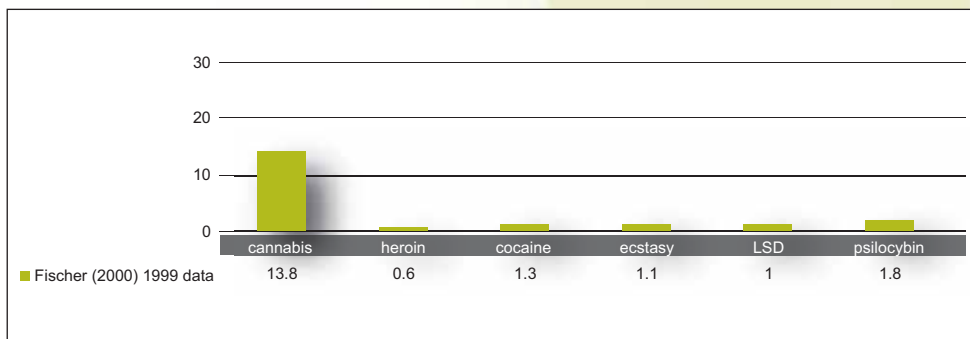
Tab. 2.2 HBSC 2002 and 2005/2006: Analysis according to age (last 12 months prevalence)

HBSC / Year	13		14		15		16		17	
	2002	2006	2002	2006	2002	2006	2002	2006	2002	2006
Cannabis	3,5	3	15,4	7,9	21,8	18,3	33,4	18,8	35,8	23,9
XTC	1	0,6	2,3	0,8	1,1	1,5	2,6	1,1	3	1,4
Amphetamines	2,2	0,8	2,2	1,3	2,7	1,8	3,5	1,5	3,9	1
Heroin	0,3	0,3	1,1	0,9	0,7	1,3	1,2	0,8	1	0,5
Medicaments	0,6	0,8	2,2	1,3	2,1	2,4	3,6	1,6	2,9	1,9
Cocaine	0,8	0,8	2,2	1,4	1,5	3,2	1,6	1,4	2	1,6
Glue/solvents	2,8	0,9	3,8	1,5	3,8	2	3,6	1,5	4,2	1,3
LSD	0,3	0,1	1,7	0,4	1,3	0,8	1,7	0,6	2,7	0,7
M. Mushrooms	0,3	0,5	2,3	0,8	3,2	2,1	4,9	1,8	7,1	2,1

LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

Fischer (1999) provides last 30 days prevalence figures for 13 to 20 year old school children. Cannabis and ecstasy prevalence figure 13.8% and 1.1%, respectively. Heroin, cocaine and LSD prevalence rates are close to last 12 months prevalence rates. Gender breakdowns are currently not available.

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





DRUG USE AMONG TARGET GROUPS

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

REFERENCE c.1

Origer A., Removille N., (2007) **Prévalence et propagation des hépatites virales A,B,C et du HIV au sein de la population problématique de drogues d'acquisition illicite, Point Focal OEDT / CRP-Santé. Luxembourg.**

EN: Prevalence study on HIV, HCV, HBV and HAV in PDUs in Luxembourg

Year	2007
Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence national PDU population
Area covered	In- and outpatient drug agencies and national prisons
Type sample	Random sampling during 8 months in 2005
Age range	> 17
Data coll. Procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES AND SEROLOGICAL TESTING
Sample size	366
Sampling frame	Random sampling
Response rate (M, F, T)	33.96%

MAIN RESULTS:

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

3. PREVENTION

Introduction

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

The present chapter provides a summary of recent universal and selective prevention measures undertaken at the national level. More detailed information and examples of good practice can be found in the EDDRA 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 co-financed by the Ministry of Health.

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

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

Direct drug prevention expenditures reached 672,000.- euros in 2000 and 900,000.- EUR in 2007. These figures include staff and operating costs of agencies and ministerial department specialised²⁸ in drug prevention.

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

²⁸ The exact estimation of prevention related costs is speculative since multiple factors influence the development of a youngster. Education, leisure activities, sport, etc may have a positive impact on resources building; they however cannot be quantified in terms of exclusive input.



anniversary, the CePT published a manual on the training of multipliers in primary drug prevention available at www.cept.lu.

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

UNIVERSAL PREVENTION

School

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

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

In 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 so-called prevention groups among all participating secondary schools in order to initiate a process of reflection on drug related themes. In 2004, the CePT managed to set up a primary prevention tool adjustable to the needs of the different secondary schools. Prevention groups are now operating routinely in several secondary schools in order to find solutions that fit each particular context.

As far as training activities are concerned, around 1,400 persons have participated in training sessions and conferences organized by the National Prevention Centre on Drug Addiction (CePT) during 2008 in collaboration with the Service of Coordination of Research and of Pedagogical and Technological Innovations (SCRIPT). The CePT proposed for instance pedagogical training for teachers of secondary schools, for educators of the primary schools in the city of Luxembourg, for the police academy of the Grand-Duchy of Luxembourg or for the employees of the penal institutions.

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

A mobile interactive exhibition on prevention called the *'Extra-Tour Sucht'* and aiming to reach students aged 15 to 18 years in school settings was further developed and adapted for instance to new trends such as shisha smoking. It was specifically designed for the Luxembourgish schools settings by the German company KomPass.

Several projects against smoking were also initiated in 2008. A contest called *'Mission not smoking'* involved 133 school classes, thus reaching 2,800 students from 12 to 16 years. The participating students committed not to smoke during six months. A second project on the subject *'School without tobacco'* took place. In this context secondary school students met in the pedestrian area in the city of Luxembourg and Ettelbrück and kindly asked people to extinguish their cigarettes, thus creating a non-smoking area.

The project *'Nach ëmmer allcool'* was developed in 2008, jointly by the CePT, the National Theatre of Luxembourg (TNL) and SCRIPT. The outcome was a theatre play, addressing prevention of alcoholism presented in secondary schools from January to Mars 2009.

The youth centre of Pétange is the first Luxembourgish organization to participate in an European action on drugs. In this context, a forum on the prevention of drug addiction took place in May 2009, in which students from the technical schools of Pétange, Esch-sur-Alzette and Arlon participated. This forum on drug addiction and the prevention in general, was organised together with the grand-ducal police, responsible young drivers, 'Main tendue a.s.b.l.' and local action for youth.

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

Family

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

Active collaboration between the CePT and 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. Discussions are currently held whether to include capacity building counselling sessions to drug addicted pregnant women and drug addicted recent parents in the new national drug action plan.

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 one agency focuses on interventions in recreational settings, namely the CePT (community project²⁹).

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

SELECTIVE PREVENTION

At-risk groups

In 2006, MDs without frontiers - Youth Solidarity (currently Jongenheem asbl) in collaboration with the Public Prosecutor's Department of Youth Protection and the Judicial Police- Drugs Unit launched a new project called **CHOICE**, which is based upon a pilot project of "early intervention of first drug offenders" (FreD) initiated by the Federal Ministry of Health and social security of Germany. The target group consists of youngsters aged 12 to 17 who entered in conflict with drug law. The overall aim of CHOICE is to offer youngsters an early and short-term intervention in order to prevent further development of drug abuse and drug addiction. An "in-take" interview allows assessing whether a participation in the CHOICE project or an individual psychological follow up is indicated. A CHOICE group consists of four interactive sessions (6 to 8 participants) which provide information on drugs, legislation and treatment services, promote auto-reflexion, reinforcement of personnel skills and motivation to change attitudes towards drugs. In a first phase, the project is regionally limited to the judicial district of Luxembourg City. Police officers hand out CHOICE flyers to youngsters in breach with drug law including all information on the intervention and inform the Public Prosecutor's department of Youth Protection. The youngsters and eventually their parents contact the CHOICE team within two weeks and the latter inform the Public Prosecutor on the participation level. A certificate testifies the participation of the youngster. In 2008, 32 CHOICE sessions have been organized (48 in 2007). An external evaluation is foreseen for 2009.

The 2004-2009 governmental programme also underlines the necessity to further develop prevention programmes for youngsters with regard to polydrug use and in particular the increasing use of alcoholic mix-drinks. Furthermore, special attention is currently given to a series of vulnerable groups.

²⁹ 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.

Thus, in 2009 Aidsberodung Croix-Rouge in collaboration with the Ministry of Health and the CHL launched a project called 'DIMPS' (Intervention mobile for sexual health) in the framework of the national action plan on Aids 2006-2010. *DIMPS* is meant to inform on risk behaviour and provide free infectious disease testing in difficult-to-access populations, such as immigrants. Combined rapid tests for HIV and HCV are proposed and the new drugs action plan foresees to broaden the mobile offer to vaccination of hepatitis A and B in case of medical indication. Currently the *DIMPS* van visits low threshold drug agencies, gay meeting places and immigration centres. As the project only started in 2009 no user statistics are yet available. However, the offer appears to show high acceptance and interest in the target groups.

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.

Special 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.

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

At-risk families

Since 2003 the Youth-and Drughelp foundation (JDH) is running a parental project with the aim to provide psycho-social aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative capacities. This long term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. In 2008, 57 different family situations have been reported, 38% of them were monoparental situations involving all in all 94 children. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

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



Recreational settings

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

Since its creation in 1995, the CePT, has initiated projects in the field of active leisure organisation: anti-drug discos, art performances, theatre, media supports (films, cartoons, etc.), seminars, ambulatory exhibitions, travel experiences, etc. The CePT increasingly ensures the national coordination of such activities. A broad offer of activities for youngsters integrating the drug prevention topic as one of the various components of **Health education** is developing. The latter approach is believed to have more impact on youngsters (users and non users) than a drug-centred approach. Indeed, human interactions in daily life situations as for instance adventure or sports activities are most adequate as a conceptual framework for the progressive integration of drug-related prevention initiatives.

In this respect, the demand reduction activities organised by the 'Mondorf Group' (joint initiatives of border regions of France, Germany, Belgium and Luxembourg) jointly with the CePT and SNJ combine a **non drug-centred approach** with **intercultural components** in organising corporate leisure activities for youngsters from border countries based on the concept of "**adventure pedagogy**". The annual "**adventure weeks**³⁰" do fit in a broader programme named "Adventure pedagogy and primary addiction prevention". Those activities primarily aim to provide the opportunity to youngsters to experience group dynamics, conflict management, limit and risk assessment as well as the feeling of solidarity within a group of socially and culturally different people. The programme further aims at the reduction of risk factors and the enhancement of protection factors, by focussing on youngsters and their environment, rather than on drugs and addiction. Regional teams specialised in drug prevention meet in autonomous working and training groups and report activities to the Mondorf Group.

The CePT continued its close collaboration with the National School for Physical Education and Sports (ENEPS) in the framework of a project called 'Give strength to children'. Information and training sessions in presence of a top professional sportsman have been organised.

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

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

The governmental programme of 2009 puts emphasis on the phenomenon of binge drinking and its increasing prevalence in youngsters. The government also intends to promote the selling of non alcoholic drinks at a lower price than alcoholic drinks in recreational setting and overall. A special working group chaired by the Ministry of Health has received a mandate to continue its work. Measures implemented according to recommendations from the referred group included a significant raise of taxes imposed on alcopops, 16 years minimum age for the purchase of alcoholic beverages and zero tolerance for young drivers. It may well be that the group will be invited to elaborate a sub-action plan on alcohol to be integrated in the general framework of the national strategy to fight addictive behaviour.

³⁰ See EDDRA

Occupational settings

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

INDICATED PREVENTION

Children at risk with individually attributable risk factors

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

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

NATIONAL AND LOCAL MEDIA CAMPAIGNS

In the framework of the international day against drug abuse and illicit traffic the new cooperate identity of the National Prevention Centre on Drug Addiction (CePT) was presented to the press. Since September 2007, CePT has enlarged its offer of existing information (library, leaflets, brochures and homepage) by adding a telephone line, which is accessible every day from 9 am to 1 pm, as well as an electronic help-line (FRO NO). The redesign of the CePT homepage simplifies the search and the access to information related to drugs and addictions.

Furthermore, leaflets on alcohol and cannabis, informing the general public on effects of referred substances, their legal status, related risks, were diffused to a very broad national public.

A flyer on solvent abuse was exclusively addressed to adults taking care of children and adolescents. A rapid assessment study within different professional groups planned in 2009 is supposed to provide a better insight in this phenomenon in Luxembourg.

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

The main objective of this campaign was to tackle interest of the general public, to motivate them to ask questions and to realise the versatility of the concept of addiction.



4. PROBLEM DRUG USE

Introduction

At the national level 'problem drug use' (PDU) or 'harmful use' is defined according to the WHO Lexicon of Alcohol and Drug terms (Geneva, 1994): *'A pattern of psychoactive substance use that is causing damage to health, physical or mental. Harmful use commonly, but not invariably, has adverse social consequences [...]'*. In contrast to the EMCDDA definition, the mode of administration (injection) is not a selective criterion in the national definition although types of substances involved are identical. Regular / long duration use of heroin via inhalation is thus included. According to the national definition, problem drug use is associated to a high probability of intervention or the need of involvement of a third party from the law enforcement or the care sector. This approach is consistent with the fact that PDU surveillance systems in Luxembourg are based on the institutional contact indicator and not exclusively on the treatment demand indicator.

Data on PDUs in this chapter originate from the national drug monitoring system RELIS developed and maintained by the national EMCDDA focal point. The RELIS network includes specialised drug agencies (100% coverage), law enforcement agencies, national prisons and since 2009, psychiatric departments of general hospitals nationwide.

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

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDUs. Low quality cocaine use in combination with heroin continues to be observed. Ecstasy-like substances and ATS are still popular even though seizure figures do suggest an inverse and currently stable trend. Methamphetamine use in Luxembourg is very limited. The use of most 'new synthetic substances'³¹ 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: around 30%) is increasingly found on the national market. Marijuana shows the highest purity but also the most important variations in terms of quality.

³¹ Substances such as MBDB, 4-MTA, Ketamin, PMMA 2C-I, 2C-T-2, 2C-T-7, 2C-D, 2C-E, TMA-2, BZP, TFMPP, 5-MeO-DIPT, 5-MeO-DMT, AMT, ALEPH 7, DXM, DPT.

PREVALENCE AND INCIDENCE ESTIMATES OF PDU

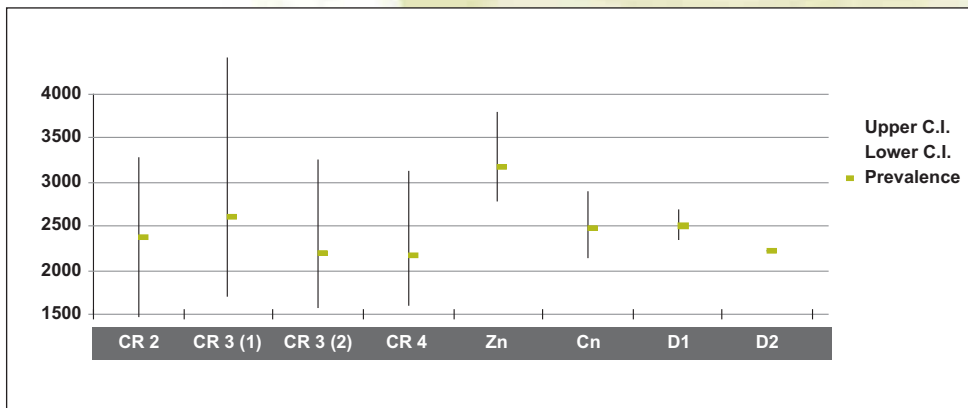
NATIONAL PREVALENCE DATA

Data presented in the present chapter have been provided by serial drug prevalence study on PDUs aged between 15 and 64 years performed on 1997, 1999, 2000 and most recently on 2003 and 2007 data (Origer 2001, in press)³². The latest, yet unpublished study, was performed in 2009 in the framework of the evaluation of the 2005-2009 national drug action plan. With this latest study based on robust 2007 data, it became possible to assess the evolution of PDU prevalence over the last decade knowing that applied methodologies and data sources referred to, during the same period, are highly comparable.

The research strategy relied on the methodological framework of the Luxembourgish Information System on Drugs and Drug Addiction (RELIS), set up in 1995 by the national focal point of the EMCDDA. RELIS stands for a nationwide multisectorial information network, including specialised drug treatment institutions, general hospitals, counselling centres and competent law enforcement agencies. As such, it provides for the most comprehensive and reliable data on problem drug users indexed by national institutions. In compliance with RELIS case definitions, the present study specifically aims at the prevalence estimation of problem use of illicitly acquired high risk drugs (HRC) in the national population aged 15 to 65 years.

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

Fig 4.1. Absolute prevalence estimation of problem HRC drug use (2007)³³ and confidence intervals

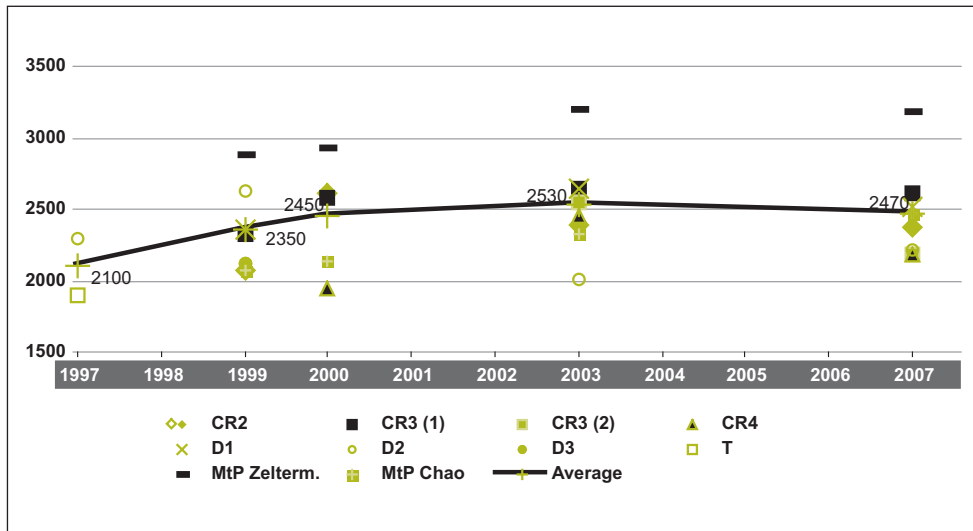


³² Downloadable at <http://www.relis.lu>

³³ CR2 / CR3 : Method « capture-recapture » 2 and 3 sources
 CR4 DIC : Capture-recapture 4 sources (weighted mean of Bayes)
 D1 : Benchmark multiplier based upon police and overdose registers.
 D2 : Benchmark multiplier based upon number of drug law offenders and law enforcement contact rates of PDUs
 D3 : Benchmark multiplier based upon mortality rates (DRD standard)
 T : Treatment multiplier



Fig 4.2. Absolute prevalence estimation of problem HRC drug use (1997 – 2007)



Tab. 4.1. Prevalence and prevalence rates according to selected sub-groups (1997 – 2007)

	1997	1999	2000	2003	2007
GENERAL POPULATION					
National population on 1 st January	418,300	429,200	435,700	448,300	476,200
National population aged between 15 and 64 years on 1 st January	281,100	287,100	291,000	300,800	322,000
HRC USERS IN CONTACT WITH THE NATIONAL INSTITUTIONAL NETWORK (low threshold agencies not included)					
Total number of indexed users (multiple counts excluded)	/	887	986	1,065	1,200
Number of drug treatment demanders in specialized institutions exclusively (Liberal GPs intervention excluded)	/	317	372	582	756
Number of drug law offenders exclusively (ad minima consume of HRC drug(s))	/	378	365	375	373
Numbers of drug treatment demanders AND drug law offenders	/	192	249	108	71
PROBLEM USE : HRC DRUGS					
Average prevalence	2,100	2,350	2,450	2,530	2,470
Average C.I.	p.d.	1,994 - 2,758	1,933 - 3,126	2,144 - 3,290	2,089 - 3,199
Total prevalence rate	5 / ¹⁰⁰⁰	5.48 / ¹⁰⁰⁰	5.62 / ¹⁰⁰⁰	5.64 / ¹⁰⁰⁰	5.19 / ¹⁰⁰⁰
Total prevalence rate - age :15-64	7.47 / ¹⁰⁰⁰	8.19 / ¹⁰⁰⁰	8.42 / ¹⁰⁰⁰	8.41 / ¹⁰⁰⁰	7.67 / ¹⁰⁰⁰

PROBLEM USE: MAIN DRUG – HEROIN

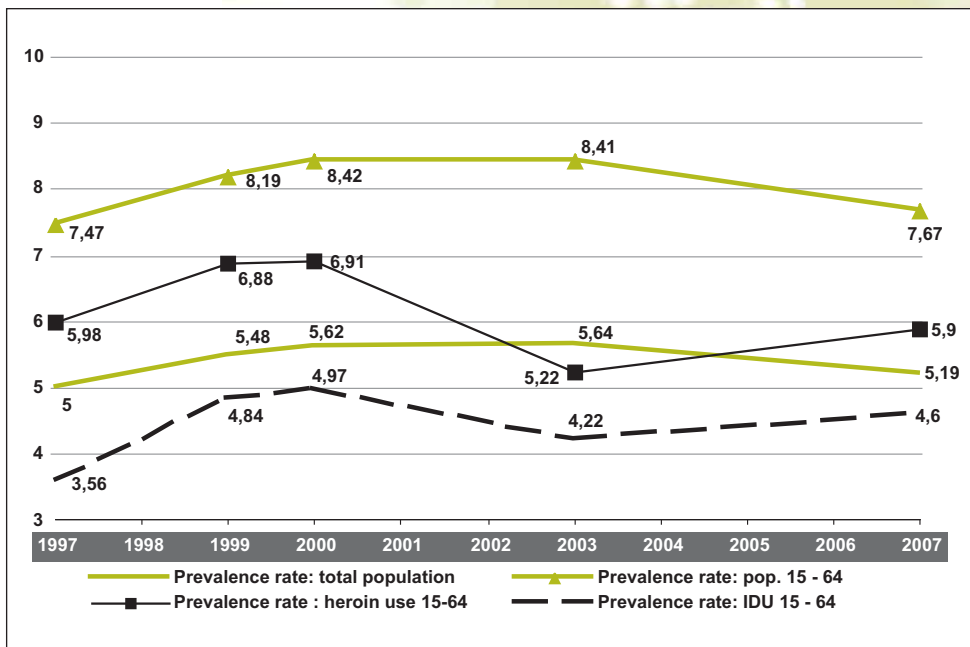
Prevalence heroin	1,680	1,975	2,010	1,570	1,900
Total prevalence rate - heroin	4.01 / ¹⁰⁰⁰	4.60 / ¹⁰⁰⁰	4.61 / ¹⁰⁰⁰	3.50 / ¹⁰⁰⁰	3.99 / ¹⁰⁰⁰
Total prevalence rate - heroin - age :15-64	5.98 / ¹⁰⁰⁰	6.88 / ¹⁰⁰⁰	6.91 / ¹⁰⁰⁰	5.22 / ¹⁰⁰⁰	5.90 / ¹⁰⁰⁰

INTRAVENOUS DRUG USE (IVDU)

Prevalence IDU	1,000	1,380	1,447	1,270	1,482
Total prevalence rate - IDU	2.40 / ¹⁰⁰⁰	3.22 / ¹⁰⁰⁰	3.32 / ¹⁰⁰⁰	2.83 / ¹⁰⁰⁰	3.11 / ¹⁰⁰⁰
Total prevalence rate - IDU - age :15-64	3.65 / ¹⁰⁰⁰	4.84 / ¹⁰⁰⁰	4.97 / ¹⁰⁰⁰	4.22 / ¹⁰⁰⁰	4.6 / ¹⁰⁰⁰

Source : Origer 2009

Fig 4.3. Prevalence rates of PDU, heroin use and iv use (1997 – 2007) per 1,000 inhabitants



Source : Origer 2009

The average of estimations performed on 2007 data provides an absolute prevalence of problem HRC drug users (PDU-HRC) of 2,470 persons (C.I. (95%): 2,089 to 3,199). In terms of prevalence rates estimates for the same age categories, 7.67 out of 1,000 habitants aged between 15 and 64 years show problem drug use.

According to serial data available for the period 1997 to 2007, absolute prevalence and prevalence rates of PDU-HRC have been showing an increasing trend until 2000. After a short stabilisation phase, a decreasing trend has been observed from 2003 onwards. A similar evolution occurred also for problem



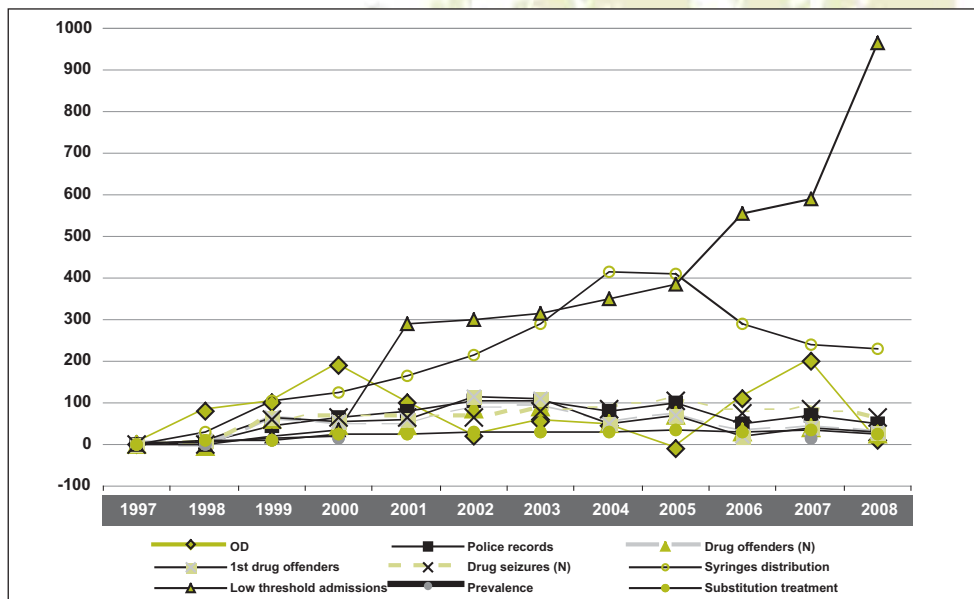
heroin use (2007: 1,900 PDUs: 5,90/1000). Although absolute prevalence of intravenous drug use (IDU)³⁴ has slightly increased compared to the situation observed at the end of the 20th century, IDUs prevalence rate in the national population aged 15 to 64 years shows an obvious decreasing trend over the referred period.

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

INDIRECT INDICATORS OF PDU PREVALENCE TRENDS

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

Fig. 4.4. Prevalence estimates (problem use of high risk drugs) and evolution of selected indirect indicators



Source: Origer 2008

Indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies except for admission statistics in low threshold drug agencies from 2000 onwards and the number of fatal overdoses between 2005 and 2007.

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

³⁴ IDU prevalence rates have been processed on basis of proportion of IDU in PDUs indexed by the highly representative RELIS data sets for respective years

The number of fatal drug-related overdoses has known a decreasing trend between 2000 and 2005, a brief increase towards 2007 and a subsequent decrease to date. Likewise other EU Member States, the evolution of the referred indicator is known to show fairly important variations due to factors such as quality of available drugs, consume patterns, availability of harm reduction services, etc. A national expert group studied these variations and came to the conclusion that high variability in substances' purities, increased polyuse and especially the combination of street drugs, substitution drugs and prescription drugs in general in out- and in-patient settings and gaps in the follow-up of patients after institutional release (detoxification, therapy, prison, etc.) are major risk factors at stake if it comes to drug-related mortality and morbidity but do not support the assumption of a significant increase of the PDU prevalence in general.

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

LOCAL OR REGIONAL PREVALENCE STUDIES

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

CHARACTERISTICS OF INDEXED 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 2008 figures 4,542 (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 explained).

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 2008 the same agencies have indexed 2,733 and 1,487 persons respectively.

Tab. 4.2. Main characteristics of PDUs indexed by the national drug monitoring system, RELIS (valid percentage)

	2000	2004	2008	TREND
Gender				
Male	77%	78%	77%	
Female	23%	22%	23%	
Nationality				
Natives	54%	54%	48%	↘
Non-natives	46%	46%	52%	↗
- of which				
Portuguese	51%	58%	38%	↘
French	17%	11%	28%	↗
Others	32%	31%	34%	



Mean age				
Male	29Y4M	31Y2M	31Y8M	↗
Female	26Y10M	28Y4M	28Y5M	↗
Total	28Y9M	30Y6M	30Y11M	↗
Primary drug				
Opiates	84%	76%	72%	↘
Cocaine	7%	16%	17%	↗
Others	9%	8%	11%	↗
Polydrug use	87%	93%	89%	
Primary administration mode				
Iv	56%	55%	45%	↘
Non-iv	44%	45%	55%	↗
Infectious disease				
HIV	4.3%	4%	4%	
HCV	40%	58%	65%	↗
HBV	25%	22%	21.1%	↘

The male/female ratio of the PDU population is stable at 3:1. During the last nine years the proportion of indexed non-native PDUs has shown strong variations but a clearly increasing tendency since 2003, confirmed by 2008 data. The population of non-native drug users largely consists of Portuguese nationals, a proportion constantly increasing until 2004 but decreasing consistently since although it is still consistently higher than the one observed in general population. Notably, one observes a remarkable and continuous increase of PDUs of French origin (28%). This trend is confirmed by last 8-years data on drug law offenders.

The mean age of indexed PDUs evolved from 28 years and 4 months in 1995 to 31 years and 8 months in 2008. Mean age of male PDUs has been increasing faster than for females. 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. In reference to years 2004 to 2008 a discontinuous decrease of minors in the overall PDU population has been observed in treatment and police data.

The mean age of native and non-native problem drug users tends to balance. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to "new" PDUs. 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 9 years. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2008.

Worth mentioning is also the significant increase of the average age of overdose victims during the last years. Respectively 90% and 46% 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.

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDUs. The proportion of **poly drug use** 89% has reached stabilisation after a record level in 2004 (93%). As already indicated, the switch to intravenous drug use occurs earlier. The ratio of intravenous opiates consume to the inhalation mode went from 2:1 over the last years to 3:2 in 2008. Provision of 'blowing paraphernalia' (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns. The prevalence of the use of cocaine as primary drug shows an increasing trend since 2000. Ecstasy-like

substances and ATS use appears to be stable which however does not inform on prevalence in general population as RELIS data refer to PDUs and not to the overall population of recreational drug users.

All indicators on cannabis use (problematic and recreational) have been on the increase for several years. The number of persons in contact with the national specialised network for (preferential) cannabis use had known a sensitive increase at the beginning of the years 2000 but decreased again in 2004 and stabilised towards 2008.

PDUs show fairly stable infection rates of HIV (4%) and HBV (21-22%) between 2000 and 2008, whereas HCV prevalence rates (65%) are high and increasing.

The residential status of indexed PDUs has improved over the last years. The geographical distribution suggests that the southern region (45,9 %) and the centre region (33,2%) are the most representative. The northern region, after a decrease in 2005 (11,5 %), has shown stability over the last three years (2008:13,9%).

All indicators included, employment status of PDUs suggest a stabilised situation since 2007, as the rate of PDUs set around 47%. After a high level plateau (46-50%) over several years a new increase is reported between 2006 and 2008 (63%). The decrease of financial autonomy of PDUs is associated to an increasing social dependency. A stabilisation at the level of revenues of illegal origin has been observed during last years as well as a slowly but continuous stabilisation of the proportion of PDUs presenting major depths.

DATA ON PDUS FROM NON-TREATMENT SOURCES

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

The ratio of male and female PDUs is almost identical to PDUs from treatment sources (81% male, 19% female offenders). Their mean age is 30 years 6 months, women being slightly younger than men (31y for male 28y4m for female offenders).

38% of the offenders are natives and 53% are foreigners. As for the last year, most foreigners were Portuguese citizens (32%) followed by French natives (28%).

75% are recidivists (had more than one police record during their lifetime). 25% were arrested for dealing drugs, 30% are charged with illegal drug possession and 41% for other crimes related to drugs. Drug-law offenders (who are also problematic drug users) are mostly arrested for heroin and cocaine. 91% are reported polydrug users, which represents a higher proportion than PDUs in treatment. 95% of these PDUs had more than one treatment episode during their lifetime.



5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

Introduction

Drug treatment is the 'use of specific medical and/or psychosocial techniques with the goal of reducing or abstaining from illegal drug use thereby improving the general health of the client'.³⁵

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, pharmaceutically assisted or not³⁶;
- **Inpatient treatment:** the patient is staying overnight, pharmaceutically assisted or not; (including detoxification);
- **Substitution treatment:** a type of medical treatment provided to opiate addicts primarily based on the delivery of a similar or identical substance to the drug normally used. Substitution treatment may be accompanied by psycho-social care;

Drug treatment is monitored and quality assurance occurs via a series of mechanisms that are described under the treatment system section.

In recent years outpatient drug treatment demand has been slightly increasing. Inpatient treatment demands are fairly stable as is the number of substitution treatment demands. A more recent trend is the increase of treatment demands for cannabis use related problems and combined alcohol abuse in youngsters at the national level and reported by the Medical Control Department in charge of referrals to specialised treatment centres abroad. Treatment demand related to cocaine use is difficult to assess as in most PDUs concomitant use of heroine is observed.

DRUG TREATMENT STRATEGIES AND POLICY

In the mid seventies the cooperation between state and NGOs working in the social field has progressively gained structure. The first (financing) convention between the Ministry of Family and a series of NGOs, signed in 1975, was the starting point of what is known today as the "Conventionned sector". Over the years the collaboration schemes between State and NGOs evolved and were extended to the Public Health sector. In 1998 the so-called ASFT law³⁷ entered in force, regulating the relationship between State and private organisations working in the social, family and therapeutic fields.

³⁵ SOURCE: Classification of drug treatment in EU member states and Norway, Expert meeting, 8-9 February 2002

³⁶ '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'.

³⁷ Loi du 8 septembre 1998 réglant les relations entre l'Etat et les organismes ?ouvrant dans les domaines social, familial et thérapeutique (entry in force: 24/09/1998)

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

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

TREATMENT SYSTEMS

ORGANISATION AND QUALITY INSURANCE

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

NGOs involved in drug treatment fall under the obligation of the above referred to 'ASFT' law (8/09/98) and the subsequent grand ducal decree of 10 December 1998³⁸, both regulating the relation (duties and rights) between State and NGOs or organisation providing psycho-medico-social and therapeutic care. The overall management of the referred agencies is ensured by a 'coordination platform' that includes a maximum of 3 members of the concerned institution and at least one representative from the competent ministry. All major decisions have to be approved by the coordination platform. All referred institutions work in close collaboration and have to be viewed as an interdependent therapeutic chain. A series of formal collaboration agreements have been signed in 2008 and 2009 between various agencies in order to insure rational use of resources and through-care. The 2010-2014 national drugs action plans foresees to further develop this synergy by creating a national network of unique reference persons for each drug treatment demander entering the specialised care system.

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

³⁸ 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)



substitution programme and prevention interventions in schools by CePT. The external evaluation of the drugs action plan also significantly contributes to assess the functioning and the gaps of the national treatment network.

Also, the **RELIS database** on problem drug users provides relevant data for evaluation purposes since it includes detailed data on drug consume patterns, socio-economic situation, risk behaviour and treatment or law enforcement contacts, etc. In the long run, drug 'careers' can be analysed by means of the RELIS indexing system, which allows following up treatment demands and law enforcement contacts of indexed drug users. These data can be used to assess the impact and the performance of specific treatment approaches. A practical example of the application of evaluation results is to be seen in the conceptualisation and external evaluation of the national drug action plan 2005-2009, which did greatly rely on RELIS data and ad hoc evaluation initiatives from field institutions.

Table 5.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 2008. **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 provided in respective sub-chapters.

AVAILABILITY AND DIVERSIFICATION OF TREATMENT

As can be seen on map 5.1 drug treatment facilities are regionalised showing, however, a high concentration and diversity within the area of Luxembourg City. All listed services are specialised with the exception of regional general hospitals providing detoxification treatment via their respective psychiatric departments. In July 2005, the first 'consumption room' has been opened in Luxembourg City. It has been integrated in the 'TOX-IN centre' providing day care, night shelter and low threshold services to drug addicts.

Legend :

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

Map 5.1 Geographical coverage of specialised drug agencies in the Grand Duchy of Luxembourg (status 2008)





The following treatment typology is applied:

Outpatient: services and offers for adults

The most relevant national outpatient treatment facility is the 'JDH Foundation'. Regional antennas of JDH are respectively implemented in Luxembourg City, in the South and in the North of the Grand Duchy and are entirely financed by the Ministry of Health. 'The Emmanuel Centre' implemented in Luxembourg-City is primarily a counselling and referral agency.

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

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

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

Outpatient: services and offers for minors

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

Outpatient: substitution treatment

Substitution treatment is currently defined as a medical assisted treatment with opioids' agonists and with antagonists (and antagonistic agonists). The objectives of substitution and maintenance treatment are manifold. They range from no-digestive dose, out-patient low threshold maintenance to abstinence oriented (digestive 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 2002³⁹ regulates the practical modalities of substitution. The referred law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of **substitution treatment licenses** granted to MDs and specialised agencies, the application of training requirements for prescribing MDs and adequate control mechanisms of **multiple prescriptions** (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a **structured**

³⁹ The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>

substitution treatment programme (JDH - mainly liquid oral methadone provided by specialised agencies) and a **lower threshold substitution treatment** offer provided by freelance state licensed MDs (MEPHENON®, METHADICT® and SUBUTEX®).

The grand-ducal decree of 30 January 2002 lists medicaments as well as preparations containing methadone (liquid oral form in programme and pill form in lower threshold prescription) and **buprenorphine** if the notice mentions substitution treatment as a possible therapeutic indication. Furthermore, **morphine-based (salts)** medications can be prescribed if the listed substances are deemed inadequate by medical authority. Finally, the decree allows for heroin prescription in the framework of a pilot project managed by the Directorate of Health. The **list of substitution substances** may be rapidly modified by amending the referred decree. In addition to drug prescription and medical care, the grand ducal decree on drug substitution treatment (30/01/2002) defines a series of psychosocial counselling services to be provided by licensed specialised centres. Licensed MDs may refer substitution patients to licensed treatment centres for more in-depth psychosocial counselling.

A **central substitution register** is about to be implemented jointly by the 'Surveillance Commission on Substitution Treatment'⁴⁰, the national drug coordinator and involved specialised treatment centres. The permission for its creation has been granted by the national data protection commission in June 2006 and it has entered its test phase in November 2007. At the moment of writing, discussions have been ongoing with the national MD association in order to find the best way to make the implementation of the substitution register and other surveillance mechanisms compatible with daily medical practice.

Outpatient: low threshold services and offers

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

Inpatient: detoxification services and offers

Physical drug detoxification is provided by 5 different hospitals via their respective psychiatric units. The most important detoxification unit implemented within a specialised department of the CHNP (15 detoxification beds) has been restructured and does not provide detoxification treatment anymore. The 'Hôpital du Kirchberg' has joined the list of national institutions providing detoxification treatment in 2005. Medical interventions and psychosocial support are provided to control and reduce withdrawal symptoms in the framework of a 1-2 week detoxification programme. Ideally, detoxified patients are referred to more psychotherapeutic oriented institutions.

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

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

⁴⁰ The decree of 30 January 2002 replaces the former 'Methadone Commission' by the 'Surveillance commission on substitution treatment' mandated to control all aspects of substitution treatment at the national level. Established in 2002, it is composed of delegates from the programme, the Directorate of Health, two pharmacists and two GPs affiliated to the programme, and is in charge of admissions, releases and exclusions of substitution treatment demanders or patients. The composition of the new commission is similar to the one of the former Methadone commission.



Inpatient: services and offers for adults

The national residential drug care centre called 'Syrdallschlass' (CTM-CHNP) is situated in the East of the G. D. of Luxembourg. The therapeutic programme of the CTM is divided into three progressive phases. The duration of a therapeutic stay varies from 3 months to 1 year.

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

The **national drug action plan** had foreseen the extension of CTM offers by creating a network of **modular therapeutic annexes** for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone, etc. These annexes are operational since September 2002 and are situated in the vicinity of the main centre (see map 5.1) in order to take advantage of training and social reintegration facilities offered by the CTM. Based on past experience, the 2005-2009 drugs action plan has foreseen the further development of these annexes. In 2008 a new annexe providing therapeutic offers to specific target groups such as mothers with child/children or patients in the last therapy phase has become operational on the very site of the main centre.

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

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

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

Tab. 5.1 Drug treatment abroad covered by health insurance scheme (1998-2008)

AGE GROUP	1998	2000	2002	2004	2005	2006	2007	2008	Males		Females	
									(2008)		(2008)	
	N	N	N	N	N	N	N	N	N	%	N	%
< 20 years		3	5	3	3	1	5	n.a.	n.a.		n.a.	
20 à 25 years		33	33	37	29	41	32	n.a.	n.a.		n.a.	
> 25 years		66	63	72	89	74	86	n.a.	n.a.		n.a.	
TOTAL	71	102	101	112	121	116	123	n.a.	n.a.		n.a.	
Mean Age		27Y9M	28Y	28Y5M	30Y7M	30Y	30Y1M	n.a.	n.a.		n.a.	

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

A specialised residential centre for problematic youngsters has been opened in the beginning of 2007 in the North of the country under the management of CHNP. A new project defined as a residential referral and rehabilitation centre for minors in a rural setting is supposed to become operational in 2009. The referred case management programme will contribute to fill current gaps in the care system for minors.

For further information on treatment availability please consult standard table 24.

CHARACTERISTICS OF TREATED CLIENTS AND TRENDS OF CLIENTS IN TREATMENT

Table 5.2 summarises drug related institutional contacts of PDUs. Inter-institutional multiple counts are not excluded meaning that a given PDU could be indexed twice and more. Hence, these data do not provide the national prevalence of PDUs but they allow following up the increase or the decrease of the latter.



Tab. 5.2 Drug related institutional contacts (Inter-institutional multiple counting included)

SETTING	NUMBER OF ADMISSIONS AND/OR CONSULTATIONS AND/OR CONTACTS				NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)							
	2000	2002	2004	2006	2007	2008	2000	2002	2004	2006	2007	2008
DEMAND REDUCTION: SPECIALISED DRUG TREATMENT												
OUTPATIENT												
- Drug Free	2,185	3,412	4,312	4,597	4,833	/	636	828	916	928	1,143	1,162
- Substitution	/	/	/	/	/	/	1,002	1,040	1,065	1,044	1,092	1,050
INPATIENT												
- Drug free	43	57	53	44	128	129	158	153	182	183	124	124
- Hospital care ⁴¹	/	/	617	637	617	600	316	429	476	484	422	397
LOW THRESHOLD AGENCIES	13,083	29,536	39,526	55,808	60,405	67,494						
SUB TOTAL A: Number of drug treatment demanders (Multiple counts not excluded) (Multiple counts excluded)							2,112	2,450	2,639	2,639	2,859	2,733
							637	n.a.	n.a.	n.a.	n.a.	n.a.
SUPPLY REDUCTION: LAW ENFORCEMENT INSTITUTIONS												
National prisons							161	101	92	243	212	332
Police - Judicial Police - Customs							1,758	2,217	1,808	1,573	1,687	1,487
SUB TOTAL B: Number of drug law offenders (Multiple counts not excluded)							1,919	2,318	1,900	1,816	1,899	1,819
TOTAL												
Number of drug related institutional contact episodes	4,031	4,768	4,539	4,455	4,758	4,542						

Source: RELIS 2008 / CNS

⁴¹ Including F11 F14, F16, F18 and F19 episodes with or without over night stay. Source: CNS

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

Overall the number of drug related contact episodes with national DR or SR agencies has reached 4,542 in 2008. Over the last decade a sensible increase in drug treatment demands has been observed (having stabilised in 2008), whereas contacts with law enforcement agencies have been decreasing. The number of substitution treatment demands begun to plateau around 2002. Outpatient counselling demand started to level off (1,050) in 2007 in contrast to the number of contacts in low threshold services, having increased and reached almost 68,000 in 2008. 4.6% (14%) of respondents are first treatment demanders, all treatment centres included. For the first treatment demanders, the proportion of female clients is 40% against 60% of male first clients.

Of clients in drug treatment, 72% are male against 28% females. The mean age treatment demanders has significantly increased during the last ten years (1997: 28 years/ 2008: 31 years and 8 months) and this mainly because of an observed increase in average male age (1997: 28Y2M/ 2008: 32Y8M). The mean age of the female clients is consistently lower (2008: 29Y1M). Respectively 66% of clients in treatment are natives against 34% of non-natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French, Italian and German citizens.

Regarding educational level of the clients in treatment, 39% have completed primary school, 59% have completed secondary school and 1% obtained a higher degree. 50% of respondents reported stable employment (weak decrease - 1997: 65%) against 10% who are benefiting from unemployment allocations. Furthermore, 22% are students or engaged in a training contract. Half of indexed treatment demanders (53%) had experiencing one or more overdose. As far as the exchange of syringes is concerned, 72% reported that they never shared syringes. IDU combined to polydrug use (89%) is the most observed consume pattern in drug treatment demanders.

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

Outpatient: services and offers for adults

RELEVANT TREND: Stabilisation of total number of clients (1,162) and decrease of first treatment rates. Stabilisation of female treatment demanders. Increasing proportion of clients aged 30 and more and under 20 years. Currently one observes a fair increase of patients presenting for cannabis related problems in non-specialised drug agencies. A current trend is also to be seen in the increasing number of young mothers and child/children seeking out and inpatient treatment.

After several years of decrease, national outpatient drug counselling centres have been showing stable admission rates over recent years and decreasing first treatment rates intra and inter-agency wide. Gender distribution shows an overall stability over the last 10 years (2008: 29%). Age distributions are varying according to the geographical situation of treatment centres. All in all, however, the proportion of treatment demanders aged 30 years and more (2008: 58%) (2006: 57%) has sensibly increased during recent years and so did the proportion of treatment demanders aged less than 20 years (9.6%) (2006 (5.6%)). Underage clients tend to decrease until 2007 and stabilised since then, mainly because specialised agencies for minors have been implemented meanwhile. Treatment demands for problem i.v. opiate use associated to multiple-use is the main demand pattern and has been on the increase from 2005 to 2007 to decrease in 2008 (2008: 53% / 2007: 57% / 2006: 51% / 1997: 72%). Cannabis-related demands have shown a clear upward trend in 2008. The prevalence of problem cocaine use is showing a weak increase compared to 2007 data.



Outpatient: services and offers for minors

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

The rate of new treatment demanders has discontinuously increased since the implementation of the referred specialised agency. The proportion of clients aged below 14 years has increased and those aged between 14 and 15 years have decreased since 2002. Cannabis use is the main reason of treatment demands (69.4%) witnessing a currently stable trend. However, the use/abuse of licit drugs and polydrug use is increasingly reported as reason of treatment. An increasing proportion of youngsters presenting psychiatric symptoms and/or socially deviant behaviour in addition to drug abuse are reported by specialised field agencies.

Outpatient: substitution treatment

RELEVANT TRENDS: Since 2002, stabilisation of number of patients in structured programme and in substitution treatment prescribed by licensed MDs - stabilisation of gender ratio (2 males/ 1 female) - Increase of substitution treatment demanders being aged 35 years+.

The number of patients admitted to the national substitution programme has been decreasing from 2000 to 2008 (89 patients in 2008), which is supposedly due to the increasing access to lower threshold substitution treatment provided by independent yet specially licensed MD's. 6 % (2%) of clients are first substitution treatment demanders. The proportion of female substitution treatment demanders (31% stable) is higher than the proportion of female PDUs in the overall drug treatment population. 28% (29%) of the clients in substitution treatment are aged under 30, 36% (32%) are between 30 and 39, while 36% (40%) are over 40 years old. The **mean age** of clients has significantly increased over the last 10 years (36 years), which is due particularly to the steep increase of the number of treatment demanders over 35 (60% in 2008, 33% in 2000). 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. 51% of substitution treatment demanders reported stable employment against 24% who are benefiting from unemployment allocations. 38% (36%) of this group had at least once in their lifetime committed a suicide attempt (45%) and 43% (32%) have been experiencing one or more overdose. Polydrug use is the most observed consume pattern (92%) in substitution treatment demanders.

The number of patients who did receive substitution treatment by prescription from independent general practitioners also tends to stabilise [(961 patients in 2008 multiple counts excluded (2005: 970)].

The National Health Found (CNS) annually provides the number of patients receiving referred substitution drugs on prescription as well as the number of prescribing MDs. One observes a 4-years stabilisation of low substitution demands addressed to accredited liberal MDs and an ongoing 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	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number of indexed patients (double counting controlled)	844	849	820	913	/	970	939	979	961
Number of indexed patients (double counting included)	/	/	1,487	1,554	1,553	/	/	/	/
Number of prescribing GPs (double counting controlled)	145	147	157	154	158	163	121	122	126

Source : Union des Caisses de Maladie 2008

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.

Outpatient: low threshold services and offers

RELEVANT TRENDS: The **number of contacts** indexed by low threshold agencies has increased dramatically over the last ten years (2008: 67,494 / 2005: 47,739 / 1996: 6,456), and so has the number of syringes distributed by the same agencies, although the number of syringes distributed has stabilised in 2005 and subsequently even decreased (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 but has been showing stability for 2 years (currently 17%). Approximately 42% of clients are aged between 25 and 34 years and an increasing proportion (36%) of clients aged 35 and more is observed. 56% (56%) of clients are natives.

Inpatient: detoxification services and offers

RELEVANT TRENDS: Drug detoxification units throughout the country have been showing a continuous increase regarding number of patients until 2006 (484) and a decrease to 397 in 2008. However, number of treatment episodes have remained fairly stable between 2004 (617) and 2008 (600). 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 demands.



Inpatient: services and offers for adults

RELEVANT TRENDS: The number of inpatient treatment demanders (detox. excluded) appears to be stable (126). The proportion of first treatment demands has sets around 40%.

42% (59%) of patients in residential drug treatment are simultaneously on substitution treatment. The proportion of male treatment demanders has set around 70-75% and an increasing mean age of clients has been observed. The referred age distribution reflects the **overall trend** observed in most adult drug treatment demanders, that is, a decrease of patients under 25 and an increase of patients **older than 30 years**. A stabilisation 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: services and offers for minors

22 clients have been admitted in the specialised residential centre for problem youngsters (CHNP-Orangerie 3). 7 clients presented substance abuse related problems. As the centre only opened in 2007 no trend data is available thus far. The new residential referral and rehabilitation centre for minors (CHNP- Foyer Putscheid) is not yet operational. First data may be available in 2010.

Treatment demand according to type of involved substance(s)

Heroin as preferential substance is reported by 66% (52% i.v./ 14% non-i.v.) of drug treatment demanders monitored by the national drug surveillance system RELIS whereas cocaine is only reported by 13% as first substance of use (6% i.v./ 7% non-i.v.). The average age at the first use of the preferred drug figures around 14Y8M, whereas the mean age of the first i.v. consumption is 19Y6M. More than half of the clients in treatment were injectors at the moment where they start a treatment (52.5%). 64% of the clients consume drugs more than once a day.

In 2008, a weak decrease in preference for intravenous heroin (1997: 60%, 2008: 52%) use was noted compared to 2007 (54%). The heroin inhalation mode in 2007 (22%) was highest since 1998, but decreased again in 2008 (14%). Polydrug use is the most observed consume pattern (89%). The i.v. heroin sub-population shows the highest mean age (31Y10M) of all treatment groups. 5% of the latter are first treatment demanders compared to 19% of non-iv heroin users.

Cocaine use as main reason of treatment demand showed a significant increase from 2004 to 2006 and decreased again in 2007 and showed a weak increase in 2008 (13%). Mean age of preferential cocaine using treatment demanders in 2007 was 29 years and 6 month. With 15% (7%) of first treatment demanders, primary cocaine users show the highest lifetime first treatment rate. Cocaine prevalence as secondary drug has decreased from 43% in 2004 to 32% in 2008. Crack neither is reported as main problem drug nor as secondary or occasional drug.

The percentage of treatment demands related to cannabis use has passed from 4% in 1997 to 11% in 2002, has decreased to 1% in between 2006 and 2008. Treatment demands related to ecstasy use are rare (1-3%) and have shown a fair stability over the last years. The same comments apply to ATS use.

6. HEALTH CORRELATES AND CONSEQUENCES

Introduction

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

1. The Special Drug Unit of the Judicial Police (SPJ) maintains a register on acute drug deaths (RSPJ). The RSPJ indexes all direct overdose cases due to illicit drug use documented by forensic evidence. As police forces are routinely informed by medical emergency services in case of a suspected overdose case, they are able to collect evidence at the site of the incident and confirm or not, in combination with post mortem toxicological evidence, the suspected overdose. RSPJ applies the following definition of acute/direct drug-related death:

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

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

Both sources are independent, meaning that for the SPJ register data collection occurs via police records and forensic evidence, while the GMR is updated according to information contained in death certificates. Discrepancies between the referred registers mainly originate from different encoding routines (e.g. death certificates often only mention primary cause of death) explaining the fact that the DRD v 0.3 systematically underestimates the SPJ based number of drug-related deaths as can be seen in figure 6.5.

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

Infectious diseases, including HIV and viral hepatitis have to be reported (notification procedure) when diagnosed to the Directorate of Health (Ministry of Health) that compiles data and is in charge of nation wide epidemiological follow up. These data do however not allow to breakdown infection prevalence according to PDU status. The national drug monitoring system RELIS therefore allows to gather self-reported data on infectious diseases in PDUs. Furthermore specific diagnosed based studies provide complementary information. The report includes data from the latest study on infectious diseases in PDUs (Origer & Removille, 2007) based on serological test results to assess current prevalence rates and apply vaccination schemes when medically indicated.



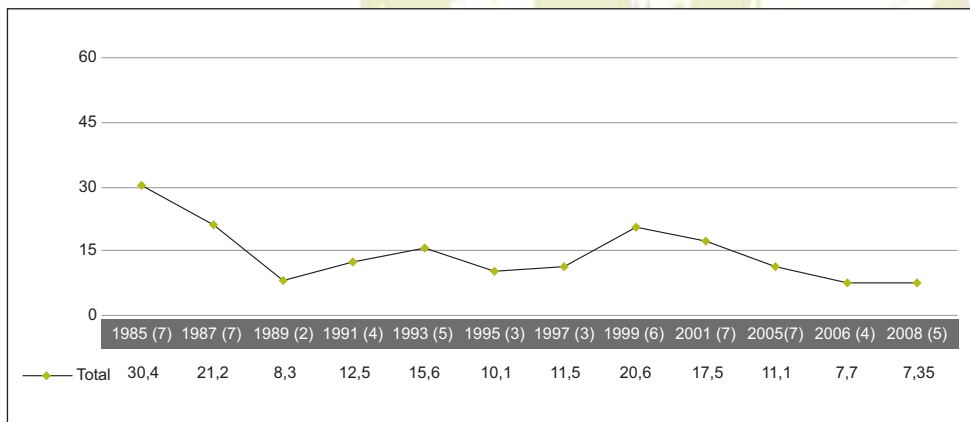
DRUG RELATED INFECTIOUS DISEASES

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

Data on drug-related infectious diseases are centralised at national level. No regional data sets exist. Official data from the national Retrovirology Laboratory of the CRP-Santé provide the number and proportion of IDUs in HIV infected patients. Between 1984 and 2008, 882 HIV infected persons have been registered at the national level; 115 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 13.04 per cent since the registration of the first HIV case in Luxembourg in 1984.

Currently intravenous drug use appears to be the third most reported transmission mode of new HIV infection since 1989 (homo/bisexual and heterosexual transmission are currently in first and second position respectively). The proportion of intravenous drug use transmission has noticeably decreased between 1998 (23%) and 2004 (5%). IDU transmission mode figured 7.35% in 2008

Figure 6.1 Proportion (%) of IDUs in newly infected HIV patients (1985 - 2008)



Source : Laboratoire de Retrovirologie – CRP-Santé. 2009 (data formatting by NFP)

A recent study by Origer and Removille (2007)⁴² assessed the national HIV, HCV, HAV and HBV in the population of problematic users of illicitly acquired drugs prevalence via serological test results. Furthermore the authors performed a cross sectional analysis of the relation between the studied infections and selected observable factors, to increase the national vaccination coverage and to refer infected persons towards appropriated medical treatment centres.

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

Tab. 6.1 Prevalence of hepatitis B surface antigens (HBsAg), antibodies to hepatitis B core antigen (anti-HBc), hepatitis C virus (anti-HCV), and HIV (anti-HIV 1 and 2) in PDUs and ever-injectors according to national recruitment settings

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

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

† Number of respondents for whom valid blood test serology for at least one infection (HBV, HCV or HIV) was available

‡ Number of respondents for whom valid blood test serology for HBV was available

ø Respondents that have injected at least once in their lifetime a drug for non therapeutic reasons

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

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

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

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

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

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2008, (N=678) 84% of RELIS indexed PDUs reported a HIV test during the last 5 months. The testing rates of female PDUs were equal to those of male PDUs.



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

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

Source: RELIS 2008

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

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

Source: RELIS 2008

HIV rates in current PDUs have been varying over the last ten years although in quite narrow margins figuring 3 to 4%.The prevalence of **HBV** infection in problem drug users has been showing a decreasing tendency during recent years based on self-reported data. The results provided by Origer and Removille (2007) study based on blood sample provide slightly higher yet consistent rates in PDUs. The **significant increase of the HCV infection rate** during the same period is particularly marked in IDUs, figuring 64.94% to 81% according to risk groups (current, ever -injectors) and applied methodologies (self-reports vs. blood tests). There are, however current signs of stabilisation. As far as co-infections are concerned and according to data from the Origer and Removille study, 2.8% of respondents showed HBVxHIV and HBVxHCV acute infections respectively, and 4.7% were simultaneously infected by HIV and HCV.

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

YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
HBV rate in drug users (RELIS self-report)	30	30	28	25	22	20.51	21.34	18.67	17.21	17.81	16.14
HBV rate in PDUs (Origer & Removille)								21.6			
HBV rate in drug treatment demanders (RELIS self-report)	27	32	27	24	20	19.79	22.69	18.58	16.46	17.95	14.68
HBV rate in IVDUs (RELIS self-reports)	33	35	30	30	25	22.76	23.93	20.08	18.32	20.16	
HBV rate in ever-injectors (Origer & Removille)								24.7			

Source: RELIS 2008

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

ANNEE	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Self-reported HCV rate in drug users (RELIS)	25	32	46	50	49	59.92	64.55	64.94	64.95	64.06	63.39
HCV rate in PDUs (Origer & Removille)								71.40			
Self-reported HCV rate in drug treatment demanders	29	41	53	54	54	60.49	66.16	66.22	63.23	63.08	61.11
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	72.02	65.48
HBV rate in ever-injectors (Origer & Removille)								81			

Source: RELIS 2008 (Origer & Removille 2007)

Summarily, HBV infection prevalence in PDUs and in drug treatment demanders is fairly stable and HCV prevalence in PDUs appears to have reached a plateau at a high level. HIV infection rates show a decrease especially referred to IDUs in treatment settings. This decrease is fairly remarkable in 2008 and has to be monitored over coming years to determine whether this is a trend or just an annual variation.

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).

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



OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

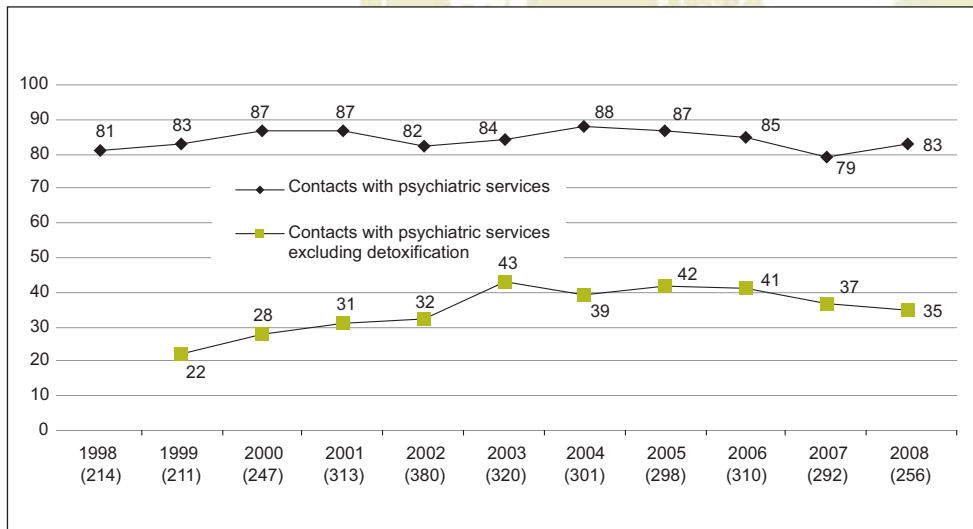
Psychiatric co-morbidity (Dual diagnosis)

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

Most common mental disorders observed in clients seeking help in specialised drug agencies or in contact with other institutions are: anxiety, depression, neurosis, psychosis and borderline behaviour. Residential drug care settings estimate that 10% of their clients show psychotic symptoms. Furthermore, Post Traumatic Stress Disorders (PTSD) are most common and show great similarities with border-line behavioural aspects as for instance rapidly changing mood and auto-destructive tendencies.

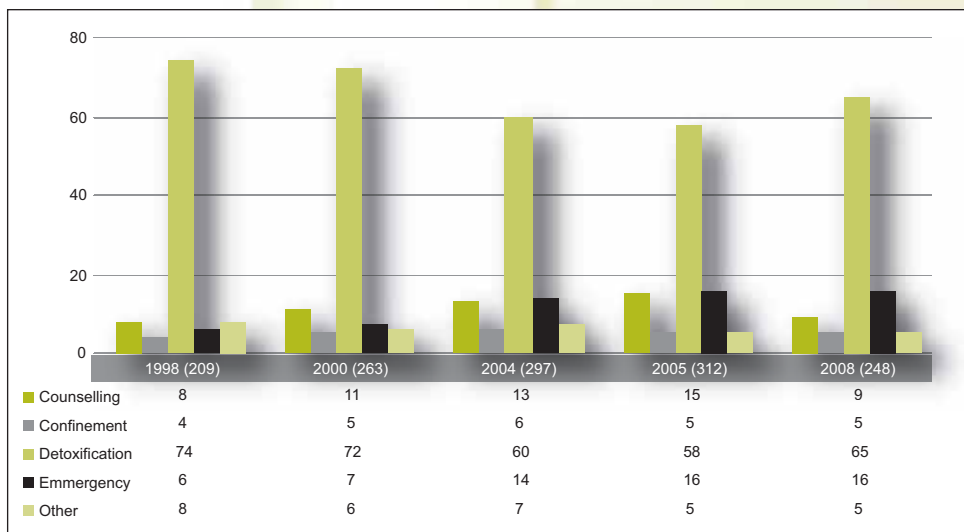
According to annual data provided by the national drug monitoring system RELIS the following picture can be drawn:

Figure 6.2 Previous contacts with psychiatric services, 1998- 2008



Source: RELIS 2008

Figure 6.3 Reasons for psychiatric care demands 1996-2008



Source: RELIS 2008

Figure 6.2 differentiates between all contacts with psychiatric services and psychiatric contacts excluding detoxification. This distinction is necessary since, at the national level, most of detoxification treatments are provided by psychiatric departments of general hospitals.

Data from 1996 to 2008 reveal a fluctuating but a fairly stable long term proportion of PDU's showing a psychiatric history, unlike the proportion of clients reporting contacts for mental problems excluding detoxification treatment, which has been following an increasing trend if compared to what happened in the end of the nineties although stabilised around 40% since 2004.

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

DD patients are considered as drug treatment demanders with specific and highly diversified needs that are difficult to encounter within traditional drug care agencies. The concept of 'multiple vulnerabilities', that is, concomitant vulnerabilities to drug abuse and mental disorders, tends to be recognised by professionals. DD patients very often present a lack of behavioural structure or stability. Usually those patients are unable to function in a regulated environment. Moreover, the requirement of most therapeutic settings include that the patients submit to detoxification treatment prior to admission. This latter requirement is often impossible to meet with DD clients as drug intake often represent a kind of self-managed auto-medication, dangerous to change radically at the beginning of a therapeutic process. It is therefore most difficult to integrate DD patients in traditional drug care settings also in terms of consistency of rules to be respected by all drug treatment demanders. Since to date 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.



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

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

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

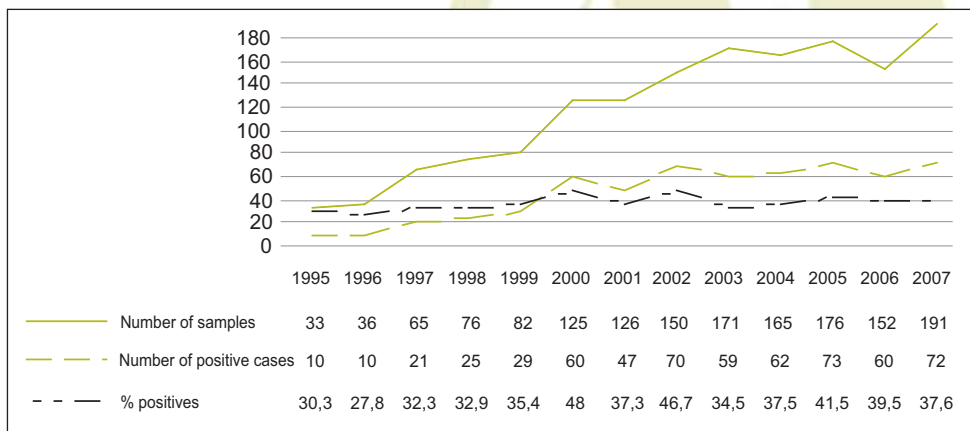
Somatic co-morbidity

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDUs except for HCV prevalence. In 2008, 81 (82) per cent of problem drug users reported a self-perceived satisfying general health condition against 53 per cent in 1997. Half of indexed PDUs report single or multiple suicide attempt(s) and 43 (48) per cent report non-fatal overdose(s) during lifetime. No significant changes have been observed during the last 6 years.

Drugs and driving

Figure 6.4 provides data on cannabis exposure of persons involved in traffic accidents from 1995 to 2007 (2008 data not available). Around 40% of tested persons were positive on cannabinoids (which doesn't mean that the effect of the latter necessarily caused the accident). This proportion has remained fairly stable over last years.

Fig. 6.4 Detection of cannabinoids - Traffic accidents (1995 - 2007)



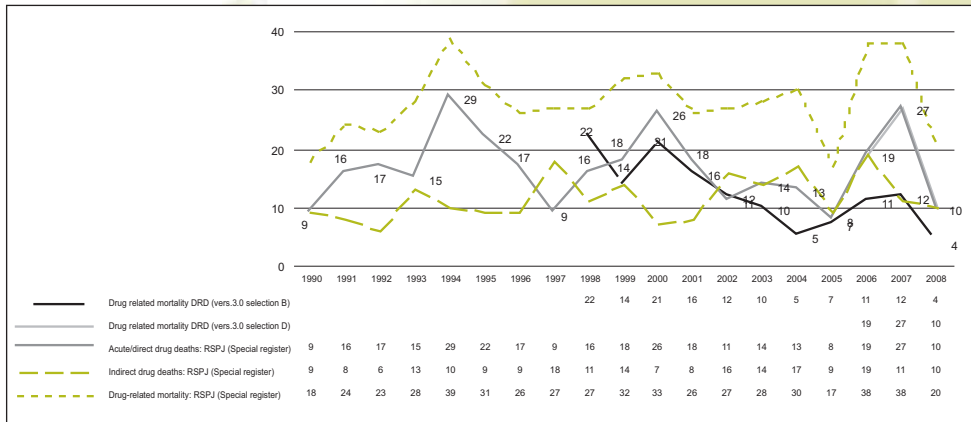
Pregnancies and children born to drug users

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

DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS

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

Figure 6.5 Evolution of drug-related death cases (direct - indirect - total mortality) from 1990 to 2008 (Origer 2009)

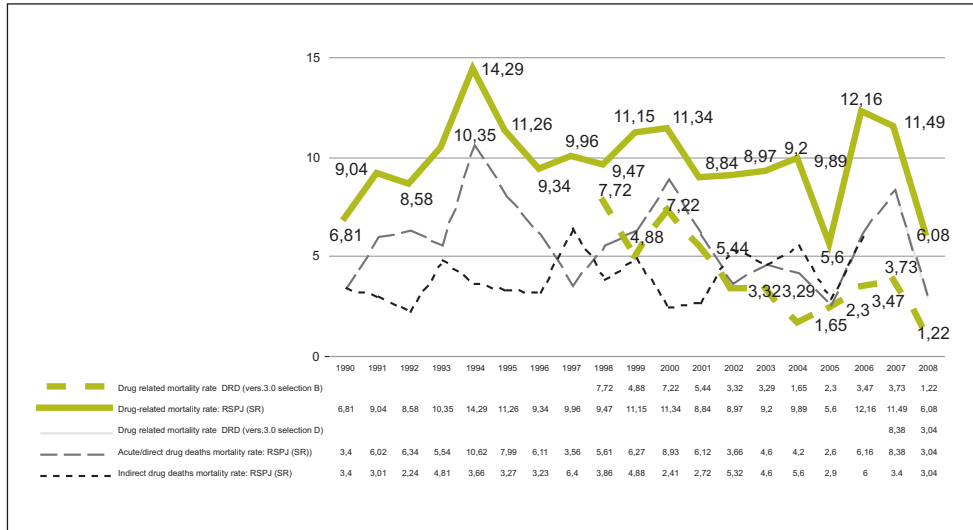


As can be seen in figure 6.5 the DRD v. 3.0 standard (selection B) appears to be a fairly weak proxy of direct, indirect and total drug deaths as indexed nationally by the RSPJ. Overall drug related mortality, however, should not be assessed by the same standard as far as Luxembourg is concerned. A very high to perfect agreement is observed between the RSPJ register and selection D (DRD v.3.0).

The number of **fatal acute overdoses** indexed at the national level has shown an overall discontinuous decrease since the beginning of the 21st century. In 2000, 26 acute drug deaths were registered whereas 10 cases were reported in 2008. Indirect drug-related deaths have known broad variations in number during the same period. These trends appear to be consistent with latest developments in most other EU Member states.



Figure 6.6 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2008 (Origer 2009)



Confronted to most recent national prevalence figures on problem drug users referring to data of 2007 (N = 2.470), (Origer 2009), **overdose rate in PDUs** situates at 0.4 % cases / PDU (1.1 % in 2000). Referred to the **total number of drug-related deaths**, indexed by national law enforcement agencies and forensic institutes, the same proportion shows weaker variations: 0.8% in 2008, 1.346% in 2000, and 1.333% in 1997. The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants⁴³ in 2000. In 2008 overdose rates of 2.07 and 3.04 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed. International comparison should be considered with caution since methodologies used to determining prevalence of DRD deaths are not necessary comparable throughout EU as shows for instance by the structural underestimation of the number of acute drug death based on the EDMCDDA DRD v.3 standard.

The overall discontinuous decrease of acute overdose cases from 1994 onwards has been associated to the regionalisation and extension of the methadone substitution programme as well as to the further development of low threshold facilities. The decreasing trend from 2000 to 2002 is thought to be a medium term consequence of the higher proportion of non-i.v. opiate users observed during that same period followed by a stabilisation around 4.5 percent. The positive evolution of direct drug deaths is to be associated to the implementation of a drug consumption room in 2005. Considering that since the opening in 2005 of the drugs injection room more than 300 overdose victims could be assisted and reanimated in this same facility, the life-saving effectiveness of such an offer is proven.

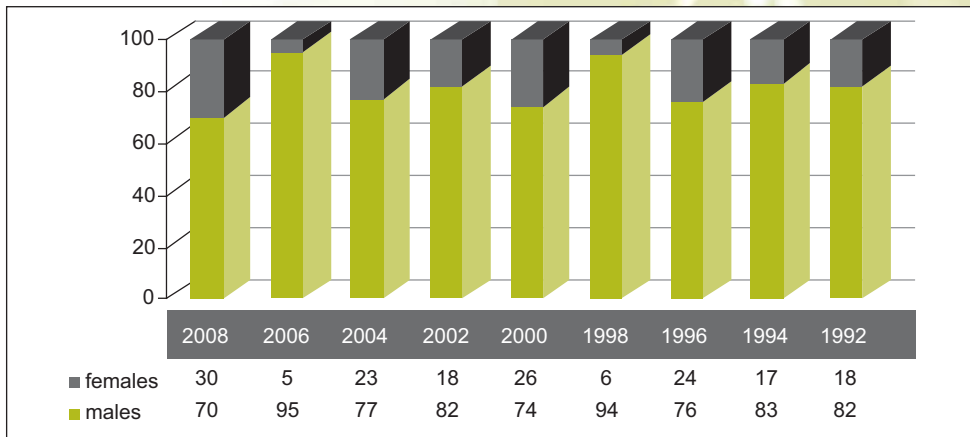
A retrospective study (1992-2006) on drug-related death cases performed in 2007 allowed a better understanding of risk and protective factors (Origer, 2008).

Forensic data by the department of National Toxicology Laboratory on Health⁴⁴ 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 15 years (in 1992: 28.4 years and in 2008: 33.16 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years remains relatively unchanged during the referred observation period.

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 victims 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 6.7 Gender distribution of direct drug-related death cases (1992 - 2008) (%)



Source: RELIS 2008

Table 6.6. Age distribution of direct drug death cases indexed from 1992 to 2008

	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	Total
< 20		3	1	1				2	1	1			1		3	3		16
20-24	2	1	4	2	1		4	2	8	3	2	2	5	6	6	6	6	60
25-29	2	6	4	1	4	2	1	5	6	6	5	5	5	10	13	2	6	83
30-34	1	8	2	1	3	4	3	2	6	3	2	2	4	5	6	3	3	58
35-39	3	5	5	1	2	3	1	5	4	3	4		1	2	1	1		41
40-44	2	2	2	1	2	3		2	1	1	3			2			1	22
45-49		1			1	2	2		1					1			1	9
≥ 50		1	1	1									1					4
Mean Age	33.16	32.33	32.5	31.48	32.17	36.64	31.18	31.5	29	29.35	32.3	26.7	28.5	29.85	26.8	24.6	28.4	293
Male	32Y8M	34Y4M																
Female	33Y8M	25Y																

⁴⁴ Département de Toxicologie du Laboratoire National de Santé



In 2008, the mean age of female overdose victims is surprisingly similar to the age of male victims, which may, however, be due to the small number (statistically speaking) of cases. The youngest victim was aged 21 years and 6 months and the oldest reached 44 years and 5 months. No underage victims were reported in 2008. Considering the nationality of overdose victims, 80% were 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 decreasing number of victims of Portuguese origin.

For more detailed data on 2008 drug related deaths please refer to standard tables 5 and 6.

Mortality and causes of deaths among drug users

In terms of **drug-related mortality** (direct and indirect deaths indexed by RSPJ), 20 cases have been indexed in 2008 (38 in 2007); prevalence has been showing fair variations since 1996, figuring roughly 17 to 38 cases per year.

The above mentioned study (Origer & Dellucci 2002)⁴⁵, 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 [20 in 2008 of which 10 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**.

Since the implementation of ICD-10 coding by the GMR (1998), a vast majority of acute drug death cases have been recorded as 'accidental poisoning' (**X40 – X49**), which is consistent with the national definition of an acute overdose death. To date over 60 % overdose cases have been indexed as follows: **X42.-, T40.-, T42.- T43.-**. At a more restricted level the code sequence: **X42.-, T40.-** includes around 70% of all reported overdoses.

Main **causes of indirect deaths between** 1996 and 2008 are, in order of importance: suicide (32%)⁴⁶, 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%).

⁴⁵ A full text version of the study can be downloaded under: <http://www.relis.lu>

⁴⁶ Valid percentage

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

Introduction

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 is directly linked to health consequences of drug use, whereas nuisance reduction is seen as a correlate of the latter.

Health care offers to drug users are provided by specialised drug care agencies as well as by the general health care system. Major efforts have been undertaken in recent years to improve data on drug treatment demands from general healthcare providers by including psychiatric departments of general hospitals in the RELIS data collection network and the pilot implementation of a national substitution treatment register. In addition to the national drug surveillance system RELIS, these new data sources and tools will allow to draw a more accurate picture of intervention outcomes.

In May 2006 a new national HIV/AIDS action plan (MH 2006) 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>

As far as availability of service is concerned, currently two agencies offer harm reduction services in the Centre, the South and the North of the country including offers such as day and night shelter and supervised injection facilities (currently only in Luxembourg City). The governmental programme 2010-2014 foresees the decentralisation of respective offers by implementing new integrated low threshold centres for drug addicts in the South and the North of the country

PREVENTION OF DRUG RELATED EMERGENCIES AND REDUCTION OF DRUG RELATED DEATHS

Research and recommendations

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

1. Opening of supervised injection rooms according to the national drugs action plan.
2. Medical controlled heroin distribution programme (foreseen by the national drugs action plan).
3. First aid training courses provided to users and their relatives and partners.
4. Gender and ethnic specific interventions.
5. Provision of morphine receptor antagonists to users and selected persons (5).
6. Creation of 'transition centres' for ex or current PDUs leaving institutional settings.
7. Development of reintegration programmes for prisoners in the framework of the recent 'Global care programme for drug addicts in prison'.



Drug injection room and low threshold shelters

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

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 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 refers to the creation of low threshold emergency shelter facilities for drug addicts to be implemented regionally. These centres do include day and night shelter as well as a supervised drug injection room.

A low threshold emergency centre for drug addicts (TOXIN) was inaugurated in December 2003 and initially provided day care and night shelter. In July 2005, the first injection room at national level has become operational and has been integrated in the TOXIN centre which from then on has been providing the whole range of harm reduction services, counselling facilities, accommodation, washing, laundering and storing facilities. It should be added that the night accommodation is not to be seen as a permanent housing facility; there is indeed a daily admission procedure. Target population for the consumption room are primarily IDUs. Inhalers might be admitted in a second phase. The main objective of the project is the reduction of drug-related harm and nuisances. More precisely it aims at reducing the risks of infectious diseases, overdoses and public nuisance in the neighbourhood, contact making with difficult to reach addicts, provision of special designed night shelter facilities and avoiding unnecessary prison journeys over night. The project was designed with the support of law enforcement agencies.

The national drugs coordinator's office elaborated the operational concept of the injection room based on available international experience and evaluations. In terms of management, all involved parties meet once a month (called 'the Monday round') to assess the current situation and emerging problems related to the functioning of the consumption room. Incidents, nuisance reports, trends, quality assurance, workload, technical improvements and safety issues are addressed by the 'Monday round' in order to promote rapid solution finding and continuous adaptation to fast changing clients' profile and consume patterns.

Table 7.1 provides an insight in clients' and occupation statistics of the TOXIN services since their opening and during 2008 respectively:

Tab 7.1 Clients statistics of TOXIN centre services

Injection Room	June 2005 - June 2009	2008 exclusively
Number of user contracts	745	208
Number of users	63,359	24,700
Number of injections	75,001	29,787
Number of non-fatal overdoses		
With loss of consciousness	53	29
Without loss of consciousness	257	119
Number of fatal overdoses	0	0
Medical emergency interventions	52	23
Day care	December 2003 – June 2009	2008
Number of clients	164,858	53,053
Night shelter	December 2003 – June 2009	2008
Number of residents	75,737	14,44

Opening hours are currently from 3 pm to 10 pm 7 days a week with a capacity of 42 beds and 7 injection tables. TOXIN facilities are mostly used by men (79%); the most commonly used drugs were heroin (83%), cocaine (12%) or both of them (4%); age category 25-34 is most represented (50%).

No fatal overdose has occurred thus far but over 300 overdoses have occurred and due to the immediate intervention of ad hoc staff all victims could be assisted, reanimated and their lives saved. The drug scene of Luxembourg-City adheres to a great extent to the TOXIN concept with the positive effect that public nuisance has significantly decreased. The current situation is also due to the fact that surveillance cameras were installed in the referred area and a large number of abandoned houses were destroyed or closed, reducing the urban life environment of drug users. The increasing number of users attracted by the TOXIN services poses however an emerging problem of clients' management given the fact that the container structure was meant to be of provisional use and is currently reaching the limits of its capacity. A permanent centre is planned to be constructed in the same area. The Ministry of Public Works jointly with the Ministry of Health has finalised architectural plans in 2007. The City of Luxembourg has finally granted the authorisation to build in September 2009.

The concept of the drug injection room can be ordered at the Ministry of Health (alain.origer@ms.etat.lu).

As most relevant drug scenes concentrate in the City of Luxembourg and in the main city in the South of the country, Esch-sur-Alzette, discussions are currently ongoing with the community council of Esch/A in order to implement a similar facility in the latter city. The aim is to further decentralise low threshold offers and enhance local city authorities' commitment in the management of regional and urban drug problems. Involved national and local authorities have recently found an agreement on the geographical location of this facility although the concept has still to be agreed on. A broad political consensus exists as far as the need of rationalised drug intervention strategies is concerned. This was recently confirmed by the fact that a special paragraph was dedicated to this issue in the new governmental programme for the years 2009 to 2014.

The law of 27 April 2001 introduced an important modification of the basic drug law with regard to overdose prevention. Art.10-1 of the referred law exempts drug users who call for assistance in case another user is in need of medical help, from prison sentences and from fines in certain circumstances. In general, witnesses meeting these conditions are not prosecuted. The primary aim of this measure is to reduce drug-related deaths occurring in consumer couples and groups. Moreover the ICD has put on its agenda the implications of routine police forces' on site presence in case of a reported and/or suspected overdose case. As a result a new information flyer has been elaborated jointly with field agencies and the Ministry of Health. The flyer contains useful information on safer injection and advice in case of overdose events. To further reduce the risk of overdose the department of health has granted a market authorisation for the national prescription of Suboxone[®] (buprenorphine & naloxone) in the framework of the national substitution programme. However, prescription of Suboxone[®] remains fairly rare.

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

Heroin assisted treatment (HAT)

The future implementation of a medically controlled heroin distribution programme, as foreseen by the national drugs action plan 2005-2009, will further contribute to reduce drug related health damage. As far as the latter is concerned the Inter-ministerial Group on Drugs agreed on the opportunity of a national heroin distribution programme in September 2007 and the national drugs coordinator has submitted a



feasibility study and an operational framework concept, elaborated jointly with national experts and partly inspired by the Swiss guidelines on Heroin Assisted Treatment (Bundesamt für Gesundheit, 2006), to the Minister of Health in May 2008. The main conclusions of the concept report (Origer 2008) are the following:

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

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

By the time of writing the HAT concept was approved by all nationally involved parties, a provisional budget has been set and agreement was reached with a specialised agency in terms of future management of the programmes. First resources are foreseen to be allocated in 2010 and the pilot phase of HAT implementation should start in 2011.

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

The lack of national detoxification capacities has become a growing problem in the drug care network in recent years. According to international standards the number of detoxification slots in general hospitals revealed to be sufficient however waiting lists of new treatment demanders became consistently longer. A reason for this has to be seen in existing gaps in the preparation of drug related hospitalisations and during the release phase. In this respect, two new projects will be addressed in the new drug action plan.

The first refers to the set up of a so called diagnostic, referral and follow-up mechanism (DDOS). The main idea is to attribute a single reference person (social worker freely chosen by the treatment demander) to each treatment demander. This reference person organises together with the patient and care institutions treatment interventions, follows up progression and guarantees access after-care offers. The reference person also represents a single contact person for involved care institutions. Furthermore, in order to allow hospitals and psychiatric department to concentrate their efforts to interventions for which they are competent, mainly medical care and withdrawal, to reduce relapses and after release overdoses, a stabilisation unit will be created with a capacity of 12 beds and a maximum stay of 3 weeks. The referred unit aims at stabilising recently detoxified persons by providing them with necessary medical care and by offering them a safe environment to start their re-integration process.

PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

Prevention

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

The objective of these interventions is straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Traditionally harm reduction (HR) measures have been focusing on IDUs since most exposed to a variety of health risks. Nevertheless, initiatives such as the provision of aluminium foils to heroin users and the current discussion on the future distribution of 'strawbags'⁴¹¹ for sniffing purposes witness a progressive switch from IDUs users to PDUs being considered as target groups. Furthermore infectious diseases prevention does not focus specifically on IDUs as shows a recent action-research project on HIV and hepatitis infection among PDUs (Origer & Removille, 2007). Interventions aiming at the prevention of drug-related infectious diseases as for instance needle exchange and substitution programmes have been initiated and developed prior to the set up of a specific legal framework. The last drug law amendment (2001) did not only allow maintaining and to further developing existing harm reduction offers but also set the foundation for the implementation of new services such as supervised drug injection rooms and medically assisted heroin distribution as foreseen by the national drugs action plan.

The objective of these interventions is straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Traditionally harm reduction (HR) measures have been focusing on IDUs since most exposed to a variety of health risks. Nevertheless, initiatives such as the provision of aluminium foils to heroin users and the current discussion on the creation of a drug inhalation facility in the new TOXIN centre shows the switch from IDUs



users to PDUs being considered as target groups. Furthermore infectious diseases prevention does not focus specifically on IDUs as shows a recent action-research project on HIV and hepatitis infection among PDUs (Origer & Removille, 2007).

The most relevant measure in the field of prevention of infectious diseases in drug users is the **national needle exchange programme** established in 1993 and co-ordinated by JDH. In addition to free of charge needle provision by specialised drug and AIDS agencies, automatic syringes dispensers/collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy. Regarding the quantity of distributed syringes, table 7.2 shows that the number of distributed syringes stabilised in 2005 and has been significantly decreasing from 2006 onwards although the return rate continues to increase. The possible reasons for these trends have been addressed by a special national working group. The hypothesis that syringes are increasingly acquired via out of NSP providers (e.g. pharmacies) could not be confirmed since over the last five years the proportion of syringes distributed by NSP points have increased in comparison to other providers. Following factors may have influenced distribution patterns:

- relocation of the main drug counselling centre in Luxembourg city in 2006 and provision gaps due to it,
- intensive presence of the police at proximity of the railway station and in the direct environments of the Drop-In service,
- the syringes distributed to the clients of the consumption room were not included in the national statistics until 2008
- the service K28 notices an increase of the distribution of aluminium sheets in 2007 (07 : 1.204/06 : 766) ; a renewed outbreak/upsurge of the consumption mode by inhalation is however not confirmed by the other services,
- the quality of the drugs on the illicit market widely influences the consumption behaviours and the injection frequency,
- the fact of having introduced a new type of syringes (where the needle is more solid) might have had as result that the same consumer uses the same syringe several times.

It is estimated, in reference to self-reported data on syringe provision from RELIS respondents, that one third of IDUs procure their syringes primarily in pharmacies. This proportion has remained fairly stable over recent years and do not directly impact on the decreasing figures from specialised needle exchange points.

Table 7.2 National needle exchange programme 1996-2008

	Distributed syringes							Collected used syringes						
	1996	1998	2000	2002	2004	2006	2008	1996	1998	2000	2002	2004	2006	2008
TOTAL	76,259	109,743	189,413	254,596	435,078	332,347	259,607	28,646 (38%)	58,886 (46%)	112,625 (59%)	211,621 (83%)	376,491 (87%)	282,909 (93%)	~249,400 ~(96%)

Source: RELIS 2008

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

Moreover, outreach interventions targeted at (drug using) sexworkers 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 analysed the relationship between the prevalence of hepatitis A, B, C and of HIV in the population of drug users with other relevant factors. Additionally a quantitative questionnaire (questions based on socio-demographic, illicitly acquired drugs consumption, consume patterns, sexual behaviour, consumption in prison, piercing/tattoo) allowed analysing associated factors. Serological analysis identified the number of contaminated cases with hepatitis A, B, C and HIV. In case of medical indication a vaccination against hepatitis A and/or B has been offered. Drug users meeting the selection criteria were recruited in LTS, NSEP, inpatient treatment centres, hospitals and in the prisons of Luxembourg. The NFP has been granted a full financing of the project by the FLTS.

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

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

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

Counselling and testing

AIDSBERODUNG (RED CROSS) is the main national counselling and prevention centre for HIV and AIDS. Prevention campaigns are conceptualised by the AIDSBERODUNG team in collaboration with the Ministry of Health and an important network of volunteers. AIDSBERODUNG is part of the RELIS network. Testing is provided by the CHL and the LNS and is free of charge. Furthermore, HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison.

A new project foreseen by the national HIV/Aids action plan 2006-2010 focuses on outreach measures in order to better reach target populations and in particular vulnerable groups. DIMPS (Mobile intervention facility for sexual health) aims to access difficult to reach sub-populations and provide prevention counselling and infectious disease testing on site to various populations. The project provides free rapid testing of HIV and hepatitis and outreach counselling and has started in May 2009 and targeted firstly scenes of drug users, sex workers and asylum seekers. Given the recent start of DIMPS no reliable client statistics are available yet, but the referred project has known a very high acceptance by users thus far.

Based on experience gathered through the DIMPS project and also on the recommendations of the Origer and Removille study (2007), discussions are currently held whether to extend the DIMPS offer to free HBV/HAV vaccination (where appropriate) for clients of specialised drug agencies.



Jointly with the Ministry of Health and the Infectious disease department of the CHL, Aidsberödung works on a decentralisation concept regarding free HIV and hepatitis testing in order to increase accessibility especially at regional level.

Infectious diseases treatment

Treatment of HIV and hepatitis infections is covered by the national 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.

A new project within national prison aims at setting up a specialised medical department for transmittable diseases (COMATEP). Given the fact that according to 2008 data 20.97% of inmates carry a transmittable disease and that 33.5% of new admissions in national prisons are drug law offenders, the project is considered to be pertinent and important also by the national drug coordination office.

Interventions related to psychiatric co-morbidity

The above referred working group 'Therapeutic Chain' has performed a needs assessment in terms of care for drug users presenting psychiatric co-morbidity. The group retained that current offers and services for double diagnostic (DD) patients are incomplete. Although the 2005-2009 national action plan foresees the creation of a specialised therapy centre for DD drug patients has not been realised.

The number of confirmed DD patients is estimated at 40-50 people (adults). These patients show explicit psychiatric disorders, are often socially disintegrated and need individual follow up although they tend not to be attracted by existing care offers. There is a need of small supervised housing units for the target group. Furthermore, the staff of specialised associations must be specifically trained to take care of DD clients. Instead of creating a specialised and centralised care infrastructure, a better follow-up of patients within existing outpatient services is needed in the first place, knowing that the referred clients only integrate with difficulties in structures with compulsory residential character. The 'Therapeutic Chain' expert group recommended in this context to fine-tune the concept of supervised / accompanied housing in order to move towards a case management approach in a private and individualised environment, knowing that DD patients often have difficulties to adapt to community oriented settings and offers.

RESPONSES TO OTHER HEALTH CORRELATES AMONG DRUG USERS

Somatic co-morbidity and general health related treatment

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

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

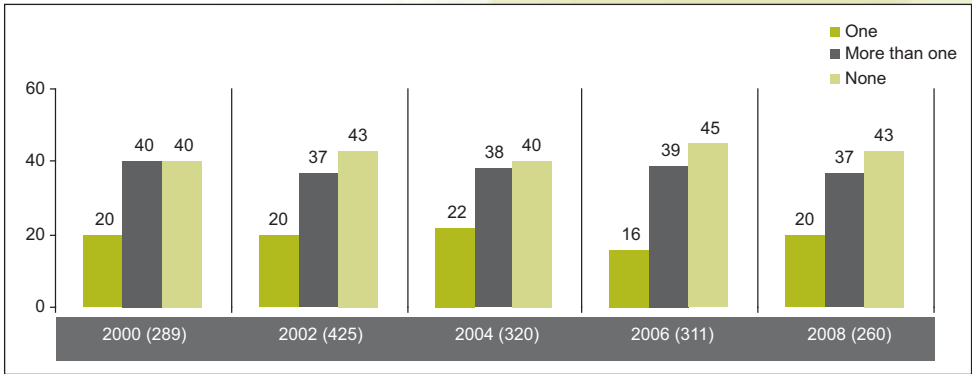
Non-fatal emergencies and general health-related treatment

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

Non-fatal drug related emergencies

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) (57%) during lifetime has been fairly stable over the last nine years.

Fig. 7.1 Non fatal, medically assisted drug overdoses in RELIS respondents (2000-2008) (valid %)



SOURCE: RELIS 2008

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 grand-ducal decree. For more details on the new legislation please refer to chapter 1 (laws).

Interventions concerning pregnancies and children born to drug users

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



Due to the improvement of, and the better access to drug related treatment and especially the spread of substitution treatment, the birth rate in drug users has increased over recent years. According to data from the national drug surveillance system, the proportion of drug users having children has progressively increased from 50% to 63% over the last 10 years (RELIS 1999, 2009). This evolution has been leading to the first parental project launched by JDH in 2003 with the aim to provide psycho-social aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative abilities. This long term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. In 2008, 57 different family situations have been taken in charge, 66.7% of them being mono parental situations involving all in all 94 children. Approximately 50% of concerned parents rely on specialised housing offers. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

Initiatives currently under discussion for inclusion in the 2010-2014 drugs action plan are training programmes and capacity building for drug using parents in order to empower them with regard to their educational role.

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 SOCIAL REINTEGRATIONS

Introduction

Social correlates of drug use typically involve Justice, Health and Educational competences. The Ministry of Health and the Ministry of Family and of Integration both intervene by financing measures to reduce social consequences ranging from early detection of drug use to social-professional rehabilitation interventions. The reduction of drug related crime involves the Ministry of Justice, focuses on supply reduction activities and the Ministry of Health implements measures targeting socio-professional re-integration aiming at reducing daily expenses and depths of drug addicts and thus the prevalence of acquisition crimes. Social reintegration programmes are mainly monitored by the involved Ministries and through associations' activity reports and activity programmes.

SOCIAL EXCLUSION AND DRUG USE

Social exclusion among drug users

The question whether substance abuse leads to social degradation and exclusion or social factors (e.g. family situation, poverty, low education or job perspectives) lead individuals to substance use is an unsolvable one, although it tends to raise competence discussions between ministries. Fact is that a vast majority of homeless and socially excluded people 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 of progressive reintegration through capacity building and the improvement of the social abilities and environment. Associations as 'Stëmm vun der Strooss' (Street voice) and Centre Emmanuel asbl, 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 below.

Drug use among socially excluded groups

Homelessness

According to latest estimations around 700 persons are currently homeless in the Grand Duchy of Luxembourg ⁴⁷. The study reported a proportion of 54% males and 46% females and a relatively young age of homeless population. Half of the population of homeless people is aged 18 to 34 years and only 9% are aged more than 55 years.

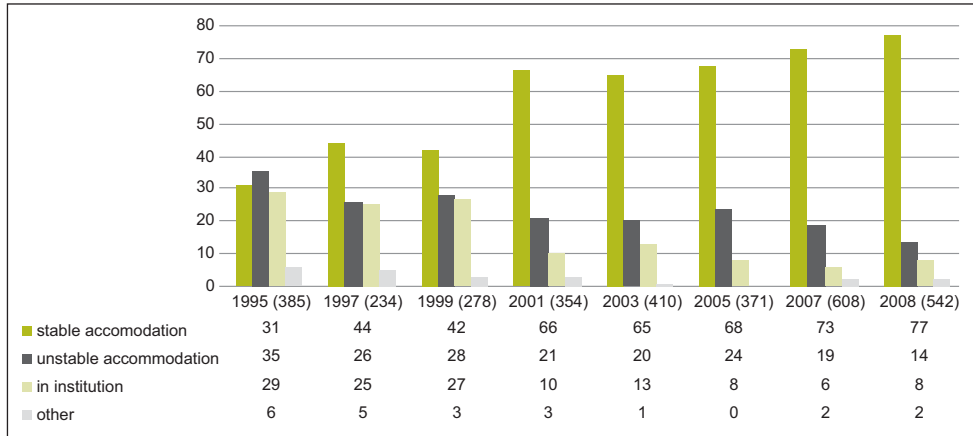
More specifically, housing status of registered drug users has markedly improved during recent years and tends to stabilise. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Currently 77 percent (73%) of PDUs report a stable housing situation (RELIS 2008). This

⁴⁷ 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



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.

Fig. 8.1 Last known housing situation of problem drug users. 1995 - 2008



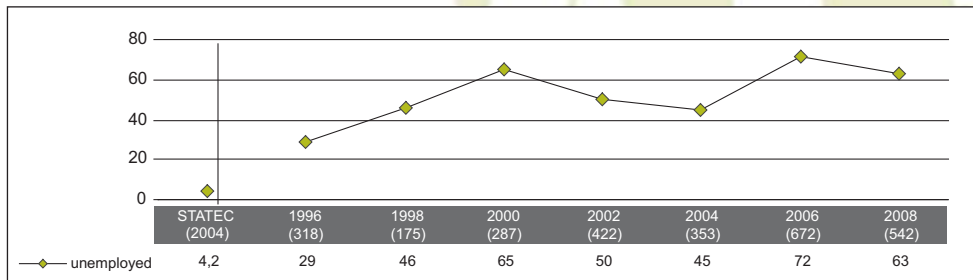
Source: RELIS 2008

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

Unemployment

Recent data suggest that the **employment status** of respondents tends to plateau, as the rate of people with a stable job (47%) has shown a fair stability over the last 3 years. The **unemployment rate** has increased from 2004 to 2008 (63%).

Fig. 8.2 Unemployment rate in problem drug users (1996 - 2008)



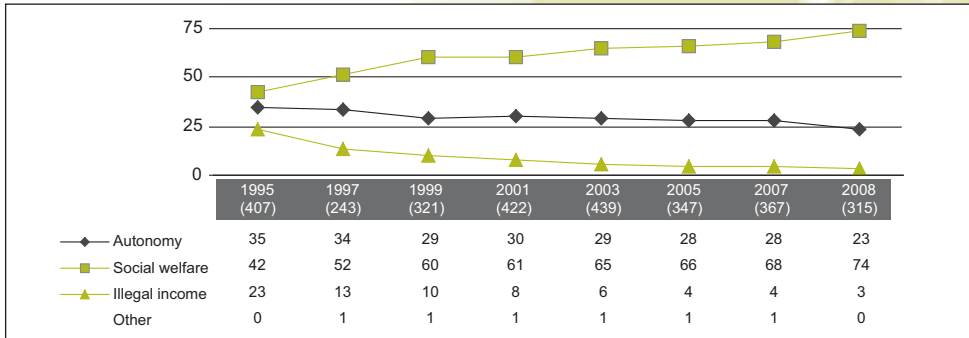
Source: RELIS 2008

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 (47% in 2008);
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 1995 (3% in 2008);
- a high proportion of respondents reporting **major debts** (>2,500 EURO) (39% in 2008).

Fig. 8.3 Primary source of income of problem drug users (1995 - 2008)

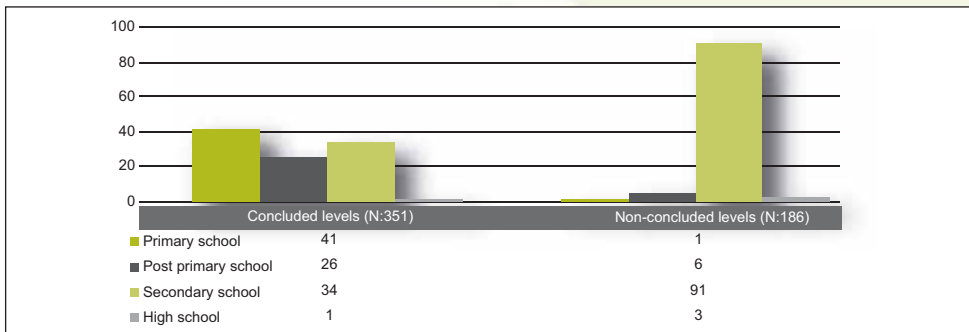


Source: RELIS 2008

School drop out

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

Fig. 8.4 Educational level of RELIS respondents (2008)



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



Regarding PDUs, the **educational level** of the latter, low and mostly incomplete, has been showing a creeping deterioration since 1999 according to baseline data from RELIS. However, an increasing proportion of respondents start secondary school without bringing their studies to term. The average age at the end of studies shows a global decreasing tendency and currently situates at 16 years and 8 months. 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.

Financial problems

39% of the population of PDUs have major debts (1997: 54%). Over the last ten years, after a peak in 1997, the percentages stayed relatively stable (around 40% since 1998) representing less than half of the PDU population. The RMG (Guaranteed Minimum Income) (47%) and the proper salary (17%) represent the main income sources of the PDUs. Between 1997 and 2008, strong variations were observed in relation with these two revenues. RMG as a primary source of revenue has known a remarkable increase from 1997 onwards in contrast to the proper salary, which decreased during the last years. Money provided by parents as first source of income has also decreased (18% in 1997 to 8% in 2008).

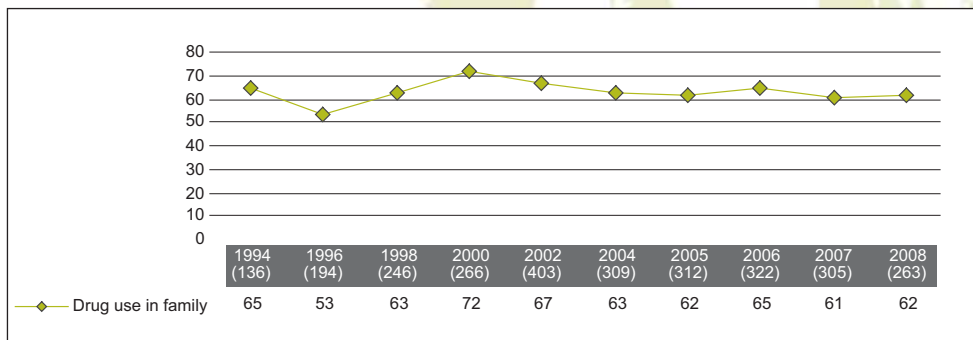
Concerning secondary income sources, 35% of respondents reported no secondary income, 34% referred to 'illegal activities'⁴⁹ and 23% were provided money by parents.

Overall, the social dependence shows an increasing tendency over the last years (74% in 2008 – 42% in 1995). Consequently, autonomy shows a decreasing tendency (23% in 2008 – 35% in 1995).

Drug use in Family

According to RELIS data, drug use in the family of origin is high and stable. Drug use in this context is defined as the use of illegal drugs or abuse of alcohol or psychotropic pharmaceuticals.

Fig. 8.5 Drug use in family of origin. 1994 - 2008



Source: RELIS 2008

⁴⁹ mainly selling of drugs

SOCIAL REINTEGRATION

Housing

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

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

A project called '**Les Niches**' functions as a kind of social real estate agency for drug addicts. Approximately 35 flats and apartments are rented by a drug-counselling centre and provided to drug addicts in need by means of tailor made renting contracts. One of the medium term aims of the project is to allow demanding drug addicts to take over the renting contract on basis of their own financial means and thus dispose autonomously of a stable accommodation. The project is jointly financed by the Ministry of Health, National Fund against drug trafficking, and the city of Luxembourg (VDL).

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.

Education, training

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

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

Employment

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

Additionally clients are offered task and job opportunities in the laundry service called '*Schweessdrëps*' (*Drop of sweat*) which covers the south of the country and is specialised in washing sports teams' uniforms. In 2008, 1 social worker and 18 clients have been working for 25 sports teams, washing, drying etc. 1,000 to 1,500 uniforms weekly. Besides these two main work-opportunities, the service also offers a therapeutic



workshop called 'Dressed for success'. In 2008, the service has been managed by 2 clients (offering them a job opportunity and responsibility). Their main task was to organise (collect, wash, store, etc) clothes offered by donors.

A new occupational project foreseen for 2009-2010 and run by the 'Street voice' ('Stëmm vun der Strooss') association will further fill the gap in occupational offers for drug addicts at the national level. The detailed concept of the residential centre offering temporary accommodation and day jobs will be described in the 2010 report.

Co-financed by the Ministry of Labour and Employment and the European Social Fund, the Centre Emmanuel association launched the project '**START**' in 2007, targeting progressive re-integration of drug users into the first job market (G. Lambrette, 2009)⁵⁰. The applied methodology combined case oriented follow-up and job coaching and aimed at helping beneficiaries to find a work or professional training place (e.g. establishing contact with companies, preparing job interviews, editing of resumes, etc.) and to assist them in their daily work routine (definition of tasks, conflict management, mediation between employee and employer, motivational follow-up, etc.). Intermediate feedback and final evaluation contributed to improve autonomy of clients and are ideally leading to a permanent work contract. As one of the main impediments regarding access to jobs by vulnerable groups, is the initially or even permanently reduced work performances, the main objective of a job coaching project is the mobilisation of individual resources and capacities of the beneficiary in tune with the need of the company he or she is given the opportunity to work for.

Between 2007 and 2008, 230 demands have been treated in the framework of the START project. 23% of demanders were female, a majority was aged 31 to 50 years and 76% presented a low professional qualification profile. By the end of the project 27 beneficiaries had signed a work contract through START and 21 persons more found a stable job indirectly due to their participation in START.

⁵⁰ LAMBRETTE, G. (2009), Projet "START!" – Constats et réflexions autour d'un projet de réinsertion professionnelle pour personnes toxicomanes au Grand-duché de Luxembourg, Luxembourg.

9. DRUG RELATED CRIME, PREVENTION OF DRUG RELATED CRIME AND PRISON

Introduction

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

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

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

Intervention of law enforcement agents based on reasonable suspicion. The '*interpellated*' person is heard and a police record occurs. At this level, however, there is no notification to the Public Prosecutor and no mention in the judicial record.

- The term '*prévenus*' (interpellated/indicted person):

Refers to persons who have been apprehended by legal enforcement agents for alleged offences against the national drug law (or against law in general).

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

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

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

Judgement by which the accused person is found guilty.

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

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

DRUG-RELATED CRIME

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



Drug law offences

As can be seen in tables 9.1, the total number of arrests (188) 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. Recently, cannabis offences have been increasing (2006 and 2008 data), followed by heroin and cocaine offences.

Tab. 9.1 Arrests broken down by type of reporting institution (1995-2008)

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

Tab. 9.2 Arrests broken down by type of offence and substances involved (1995-2008)

Substance	Offence	1995	1997	1999	2001	2003	2004	2005	2006	2008
Heroin	Use & Traffic	68	57	48	41	21	32	28	40	43
	Traffic/Deal	21	53	18	8	22	19	14	29	30
	Use	24	7	27	8	4	20	20	26	14
	Total	113	117	93	57	47	71	62	95	87
Cocaine	Use & Traffic	20	27	21	27	19	21	21	26	26
	Traffic/Deal	7	23	9	9	30	64	42	38	21
	Use	10	6	12	4	3	9	15	21	3
	Total	37	56	42	40	52	94	78	85	50
Cannabis	Use & Traffic	25	18	32	23	52	16	17	42	61
	Traffic/Deal	1	11	8	1	17	20	27	36	11
	Use	4	4	3	15	9	14	25	15	18
	Total	30	33	43	39	79	50	69	93	90
Amphetamines	Use & Traffic		2	1	2	2	0	0	0	3
	Traffic/Deal				0	0	0	1	0	2
	Use	2			0	0	0	0	2	0
	Total	2	2	1	2	2	0	1	2	5
Ecstasy (MDMA, etc.)	Use & Traffic	3	3	3	1	1	1	3	4	2
	Traffic/Deal	1	3		0	0	1	6	1	0
	Use	1			0	1	1	3	2	1
	Total	5	6	3	1	2	3	12	7	3
LSD	Use & Traffic		1	1	0	0	0	0	0	1
	Traffic/Deal				0	0	0	0	0	0
	Use				0	0	0	0	0	0
	Total		1	1	0	0	0	0	0	1
Total number of arrest motives independently of involved substances	Use & Traffic				59	57	48	46	85	103
	Traffic/Deal				13	61	93	63	87	53
	Use				20	15	35	45	47	31
	Total	128	154	108	92	133	178	154	219	187

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2008

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP), stable between 1996 and 1998, showed an important increase from 1998 to 2003 (825 to 1,660) and has been stabilising since then (2008: 1,219 rec.).

The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 1998 followed by a subsequent increase. From 2003 onwards, one observes a significant decrease (1,487 in 2008) in drug law offenders. The number of arrests on the same charge has decreased from 154 in 1997 to 135 in 2003 to increase and stabilise again in recent years (2008: 188 arrests).

Table 9.3 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 2008.

Tab. 9.3 Number of national law enforcement interventions (1995-2008)

Année	DRUG LAW ENFORCEMENT RECORDS								PREVENUS (Offenders)							
	95	97	99	2001	2003	2006	2007	2008	95	97	99	2001	2003	2006	2007	2008
S.P.J.	123	137	343	216	239	190	177	110	152	182	434	321	369	248	203	128
Gendarmerie	198	255	782						319	335	916					
				1,126	1,326	824	998	881				1,272	1,753	1,007	1,160	1,009
Police ⁵¹	199	177	189						371	280	283					
Customs ⁵²	244	236	173	113	95	186	197	228	421	408	306	182	148	320	324	350
Total	764	805	1,187	1,455	1,660	1,200	1,372	1,219	1,263	1,205	1,939	1,776	2,270	1,575	1,687	1,487

Source: Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 85% **males**; a proportion that has been varying between 79% and 89% during the past decade. Since 1997, **non-natives** (58.7% in 2008) 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 2007/2008 data reporting a decrease from 808 in 2003 to 546 in 2008. Also the **percentage of minors** (< 18 years) among drug law offenders having increased between 1994 (4.9%) and 2000 (8.7%) shows a clear decrease in 2004 (5.7%) and tended to stabilize from there on (2008: 5.5%). Heroin and cocaine are the main drugs involved in first drug offences.

Tab. 9.4 Socio demographic data on 'prévenus' (1986-2008)

Year	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
AGE																	
0-14	9		7	6	1	3	7	27	21	11	15	41	24	9	8	11	8
15-19	121	212	179	320	169	270	249	415	413	399	647	602	334	436	279	318	282
20-24	264	569	383	527	403	447	321	519	497	566	650	557	510	617	415	480	436
25-29	119	220	278	371	309	304	220	448	354	299	388	375	278	345	323	321	274
30-34	49	67	124	159	186	191	187	269	208	194	219	254	250	230	188	216	205
35-39	17	29	27	52	65	80	76	131	113	139	177	162	190	174	136	162	134
≥ 40	17	19	43	46	21	42	78	84	108	113	82	174	126	153	181	165	129
unknown	27	21	30	50	20	31	32	46	44	55	40	106	95	70	43	14	19
TOTAL	623	1,137	1,071	1,531	1,174	1,368	1,170	1,939	1,758	1,776	2,218	2,271	1,808	2,034	1,575	1,687	1,487
Male	503	970	851	1,248	938	1,138	958	1,658	1,415	1,546	1,905	1,935	1,581	1,751	1,319	1,484	1,263
Female	120	166	220	256	209	173	193	248	241	215	292	288	181	237	218	190	206
gender unknown	0	1	0	27	27	57	19	33	44	15	21	48	49	46	38	13	18

Source: Specialised Drug Department of the Judicial Police 2008

⁵¹ 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

⁵² 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



Tab. 9.5 Distribution of 'prévenus' according to first offence and underage status (1992-2008)

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

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2008

Tab. 9.6 Distribution of first offenders (use and use/traffic) according to substance involved ad minima (1992-2008)

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

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2008

Other drug-related crime

The routine data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results summarise the situation observed in 2008:

- 92% of drug users indexed⁵³ by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime.
- 79% of the total PDU population show multiple law enforcement contacts (stable).
- The proportion of 'interpellations' for other reasons than presumed offences against the drug law (e.g. **petty crime** such as criminality linked to drug supply or fights) has been decreasing since 1997 (38%) and has been fairly stable in recent years (2006: 34% and 39% in 2008).
- 62% (63%) 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 (31% stable) has stabilised during the last years.

⁵³ Persons who have been indexed by the RELIS network during a reporting year.

PREVENTION OF DRUG-RELATED CRIME

In recent years, involvement of major cities in the management of drug-related problems and nuisances has developed. So-called municipal 'prevention committees' that include local authorities, police forces and specialised NGOs are in place. The setup of the first national drug injection room in Luxembourg City obviously enhanced the involvement of municipal authorities. The Ministry of Health chairs a management group that is mandated to follow up developments with regard to the injection room and to react precociously to emerging problems. The national action plan clearly emphasises the importance of a visible involvement of major cities in the management of public safety and order, urban nuisance and hygiene problems related to drugs to guarantee the necessary decentralisation of demand reduction offers and supply reduction interventions.

As far as preventive measures targeting youngsters are concerned, a mechanism has been put in place in 1996 aiming at underage and juvenile drug use offenders and in order to prevent recidivism. The **Youth Solidarity** (Jongenheem asbl) project is financed by the Ministry of Health and intervenes in case a minor of age has been running in conflict with law enforcement forces with respect to a drug-related offence. In this respect the Youth Solidarity team may be considered as a crisis situation manager, offering their services to drug offenders referred by judicial and penal institutions. The available services are free of charge.

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

Tab. 9.7 Clients' core statistics SOLIDARITE-JEUNES 1997 – 2008

YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number of episodes	46	99	132	195	208	231	267	249	322	352	357
Referral from the criminal Justice system	26.1%	26.3%	41.4%	44.1%	44.2%	37.2%			46.2%	44.4%	43.4%
Gender distribution											
Female	28%	26.3%	34.1%	32.3%	34.1%	31.6%	31.9%	31.3%	30.1%	24.4%	30.5%
Male	72%	73.7%	65.9%	67.7%	65.9%	68.4%	68.1%	68.7%	69.9%	75.6%	69.5%
Age distribution											
< 14						9.5%	4.9%	2.0%	4.7%	4.6%	5.9%
14-15						38.1%	30.0%	22.9	27.9%	25.6%	24.9%
16-17						39.8%	46.4%	43.4%	46.9%	46.6%	50.4%
> 17						12.6%	18.7%	20.5%	16.5%	18.5%	15.9%
unknown								11.2%	4.0%	4.7%	2.9%
Main substance involved											
Cannabis						83.1%	72.4%	71.5%	73.3%	67.7%	69.4%
Heroin						3.5%	4.5%	5.6%	3.7%	2.5%	1.7%
XTC/Cocaine						1.3%	2.2%	0.4%	1.6%	1.1%	0.6%
Legal drugs						2.6%	3.0%	2.4%	3.1%	5.1%	7.8%
Polydrugs						d.m.	1.9%	3.2%	3.7%	5.4%	4.5%
Other						1.3%	3.3%	2.0%	2.5%	2.5%	2.5%
None						8.2%	10.6%	10.4%	10.2%	9.6%	8.7%
Unknown						0.0%	2.2%	3.7%	2.5%	6.1%	4.8%

Source: Solidarité Jeunes (Jongenheem), 2008



INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Alternatives to prison

The Grand-Duchy of Luxembourg counts two state prisons at the national level; the CPL situated in the vicinity of Luxembourg City and the CPG implemented in the East of the country.

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

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

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

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

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

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

DRUG USE AND PROBLEM DRUG USE IN PRISONS

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

MAIN RESULTS:**Drug use in prison**

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

Risk behaviour

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

Miscellaneous

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

Source: Schlink, 1999

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

RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS

Table 9.8 provides the number of general admissions and the number of admissions according to drug-related convictions (DELIT 'STUP') in both national prisons from 1989 to 2008.

Tab. 9.8 *General and DELIT 'STUP' admissions in both national prisons (1989 - 2008)*

Year	1989	1990	1992	1994	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
New entries (Total)					685	858	796	859	767	641	794	1.141	1.078	1.341	1.043	1.030	990
New "STUP" entries	163	244	157	288	292	309	167	139	161	119	101	143	92	247	243	212	332
					42.6%	36%	21%	16%	21%	18.6%	12.7%	12.5%	8.5%	18.8%	23.3%	20.6%	33.5%

Source: Greffe CPL, CPG. 2008



Drug treatment (including number of prisoners receiving opioid substitution treatment)

Following the law of 27 July 1997 concerning the modification of the penitentiary organisation⁵⁴, a pilot project named 'Global Drug Care Programme in Prison' (2000-2005 - TOX project) was set up by a group of experts assigned by the Ministry of Justice in 1999. The concept was designed to implement, among other objectives primary, prevention measures in regard to drug consumption and infectious diseases. The overall aim of the project was to integrate drug dependant inmates into a medico-psycho-social drug care network in order to reduce recidivism, risks and criminality after release from prison. The implementation of the project had to be adapted to the two different prison settings. Joint financing by the Ministry of Justice, the National Fund against drug trafficking and the EU (regarding evaluation) was ensured.

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

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.

Regarding **substitution treatment in prison**, three scenarios may occur:

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

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

⁵⁴ 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.

Official figures show that 20% of the inmates (of full age) who entered CPL in 2008 received drug substitution treatment, representing a total of 216 people and 65% of persons entering prison due to drug-related offences.

Tab. 9.9 Number of inmates receiving opioid substitution treatment (2008)

Year	2008
Methadone (Mephenon)	215
Subutex	1
(Total)	216

Source: Comité de Surveillance SIDA: Rapport d'activités 2008

The average dose of distributed methadone was 30mg per day (minimal dose 2.5mg and maximal dose 110mg). The average period of treatment was 123 days.

Prevention and reduction of drug-related harm

In 2008, the activities of the previously referred to TOX-programme in prison were centred on three pillars:

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

The TOX programme in the CPG has established psycho-educational activities. The group has focused on two axes:

- **Health development and**
- **specific psycho-educational practice** for the drug-addicted inmates within a collective pavilion without drugs (specific entourage of at least 4 months with an optional prolongation).
- follow-up of the drug free section together with the « Program Charly » started in May 2007, as preparation for multidisciplinary and intensive therapy: 25 (11) inmates.

As far as the CPL is concerned, in 2008, 192 (147) admission demands were addressed to the TOX programme. 151 (92) demanders were provided with an individual psychosocial follow-up. 25 (28) clients have benefited from an individual counselling in prevention of STD. Furthermore, a drug addiction platform has been created and a new e-learning project started in 2008.



The CPG reports for 2008, 7 withdrawal prevention modules, 5 tobacco prevention modules, 3 HIV/AIDS prevention modules and 8 speaking groups. 70 clients were provided with an individual psychosocial follow-up and 873 individual counselling sessions were held.

In 2007, the external evaluation report⁵⁵ of the TOX project has been published and recommended the continuation of the action. The programme is currently part of the RELIS routine data reporting network (since 2009, first data expected in 2010).

PREVENTION, TREATMENT AND CARE OF INFECTIOUS DISEASES

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

In 2008, approximately 650 HIV tests have been carried out. 12 tests were positive (10 men and 2 women), 6 co-infections (HIV/HCV) were diagnosed in known drug-users. 2 of them were screened in prison (one of them infected indoor). To prevent further contamination, vaccination against hepatitis B and A is recommended to those who present a negative serology.

A structured syringes distribution programme has officially been launched in 2005 in the framework of the global drug care programme in prison. In order to enrol, inmates have to send a written request to the prison's doctor. After counselling, the inmate is handed a kit containing 2 syringes which may be exchanged at the nursery. As the consumption and possession of drugs is illegal, those inmates in possession of a syringe in its kit, are exempted from sanctions for detention of injection paraphernalia. In 2008, 36 kits have been distributed and 178 syringes exchanged. The programme is under medical secrecy and is operational although a series of changes are currently being discussed to increase the coverage and impact of the programme.

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

In order to meet specific needs in terms of infectious diseases in prison settings, the creation of a specialised transmittable disease counselling offer (COMATEP) involving prison administration and CHL is currently under discussion.

Prevention of overdose-risk upon prison release

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

⁵⁵ TREPOS, J.-Y. (2007) Evaluation du projet global de prise en charge des personnes toxicodépendantes en milieu pénitentiaire au Grand-Duché de Luxembourg, Université Paul-Verlaine, Metz.

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

Besides, the law of 27 April 2001 introduced an important modification of the basic drug law with regard to overdose prevention. Art.10-1 of the referred law exempts drug users who call for assistance in case another user is in need of medical help, from prison sentences. This change is supposed to reduce drug-related deaths occurring in consumer groups. A new flyer addressing among others measures to be undertaken by witnesses of a drug-related overdose and the genuine legal situation was elaborated and will be broadly distributed among PDUs in various settings in 2009.

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

REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

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

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

The Centre Emmanuel (see above chapter on social reintegration) also contributes in various ways to (re)insert drug users as far as (re)integration is possible.



10. DRUG MARKETS

Introduction

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

Overall, the national **drug market has become of a more aggressive nature** in terms of selling techniques. New distribution networks have developed in recent years and operate in an obviously professional way and by doing so have significantly increased drug availability and in particular the supply of **cocaine and cannabis**. Dealers increasingly tend to actively approach confirmed or potential clients. More recently ethnic groups join to improve their drug distribution strategies whereas previously none of these criminal groups actively searched contact with other groups. Moreover it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible to police as for instance private flats or bars.

Asylum demanders implicated in illicit cocaine trafficking mainly originate from West African countries, particularly from the Ivory Coast. Their number tends to stabilise. In regard to heroin trafficking, no predominant profile of nationality has been reported. A large number of drug traffickers come from North Africa by transiting through Belgium. Numerous traffickers have changed from heroin to cocaine and currently are also involved in cannabis traffic.

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

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

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

AVAILABILITY AND SUPPLY

Perceived availability of drugs

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

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

QUESTION a: It is easy to get illicit drugs in Luxembourg ?

	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%
UE	61.9	63%	54.9	57%	76.0	79%	72.3	76%

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

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

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



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

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

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

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

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

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

Origins of drugs

The national production of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2008 no clandestine drug-manufacturing laboratory has been dismantled at the national level. Law enforcement sources⁵⁶ indicate that currently the majority of illicit drugs consumed in the G. D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). Till the beginning of the nineties, most of the persons involved in illicit drug distribution were consumers who supplied themselves in the Netherlands or acquired limited extra quantities of drugs in order to sell them within restricted local networks. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market.

Drug Trafficking patterns

The **expansion of more structured distribution networks** by organised criminal associations has been reported earlier. More recently different ethnic groups started to create synergies in drug distribution and traffic, whereas previously these groups have been operating separately. The proportion of non-natives involved in drug trafficking has been increasing until 2005 and has been decreasing quite sensibly although non-natives drug traffickers represent 74% (60% in 2007). Typically, involved dealers carry small quantities of drugs hidden in their mouth ready to be swallowed promptly in case of police controls. Initially drugs of high quality have been sold at low prices. Progressively however the quality and diversity of sold drugs have been decreasing. The national **drug market has been flooded by a high proportion of low quality injection drugs**, which has induced major changes in consume patterns of national drug users.

⁵⁶ Non published information from the Specialised Drug Unit of the judicial Police

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

SEIZURES

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

Quantities and numbers of drug seizures

Striking variations have been observed as to the quantity of illicit substances seized since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002⁵⁷. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. Cocaine seizures (quantity) are highly variable since the beginning of the nineties. Compared to 2007 data, the quantity of seizures of nearly all listed substances went up in 2008 (except for heroin). This observation particularly applies to cannabis and cocaine.

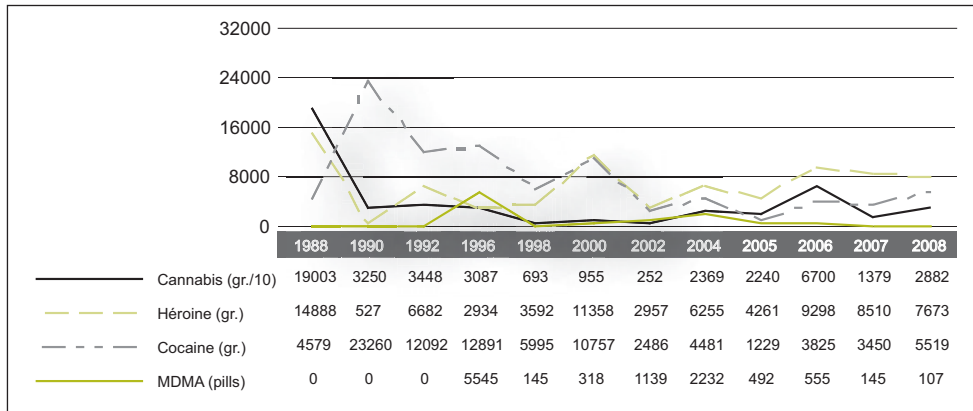
Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1990. Since 2000 the number of cannabis seizures has clearly increased but likewise the number of heroin and cocaine seizures tends to stabilise. Markedly, the number of cannabis seizures has risen from 167 to 580 between 1994 and 2008. The total **number of persons** involved in traffic has followed a constant upward trend until 2000 and stabilised afterwards (2008: 1487 (1072) persons). A confirmed majority of offenders are involved in cannabis traffic and are non-natives. For detailed information, see standard table 13.

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

⁵⁷ Non-transit drugs destined to the national market

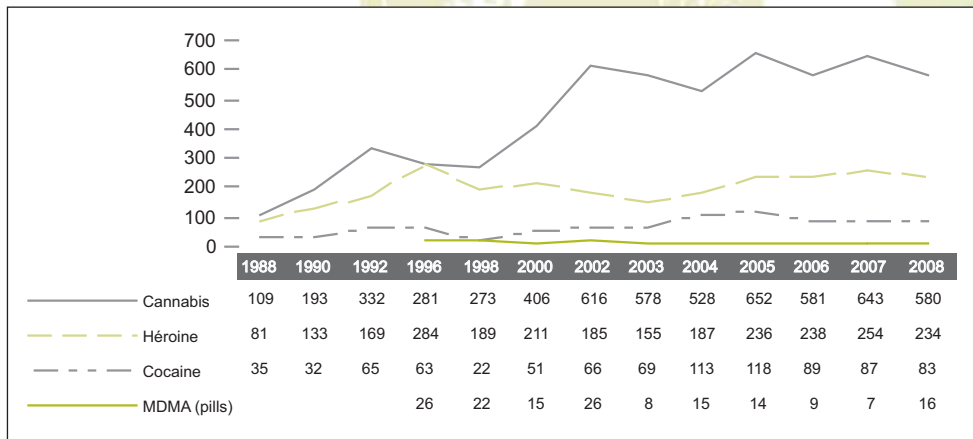


Fig. 10.1 Total quantity of seizures: heroin, cocaine, ecstasy type (1988 - 2008)



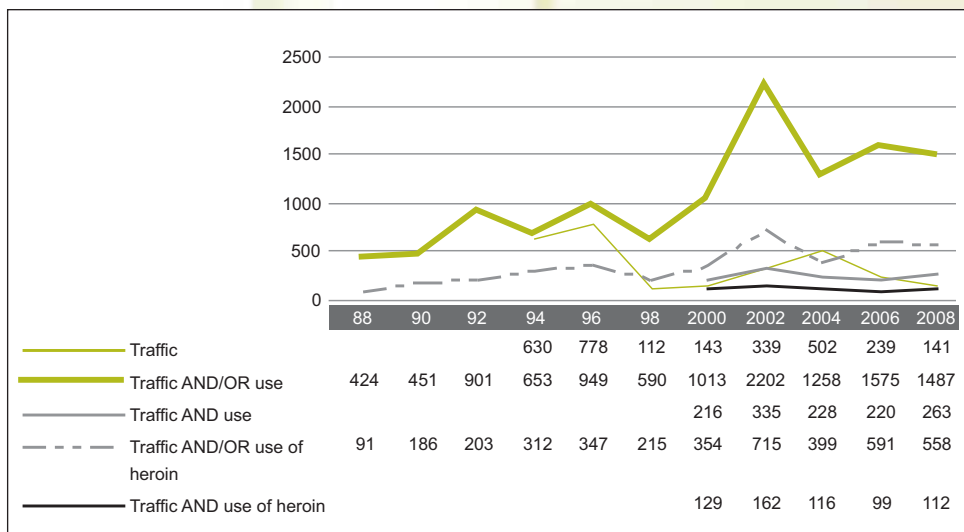
Source: Specialised Drug Department of the Judicial Police 2008

Fig. 10.2 Total number of seizures: Cannabis, Héroïne, Cocaine, MDMA (1988 - 2008)



Source: Specialised Drug Department of the Judicial Police 2008

Fig. 10.3 Number of offenders involved in seizures according to type of offence (1988-2008)



Source: Specialised Drug Department of the Judicial Police 2008

Number of illicit laboratories and other production sites dismantled

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

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



PRICE/PURITY

Price of drugs at retail level

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen from 1998 to 2002/2003 but broader price ranges as well as higher maximum prices for cocaine and heroin have been observed since 2004, which is due to a high variability of purity. Cannabis and derivatives however have known a fair stability during the last 7 years. Heroin is frequently sold as 'boule' containing 0.2-0.4 grams for 12-25. - EUR. Typical street retail cannabis is sold in pieces of 2.5 to 3 grams for 25. – EUR.

Table 10.2 Price per unit evolution at the street level (1994-2008)

	1994	1998	2000	2002	2004	2005	2006	2007	2008
Cannabis									
Haschisch		5-6	7.4	7	7.3	7.3	8	8	8-10
Marijuana		2.5-3	6.2		7.3	7.3		7.5	5-10
Cocaine	100-150	120-170	90	50	20-120	20-110	30-100	30-100	70-100
Héroïne (brown)	65-150	90-150	74.4	50	82	80	50-90	50-90	60-80
STA		25-30	n.a.	25	n.a.	n.a.	5	5	20
Ecstasy		9-13	10,7	7	10	10	5	5	5-15
LSD	11-13	1-13	n.a.	n.a.	10	10	n.a.	n.a.	5-15

Sources : Specialised Drug Department of the Judicial Police confirmed by Tox-In 2008

Price: expressed in EURO at street level.

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

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

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

Purity/potency of illicit drugs

Compared to the situation in 2003, purity of heroin and cocaine has remained fairly stable. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (over 30%) in herbal cannabis samples seized in Luxembourg in 2007.

Attention has to be paid to the striking differences in maximum and minimum purities of all substances. For instance heroin and cocaine show very high maximum purity rates. These values should however be considered carefully, the sampling may contain intermediary seizures, not ready for street consumption and to which cutting agents were supposed to be added.

Historically high maximum concentration of THC in cannabis samples seized in Luxembourg has been observed in 2007. Herbal cannabis showed highest maximum levels of THC concentrations (31.05% in 2007, 25% in 2008). In 2008 the figures for THC concentration have been similar for herbal (25%) and resin (22.45%) cannabis for the first time since reported. For more detailed information please refer to standard table 14.

Table 10.3 Purity of drugs at street level (1994-2008)

	1996	1998	2000	2002	2004	2006			2007			2008		
	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.
Cannabis (THC)			8.03	7.96	6.94	0.15	25.85	7.36	2.2	31.05	9.61	1.60	25	9.82
Marihuana									3.5	31.05	10.21	1.60	25	9.75
Hashish									2.2	18.02	8.52	2.25	22.45	10.3
Cocaïne	60-90	60-90	60.25	62.99	62.37	11.7	100	61.78	4.25	97.11	54.65	9.20	99.20	52.13
Héroïne (brown)	15-23	20-25	17.59	9.97	17.07	3.6	40.9	14.48	3.85	22.75	14.95	0.95	56.70	14.5
STA				15.09	9.44	3.6	15.35	7.1	2.7	33.25	13.81	0.50	43.65	18.2
Ecstasy⁸⁸														
(MDMA)			35.5	71.11	29.77	1.2	43.98	26.44	0.20	39.29	20.52	4.83	68.28	23.52
(MDEA)			6.8		6.25				0.69	1.81	1.25	18	28.23	23.57
(MDA)														
Psilocyline				0.15	0.41	/	/	/	/	/	/	/	/	/

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

Purity: For cocaine, heroin and amphetamines, purity is expressed in percentages of pure active substance at the street level. For cannabis, purity refers to percentage of THC.

Composition of illicit drug tablets

Information for this section was provided by the National Laboratory of Health (LNS) and formatted by the NFP.

A total of 64.5 tablets have been analysed for 2008, provided from 49 different samples.

18 samples contained exclusively MDMA as active substance and 8 samples MDMA and ATS traces and 2 samples MDMA and mcPP. Two samples were exclusive: the first containing mcPP mixed with metoclopramide and the second MDMA, MDA and MDE. A third group of analysed products were composed of methadone.

The last category of pills or tablets analysed contained non-scheduled (schedule I or II) substances such as Ibuprofen and paracetamol. Most common cutting agents found in MDMA, amphetamine or mcPP containing products were sugar and caffeine.

For detailed information please refer to standard table 15.

⁸⁸ Ecstasy : dose in mg/pill



PART B:

SELECTED ISSUES

11. MARKET AND PRODUCTION OF CANNABIS

MARKETS

History of cannabis domestic production

Cannabis is the most prevalent illicit drug in the Grand-Duchy of Luxembourg. In recent years potency of cannabis (THC levels) has been increasing and so did risks associated to its use especially with regard to the high and unpredictable variations in purity.

The number of persons in contact with the national specialised network for (preferential) cannabis use had known a sensitive increase at the beginning of the 21st century but decreased again to stabilise between 2005 and 2008. Respectively 90% of current PDUs have tried cannabis while being minor of age.

The percentage of treatment demands related to **cannabis use** has passed from 4% in 1997 to 11% in 2002 and has decreased to 1% between 2006 and 2008. 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: around 30%, mean: 9.61%) is increasingly found on the national market. Marijuana shows the highest purity but also the most important variations in terms of quality.

A more recent trend is the increase of treatment demands for cannabis use related problems associated to alcohol abuse in youngsters as reported by the Medical Control Department in charge of referrals to specialised treatment centres abroad.

Local cultures of cannabis remain rather insignificant in terms of quantity. Generally spoken, Luxembourg is not a cannabis producing country. If cultures of cannabis are detected, they are mostly attributed to single cannabis users who grow cannabis plants only for their personal consumption. No plantations aiming at a professional distribution of cannabis have been detected thus far on the national territory. Concerning the type of cultivation of cannabis, cases of indoor (mainly) and outdoor cultivation have been detected as well as some isolated cases of hydroponic cultures. One has to bear in mind that these plantations are of smaller sizes and for personal use only. A single headshop is located in Luxembourg city. It mainly sells bongos of different types and auxiliary tools. No genuine "Grow shop" does exist at national level.

Legislation

The law of 27 April 2001, amending the law of 19 February 1973 concerning the sale of medicinal substances and the fight against drug addiction, decriminalized cannabis consumption as well as the possession for personal use. The law introduces a classification of substances into two categories: A (other controlled substances) and B (cannabis).

The use of cannabis remains illicit but the use and possession for personal use does not imply prison sentences anymore. A cannabis user may be sentenced to pay a fine ranging from 251 to 2,500 EUR. Prison sentences from 8 days to 6 months and/or a fine ranging between 251 and 2,500 can be applied if cannabis use occurs in presence of minors, in schools or at the workplace. Also, in case adults use cannabis with minors, the sentence can increase up to two years of imprisonment (and/or a fine of 500 to 25,000 EUR) and up to 5 years (and/or a fine of 500 to 12,500 EUR) in case a medical doctor or pharmacist uses cannabis in certain settings as prison, school, social services and their immediate vicinity (Art.7B1).

In case of cannabis production and trafficking prison sentences ranging from 1 to 5 years and/or a fine ranging from 500 to 1,250,000 EUR are foreseen. These sanctions do also apply for the provision (transportation, possession, distribution and fabrication) of equipments and materials used for the culture and the production of cannabis. A minimum of 2 years of imprisonment and a minimum of 1,000 EUR are requested in case this offence has been committed in prison, in schools or in a social service (or in the immediate vicinity of those). The law does not explicitly foresee a distinction between small-scale and large-scale drug trafficking. The respective sentences currently range from 1–5 years' imprisonment and/or a fine, while imprisonment of 5–10 years is foreseen if the distributed drug has caused severe damage to health (e.g. incurable diseases). If the drugs had fatal consequences for the user, the punishment may increase to 15–20 years.

Consumer market shares of different cannabis products

At national level import and consumption of cannabis are estimated to a share of 90% relating to cannabis herb and 10% to resin. Concerning sinsemilla or other types of cannabis herb with high THC concentration, it is difficult to provide any estimation. The last ten years, cannabis showing high THC concentrations was increasingly found on the national market with maximum THC concentration up to 30% (mean 10%).

Distribution of cannabis at national level

For some years the expansion of more structured distribution networks has been observed. "Drug professionals" have joined the national illicit drug market and have developed structured commercial distribution networks. Over the last 3 years the proportion of non-natives implicated in drug traffic can be estimated up to 80%. A significant number of West and North African nationals as well as citizens originating from Cap Verde appear in drug trafficking law offenders.

A considerable number of traffickers switched from the sale of heroin to the sale of cocaine and currently are also implicated in the sale of cannabis. Overall, the national drug market has become of a more aggressive nature in terms of selling techniques. More recently ethnic groups have joined and improved their drug distribution strategies whereas previously none of these criminal groups actively searched contact to other groups.



Cannabis wholesale prices, 2008 (if possible 2004-2008)

Cannabis and derivatives have known a fair stability over the last 7 years as far as street prices are concerned. Typical street retail cannabis is sold in pieces ("grip" bag) of 2.5 to 3 grams for 25.- EUR.

Table 11.1 Price per unit evolution at the street level (1994-2008)

	1994	1998	2000	2002	2004	2005	2006	2007	2008
Cannabis									
Haschisch	5-6	5-6	7.4	7	7.3	7.3	8	8	8-10
Marijuana		2.5-3	6.2		7.3	7.3		7.5	5-10

Sources : Specialised Drug Department of the Judicial Police confirmed by TOX-IN 2008

Typology of retail outlets for cannabis sale

As referred to under point c), drug traffickers are mostly implicated in polydrug dealing.

The main retail outlets for cannabis sale are public spaces (often in the vicinity of train and bus stations), locations where youngsters meet (bars, etc.) and areas close to schools.

Cannabis sources and transaction sizes

Most of cannabis users buy their doses at the national illicit drug market. Some users grow cannabis plants at home to share with other users. Different names for cannabis exist: grass, marijuana, weed, dope, pot, joints, hashish or shit. Standard units for the purchase of cannabis resin go up to 4 grams and herbal cannabis is mostly sold in bags ("grip") containing 2.5 to 3 grams. Prepared joints are not or very rarely sold on the national illicit drug market.

SEIZURES

Contextual info: supply reduction organisation and activities

The following units of the Grand-Ducal Police (Ministry of Justice) are involved in the fight against drugs:

- Specialised Drug Department of the Judicial Police (national and international investigation),
- Departments of search and criminal investigation (SREC) of the 6 regional sectors (national and regional investigation),
- Intervention centres and commissariats of proximity (controls, selective investigations,...).

The anti-drugs division – "division anti-drogues et produits sensibles" (seizures, home visits, body visits) and the tracking dogs brigade of the Administration of Customs (Ministry of Finance) are also involved in supply reduction activities.

The fight against drug trafficking is one of the priorities of the Grand-ducal Police. The Grand-ducal Police organises repression activities (investigations, controls) as well as prevention activities.

Seizures of plants and/or plantations, 2006-2008

Table 11.2 Quantities of cannabis plants and products seized between 2006 and 2008 (Total)

	Quantities of drugs seized 2006-2008														
	Kilograms			grams			numbers of units			type of unit			Number of seizure cases		
	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08
Cannabis plant			105				45	3	25	plants	plants	plants	4	2	3
Cannabis herb (marijuana)	62	13	20	412	330	700							464	532	464
Cannabis resin (hashish)	4	0	8	584	460	80							117	111	113
Cannabis oil															

Source: Specialized drug department of the Judicial Police 2008

As stated above, the Grand-Duchy of Luxembourg is not a producing country for cannabis (e.g. 3 plants seized in 2007). If cultures of cannabis are detected, they mostly can be attributed to single cannabis users who grow cannabis for personal use only. Police sources indicate that the type of material seized in relation to the use and production of cannabis are mainly UV lamps and cannabis bags ("grips").

Origin of cannabis products seized, 2006-2008 (if possible 2004-2008)

Law enforcement sources indicate that the majority of cannabis products consumed in the Grand-Duchy of Luxembourg (herb and resin) originate from the Netherlands (99%). Cannabis resin, even if it mainly originates from Morocco, is transported (hub) to the Netherlands and from there distributed to other European countries. For several years one observes countries such as Albania and Afghanistan being increasingly involved in the production of cannabis. The Balkan route still constitutes the main transport land route.

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 road network is the main transport and transit route for cannabis.

Breakdown of cannabis seizures by product and by amount seized, 2008

Great variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency of cannabis seizures until 2002. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. Compared to 2007 data, the quantity of seizures of nearly all listed substances went up in 2008 (except for heroin). This observation particularly applies to cannabis.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1990. Since 2000 the number of cannabis seizures has clearly increased. Markedly, the number of cannabis seizures has risen from 167 to 580 between 1994 and 2008. The total **number of persons** involved in traffic has followed a constant upward trend until 2000 and stabilised afterwards (2008: 1487 (1,072) persons). A confirmed majority of offenders are involved in cannabis traffic and are non-natives. This may suggest that greater quantities of drugs are trafficked by smaller groups of traffickers.



Table 11.3 Breakdown of cannabis seizures by product and by seized amount in 2008

CANNABIS PRODUCT TYPE	SEIZURES	AMOUNT	UNIT
HERBAL	464	20.733	KG
RESIN	113	8.084	KG
PLANTS	3	105 ⁵⁹	KG
		25	PLANTS

Source: Specialized drug department of the Judicial Police 2008

Table 11.4 Number of herbal cannabis cases and total amount seized for the following weight classes:

	≤ 150 g	150 g - 1 kg	1 - 50 kg	> 50 kg
CASES	451	10	3	0
AMOUNT SEIZED	3298 grams	4375 grams	13.063 kilograms	0

Source: Specialized drug department of the Judicial Police 2008

Table 11.5 Number of cannabis resin cases and total amount seized for the following weight classes:

	≤ 150 g	150 g - 1 kg	1 - 50 kg	> 50 kg
CASES	109	2	2	0
AMOUNT SEIZED	649 grams	975 grams	6.459 kilograms	0

Source: Specialized drug department of the Judicial Police 2008

Table 11.6 Largest single seizures

CANNABIS TYPE	LARGEST SEIZURE
HERBAL	8.973 kg
RESIN	5.332 kg

Source: Specialized drug department of the Judicial Police 2008

⁵⁹ For one (the largest) seizure, plants have not been counted but weighted (therefore expressed in kg).

OFFENCES

Cannabis supply-related offences reported by the police, 2006-2008

The following table shows the number of arrests broken down by type of offence and substance involved (1995-2008):

Table 11.7 Number of arrests by involved substance and offence 1995 – 2008:

Substance	Offence	1995	1997	1999	2001	2003	2004	2005	2006	2007	2008
Cannabis	Use & Traffic	25	18	32	23	52	16	17	42	n.a.	61
	Traffic/Deal	1	11	8	1	17	20	27	36	n.a.	11
	Use	4	4	3	15	9	14	25	15	n.a.	18
	Total	30	33	43	39	79	50	69	93	n.a.	90
Total number of arrest motives independently of involved substances	Use & Traffic				59	57	48	46	85	n.a.	103
	Traffic/Deal				13	61	93	63	87	n.a.	53
	Use				20	15	35	45	47	n.a.	31
	Total	128	154	108	92	133	178	154	219	226	187

Source: Specialized drug department of the Judicial Police 2008

Over the last 5 years, arrests related exclusively to cannabis traffic / deal have followed a decreasing tendency in reference to the total number of arrest motives independently of involved substances (2003: 22%, 2004: 11.2%, 2005: 17.5%, 2006: 16.4%, 2007: n.a, 2008: 6%).

The Specialised Drug Department of the Judicial Police reports the following number of offenders ('prévenus') broken down by type of offence and substance involved (2004-2008):

Table 11.8 Number of drug law offenders by involved substance and offence 2004 - 2008:

Substance	Offence	2004	2006	2008
		N	N	N
Cannabis	Use & Traffic	119	117	151
	Traffic/Deal	93	105	35
	Use	624	598	650
	Total	836	820	836
Total number of accusation motives independently of involved substances	Use & Traffic	296	280	278
	Traffic/Deal	502	239	141
	Use	1.265	1.414	1.278
	Total	1.760	1.537	1.485
Total number of offenders		1.808	1.575	1.487

Offences exclusively related to cannabis traffic (and retail dealing) range between 2.4%% to 6.8% (5.2%: 2004, 6.8%: 2006, 2.4%: 2008) with regard to the total number of accusation motives independently of involved substances. These figures do not suggest an upward trend in cannabis traffic offences the last 5 years.

Regarding the breakdown of the cannabis supply offences by production, it has to be stressed that Luxembourg is not a producing country of cannabis and cases of cannabis cultivation are very rare.



12. PROBLEM AMPHETAMINE AND METHAMPHETAMINE USE, RELATED CONSEQUENCES AND RESPONSES

EPIDEMIOLOGY OF AMPHETAMINE AND METHAMPHETAMINE USE

History of (meth)amphetamine use

Epidemiological data of illicit drug use became available at national level in the course of the 70s. During that period, heroin, cocaine and cannabis consumption started to spread. During the eighties the use of cocaine, heroin and cannabis still remained important but a notable decrease of hallucinogenic substances (mainly LSD) has been observed.

Since 1988 an increasing consumption of pharmaceuticals diverted from their therapeutic use and amphetamines appeared. Also in the mid nineties a growing tendency of amphetamine use was observed as well as the first national seizures of MDMA. An increasing trend in the use of ecstasy-like substances primarily in youngsters was observed subsequently. Since 1998 an increase of heroin and cocaine prevalence occurred. The consumption of cannabis as well as the use of synthetic drugs had followed an increasing tendency. To date, ecstasy-like substances and ATS remain popular even though seizure figures do suggest an inverse and currently stable trend.

Scientific articles documenting exclusively the history of (meth)amphetamine use at national level do not exist.

Trends and patterns of (meth)amphetamine use

The study "Drugs and chronic alcohol abuse in drivers" (2005)⁶⁰ assessed the proportion of medicinal drugs (benzodiazepines, antidepressants, neuroleptics, etc.), illicit drugs (cannabinoids, opioids, amphetamine derivatives and cocaine metabolites) and chronic alcohol abuse in bloodspecimens from randomly selected 210 drivers (179 males, 31 females/mean age for both males and females: 39 years), apprehended in Luxembourg from autumn 2001 to spring 2002 for whom blood alcohol concentration (BAC) were determined. The study aimed at providing an indication of the extent of psychoactive substance use in vehicle drivers by gender and age. Alcohol was detected in the majority of cases (88.1%), medicinal drugs were detected in 22.9% and illicit drugs were detected in 10.5% of drivers investigated. Traces of illicit drug use not combined to alcohol use were reported for only nine drivers. Concerning the detection of amphetamines, the detection threshold was 30 ng/mL. Amphetamine use had not been detected among the population studied.

Concerning the study "Prevalence and spreading of viral hepatitis A, B, C and HIV in problem users of illicitly acquired drugs" (2006)⁶¹ several questionnaire items of the study referred to drug use patterns. The study analysed a total of 368 (validated) questionnaires which had been answered by PDU respondents from national residential treatment centres, ambulatory treatment centres, low threshold services and national

⁶⁰ 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.

⁶¹ 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

prisons. A total of 208 respondents (56.6%) out of 368 (84.2% ever injectors and 15.8% never injectors) declared having consumed amphetamines. These respondents indicated a mean age of first consumption of amphetamines at 18.69 years (min. age: 11 years and max. age: 37 years/ standard deviation: 4.8). Concerning the item "frequency of consumption (or injection) of drugs in the last 2 months", 17 persons reported amphetamine use within the last 2 months (11.8% more than 4 times per day, 0% 2 to 4 times per day, 5.85% 2 to 6 times per week, 5.85% 1 time per day, 0% once a week and 76.5% occasionally). Concerning age, 13 respondents (N=17) having reported the use of amphetamines during the last two months (11.2%), were aged less than 30 years whereas 4 respondents (4.3%) were aged more than 30 years.

Table 12.1 refers to amphetamine use history (first amphetamines use to last use):

Table 12.1 Amphetamine use history (first amphetamines use to last use):

Amphetamines		
	N	%
	200	100
0-2 years	105	52,5
3-5 years	37	17,5
6-9 years	27	13,5
>= 10 years	33	16,5
No data available	8	

Source: Origer et Removille 2007

The study revealed that hallucinogens, amphetamines and "other stimulants" (other than cocaine) are in majority consumed for a two years period. In comparison, cannabis constitutes the drug which is consumed for the longest period of time: more than 10 years. Concerning the item "last consumption of drugs", respondents declared that the consumption of hallucinogens (84.4%), amphetamines (76.3%) and "other stimulants" (64.4%) dates back to more than 2 years.

The study also revealed a significant increase of the probability ($p < 0.05$) to present a hepatitis B infection in relation to the length of time of amphetamine consumption which however is not the case for the other infections studied. Also the moment of the last use of amphetamines by ever injectors appeared to be a risk factor for HCV infection.

Considering only the respondents from national prisons, a total of 142 questionnaires have been analysed. In all, 13.5% of respondents were never injectors (19/141) and 86.5% were ever injectors (122/141). Concerning questions on drug consumption habits, 46.1% (65/141) of drug dependant prison inmates declared having consumed amphetamines during lifetime. Concerning the item "last consumption of drugs", "prison" 85.9% of respondents indexed as ever injectors (N=64) reported amphetamine use dating back to more than two years.

As also stated above, the study reveals a statistically significant relation between the "amphetamine career" and a hepatitis B infection ($p = 0.012$) among ever injectors from prison centres. An ever injector from a penitentiary institution has a 6.4 times higher chance to be infected with hepatitis B when having consumed amphetamines for more than 6 years than respondents with no or shorter use of amphetamines.



Prevalence estimates of problem (meth)amphetamine users

Table 12.2 presents preferential drug use (1 to 3) of PDUs registered by the national monitoring system "RELIS":

Table 12.2 Preferential drug reported by indexed current PDUs (2008)

Main Drug (valid %)	PREFERENCE 1						PREFERENCE 2						PREFERENCE 3					
	98	01	04	06	07	08	98	01	04	06	07	08	98	01	04	06	07	08
ALCOOL		1					2	4	4	4	6	4		8	10	7	12	21
CANNABIS AND DERIVATES	3	11	5	1	3	0	29	28	21	18	23	31	41	34	38	43	37	39
INHALANTS, VOLATILES SUBST.																		
HALLUCINOGENES (LSD, PCP, etc.)	1				1	1	4	1			1	2	5	4	3	3	2	3
HYPNOTICS AND SEDATIVES	1						4	8	6	7	6	9	12	14	20	20	20	15
STIMULANTS CNS						1	1											
MDMA (XTC)	6	3	2	2	2	2	7	4	4	1	4	2	10	7	6	6	2	7
Amphetamines	2		1	1	1	1	3	3	2	2	0	1	6	3	1	4	2	2
Crack (ex. cocaine freebase)									1		1	0	1					1
Cocaine (other administration routes)	4	7	9	7	7	13	18	14	20	19	16	13	7	7	6	4	7	4
Cocaine (i.v.)	3	2	7	10	8	4	15	12	22	25	21	16	7	5	5	5	4	3
OPIACES /OPIOIDS (non specified)	2	1	2															
Substitution products (illegal consumption)								2	2	2	3	3	1	1	3	2	3	2
Substitution products (prescribed)	1	6	3	1	1	7	5	6	6	4	5	4	4	6	5	3	4	3
Heroin and other opiates	36	22	23	20	30	31	4	9	4	3	3	8	3	3	3	1	2	2
Heroin and other opiates (i.v.)	41	47	48	57	47	41	7	8	7	12	11	6	3	6	1	1	1	0
OTHER PSYCHOACTIFS SUBSTANCES							1								1		1	0
N	574	724	687	737	734	678	397	561	526	506	463	356	255	375	350	348	273	191

Source: RELIS 2008

Only 1% of PDU's indexed by RELIS reported in 2008 amphetamine as main drug. The RELIS network includes specialised drug agencies, psychiatric departments of a series of general hospitals, law enforcement agencies and national prisons.

Amphetamines are also rarely cited (1%) as drug of first contact.

Table 12.3 shows the ages of first use of amphetamines and other drugs:

Table 12.3 Age of onset of amphetamine use reported by indexed current PDUs (2008)

AGE 2008 (2007)	10-13	14-15	16-17	18-19	20-21	22-25	26-33	+33
ALCOOL		39(39)	39(43)	10(11)	8(5)	2(2)	0(2)	2(0)
CANNABIS AND DERIVATES	34(36)	33(32)	23(21)	6(9)	2(2)	1(0)	1(0)	
INHALANTS		33(20)	33(60)		33(20)			
HALLUCINOGENES (LSD, PCP, etc.)	9(13)	42(35)	26(30)	14(19)		7(3)	2(0)	
HYPNOTICS AND SEDATIVES	4(7)	8(7)	27(21)	22(30)	12(16)	10(5)	12(9)	4(5)
STIMULANTS SNC		0(17)	50(33)	50(17)	0(17)	0(17)		
MDMA (XTC)	10(8)	34(38)	28(26)	7(13)	9(6)	7(7)	3(2)	
Amphetamines	11(8)	0 (16)	44(32)	22(36)	22(8)			
Crack (ex. cocaine freebase)		17(20)	50(20)	0(20)	0(20)	33(20)		
Cocaine	5(6)	15(18)	14(21)	26(17)	16(17)	14(12)	9(6)	1(3)
Cocaine (i.v.)	5(6)	17(12)	20(21)	21(24)	15(14)	13(14)	8(8)	
OPIOIDES			50(50)	50(50)				
Substitution products (illegal cons.)	0(17)	50(17)		0(17)		0(17)	50(33)	
Substitution products (prescribed)			20(15)	20(8)	30(38)	30(8)	0(23)	
Heroin and other opiates	3(4)	22(20)	22(23)	17(19)	9(17)	16(7)	11(8)	1(2)
Heroin and other opiates (i.v.)	5(4)	16(15)	25(25)	19(25)	13(11)	16(17)	5(3)	1(0)
AUTRES PROD. PSYCHOACTIFS	14(0)	14(0)	14(10)	28(20)	0(20)	0(30)	14(10)	14(10)
N = 950								

Source: RELIS 2008

One may note that in 2008 and regarding age group 18 to 19 years, the majority (36%) of current PDUs report their first consumption of amphetamines followed by age group 16 to 17 years (32%). In 2008, however, the majority of PDUs reported onset of amphetamines use between the age of 16 and 17 years (44%).

Treatment demand for (meth)amphetamine use

Treatment demands related to ATS use are rare (1-2%) and have shown a fair stability over the last years.

Production sites and laboratories, origin of products and trafficking routes, precursors seizures

In 2003 one clandestine laboratory of amphetamines has been detected in the Grand-Duchy of Luxembourg.

Table 12.4 shows the number and quantities of seizures of amphetamine and methamphetamine:



Table 12.4 Number and quantity of seizures of amphetamine 1995 - 2008

Substances	1995		2000		2004		2005		2006		2007		2008	
	Q	N	Q	N	Q	N	Q	N	Q	N	Q	N	Q	N
Amphetamines	0.03	9	0.157	9	0,951	4	83.3	2	11.44	4	1.60	3	0.172	19
Methamphetamines														

Source: RELIS 2008

As one may note the number of amphetamine seizures are relatively limited and situate between 2 and 9 seizures from 2000 to 2007. In 2008, however, the number of amphetamine seizures has risen to 19. To date, no methamphetamine seizures have been registered. In 2005 the most important seizure of the last years of amphetamine was registered and amounted 83.3 kg.

OVERVIEW OF HEALTH AND SOCIAL CORRELATES OF CHRONIC AMPHETAMINE AND METHAMPHETAMINE USE

Health and social correlates of chronic (meth)amphetamine use

To date, no case of (meth)amphetamine related death has been registered at national level.

RESPONSES TO CHRONIC AMPHETAMINE AND METHAMPHETAMINE USE

Health, social and legal responses addressing (meth)amphetamine use or chronic use

Services, interventions or programmes especially dedicated to (meth) amphetamine use do not exist at national level. All specialised drug treatment centres at national level accept clients with all kind of substance abuse.

Quality assurance and best practices

As stated above no specific guidelines especially dedicated to the treatment, harm reduction, rehabilitation and social reintegration of (meth)amphetamine users exist at national level. As the majority of national PDU's are polydrug consumers, the national treatment and care institutions are primarily specialising in prevention, treatment and care for polydrug users and intravenous use.

PART C:

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A. RELIS drug monitoring system

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

The main objectives of RELIS are the following:

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

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

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

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

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

One of the main benefits of the described procedure is that no personal data can be inferred directly from the identification code. The indating and encoding procedures are carried out at the very level of the field institutions. Thus, NFP is provided with individualised data (reporting protocols) without any reference to



identifying information or attributors on the indexed persons, which is undoubtedly one of the major preoccupations of field institutions.

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

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

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

B. Register on drug law offenders (SPJ)

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

C. General Mortality Register (GMR)

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

D. Special Overdose Register (SR) of SPJ

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

E. AIDS and HIV register (CRP-SANTE)

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

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

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

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

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

The implementation of EWS relies on a network of institutional **key-informants**. Currently all specialised drug agencies (low/high threshold) at the national level are involved in the data providing process in terms of routine data transmission on new trends. Recently two new agencies have joined the EWS network, namely a counselling centre for drug users 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 been 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 night-clubs, public events or rave parties. No such activities have been planned or carried out under the authority



of public administrations. Taking into account that the first official seizure of 'ecstasy' has only been recorded in 1994, harm reduction and close monitoring activities in this particular field were previously not viewed as a priority.

In October 1995, a **new drug help line** was created, under the responsibility of the CePT. Given its easy access and the anonymity it guarantees, phone help lines often represent the first step with regard to further orientation or treatment demand proceedings and as such are able to provide high quality data on recent trends in drug use. The national Drug Help Line has been included in the EWS system in the course of 1999. In 2008 the drug phone help line has been replaced by an drug help on-line service run by CePT (Fro NO)

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

G. Documentation Centres (NFP / CePT)

The **Centre Logistique de Documentation sur les Drogues et les Toxicomanies (CLDDT)** is a logistic documentation service run by the NFP since 1995. CLDDT runs the only computer-based national documentation management base specifically focusing on licit and illicit drugs. The CLDDT indexes about 2,900 documents mainly in French, German and English language. Users of information services provided by the CDTL are mainly researchers, journalists, policy makers, drug treatment and prevention specialists, and general public. The majority of indexed documents are paper-based and abstracts are provided.

In addition to its function of documentation base, CLDDT also ensures the conceptualisation and execution of drug documentation dissemination strategies as required by the NFP. Topic-specific mailing lists have been developed and maintained by active contact making and demand response.

CLDDT is linked to the **Centre de Documentation du Centre de Prévention des Toxicomanies** run by CePT since 1996. The CePT documentation centre mainly focuses on primary prevention, training and evaluation in the fields of licit and illicit drugs. The current stock approaches 1,000 documents or media supports. Queries are handled manually and no computer-based consultation facilities are provided.

Alphabetic list of relevant Internet addresses

<http://www.ceps.lu/>
<http://www.cept.lu/>
<http://www.crp-sante.lu/>
<http://www.ecbap.net/>
<http://eddra.eu.int/>
<http://eldd.emcdda.eu.int/>
<http://www.emcdda.eu.int/>
<http://www.etat.lu/>
<http://www.etat.lu/MS/>
<http://www.gouvernement.lu/>
<http://www.ilres.com/>
<http://www.jdh.lu/>
<http://www.legilux.public.lu/>
<http://www.msr.lu>
<http://www.police.public.lu/PoliceGrandDucale>
<http://www.relis.lu/>
<http://www.statec.lu/>
<http://www.unodc.org/>
<http://www.who.int/>



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