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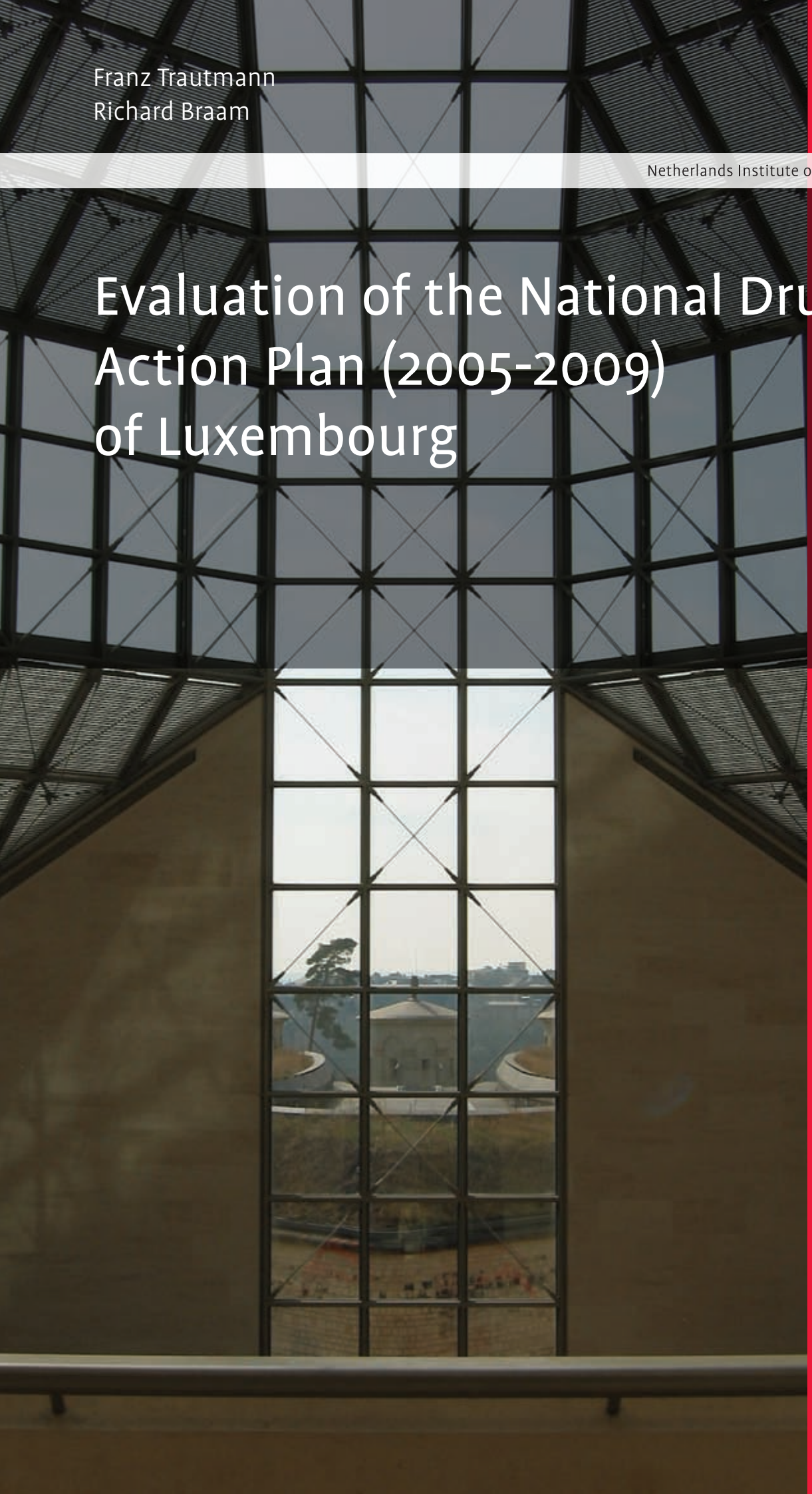

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1. Summary

On request of the Luxembourg Ministry of Health, the Trimbos Institute has conducted an evaluation of the National Drug Action Plan of Luxembourg (2005-2009).

This evaluation report starts with a summary, followed by chapter 2 with a short description of the objectives, structure and priorities of the Strategy and the Action Plan. Based on this we have identified the key questions and guiding principles for the evaluation.

The third chapter describes the project methodology and activities.

In chapter 4 a balance sheet of the actions and progress is presented, based on a survey (questionnaires) among stakeholders. Chapter 5 describes the results of a SWOT analysis based on interviews with stakeholders, while chapter 6 follows with a discussion on findings.

Finally, recommendations are made in chapter 7.

2. Introduction

Background and contents of the Luxembourg Drug Action Plan (2005-2009)
The current National Drug Strategy and Drug Action Plan (2005–2009) of Luxembourg are built upon the results of the first Drug Action Plan (2000-2004) and the results of this policy as monitored by the national focal point of Luxembourg. In order to optimize its impact, the new Action Plan has taken into account relevant elements from EU and EC treaties, the EU Drug Strategy 2005-2012 and the EU Drugs Action Plan 2005-2008, which was endorsed under the Luxembourg EU presidency.

The **general objective** of the National Drug Strategy and the Action plan is to contribute to a high level of protection in terms of public health, public security and social cohesion.

Both documents are **constructed** on the basis of two 'pillars', i.e. demand reduction and supply reduction and four transversal axes, i.e. risk, damage and nuisance reduction, research and information, international relations and coordination mechanisms.

The strategy formulates the following **priorities** for the two pillars and (most of) the transversal axes:

- **Demand reduction**: to enhance the efficiency and efficacy of primary prevention and information campaigns aimed at different target groups; to enhance the diversity, capacity and accessibility of prevention and treatment services nationwide (including the introduction of controlled administration of drugs).
- **Supply reduction**: to enhance the efficacy of actions in the field of supply reduction; to improve the knowledge base upon which the policy measures against drug production and trafficking are taken; to combat money laundering and organised crime. Furthermore regional and international co-operation is a priority.
- **Risk, damage and nuisance reduction**: to enhance the capacity of low-threshold services and to make them complementary to the existing services; to reduce drug related deaths and infectious diseases within the target groups.
- **Research and information**: to develop the infrastructure and means needed for research and information collection; to frame drug-research into national and international networks; to improve the exchange of knowledge between researchers and policy makers; to improve the distribution of information to various target groups; to give special attention to the evaluation of the actions that have been undertaken.
- **International relations**: no priorities are specified here.
- **Coordination mechanisms**: no priorities specified. Luxembourg has a rather light coordination structure: the activities in the field of demand reduction are a responsibility of the Ministry of Health and coordinated by a National Drug Coordinator; in the field of supply reduction and foreign affairs, the Ministries of Justice and Foreign Affairs and Immigration have their own responsibilities; the drug coordinator has an advisory role here and chairs a Groupe Interministériel Toxicomanie (GIT) in which all the relevant Ministries and other parties are represented.

The **Drug Action Plan** is the translation of these priorities into specific actions within the framework of the following criteria:

- The implementation of the actions has to be based upon a multilateral consultation of experts and responsible authorities.
- The actions must be realistic and measurable.
- The action plan has to indicate the time frame, budgets and institutions responsible for the implementation.
- The actions will have to contribute to the realisation of at least one of the priorities of the Strategy.

- The national Drug coordinator, jointly with the GIT must be able to supervise and secure the implementation of the Action Plan.

The Action Plan itself consists of 55 actions, clearly formulated in terms of content, responsible institutions, required budgets and time plan. These actions are in addition to the (long-term) services and programmes yet existing. The latter are covered by separate contracts ('conventions') of the involved services with the Ministry of Health.

The GIT has mandated the National Drug Coordinator in 2007 to make a mid-term evaluation of the implementation of the Drug Action Plan, i.e. from 2005 until the end of 2007. The GIT presented this mid-term evaluation at the beginning of 2008. Main finding was that 82% of the actions completely executed completely or for the best part. Furthermore the assessment suggested that this positive outcome had a direct relationship with the strong increase of the available budgets. For example, the budget of the Ministry of Health for demand reduction activities rose with 224% between the year 2000 and 2007.

After the mid-term[1] evaluation it was announced that a final evaluation of the Strategy and Action Plan 2005-2009 would be realised before the end of 2009. In this study we present the results of this final evaluation.

[1] Ministère de la Santé`, Bilan mi-parcours de l'état de progression de l'implémentation du plan d'action 2005 – 2009 en matière de lutte contre les drogues et les toxicomanies, Luxembourg 2007

3. Methodology

Scope of the evaluation: The evaluation is meant as a critical analysis of the implementation of the National Drug Action Plan of Luxembourg 2005 - 2009. It will build on 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. This evaluation is not an evaluation of facts and figures but a stock-tacking of the opinions and experiences of stakeholders who are involved in the implementation and execution of the action plan. The results and recommendations reflect the appreciation and priorities of the stakeholders.

The information gathered helps to answer the following questions:

- ***Priorities:*** Did the Action Plan address the priorities put forward by the different stakeholders appropriately, e.g. by clear problem definitions and clearly defined actions?
- ***Conditions:*** Were circumstances sufficient to realise the actions formulated in the Action Plan, e.g. by providing the necessary instruments and resources, by dividing and defining the responsibilities of involved services and organisations and by facilitating cooperation between the different stakeholders? Has the existing co-ordination structure proven 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 run properly (management, involvement/input from stakeholders, etc.)?

Data triangulation

The evaluation has been conducted with a relatively small budget and a limited time frame. To overcome these limitations we have chosen for the method of data triangulation. Data triangulation is a scientific method that makes use of multiple indicators and data sources to get a reliable picture in a short period of time. It brings together various data sources, and combines various methods to collect this data. This helps to avoid and correct biases of a single source of information that might cover only part of the phenomenon one is interested in. It gives a more complete picture, including the provision of context information, which facilitates a better understanding of a complex phenomenon. To incorporate as many different views as possible, stakeholders have been selected from different backgrounds, governmental as well as from NGO's.

The methods for data triangulation used in this evaluation are the following:

- Survey (questionnaires among stakeholders, reassessment of the mid-term evaluation).
- Follow-up interviews with stakeholders (SWOT analysis).
- Focus groups (to recheck information, solve diverging answers and discuss recommendations/priorities for the new Drug Action Plan).

Reassessing mid-term evaluation

At the end of 2007 a mid-term evaluation was conducted. The results of this final evaluation are compared with the outcomes of the mid-term evaluation and are presented in chapter 4. The balance sheet that was used in the mid-term evaluation to evaluate all actions within the National Drug Action Plan is used as a guide line in this final evaluation. The balance sheet on both evaluations is presented in annex 3.

Questionnaires

First part of this evaluation was a questionnaire presented to stakeholders reflecting on findings from the mid-term evaluation. We focused per item of this evaluation (including the items which were already evaluated as 'accomplished' in the mid-term evaluation) on the following three questions:

1. What is the state of affairs now: realised – not realised (still in progress, cancelled, other).
2. What is your personal judgment of the result/outcome (global judgment of the result, offering a scale from 1 to 7, from excellent to poor, asking for explanations of the interviewee's rating).
3. Are follow-up actions required (if yes: what and what is the relevance/priority – if no: why not).

The questionnaire was sent to a selection of stakeholders from both government and NGO's (in total 22, of which 14 government representatives and 8 NGOs) that were selected by the Ministry of Health on basis of their expertise of and involvement in the topics discussed. Twelve stakeholders completed and returned the questionnaire, five from governmental organisations (prison, foreign affairs, police, state prosecutors and ministry of Health) – and seven from NGOs (from different fields such as low threshold and harm reduction services, drug counselling, prevention and detoxification). A number of respondents answered (almost) all the questions while others chose to fill in only questions concerning their own field of expertise.

Interviews
Interviews were held with eight respondents, both key policy makers and key policy 'implementers', covering the two pillars and the four transversal axes mentioned in the National Drug Strategy and Drug Action Plan.

The information collected through the questionnaires served as background information for follow-up interviews and focus groups with different stakeholders. The interviews focused on the results of the questionnaires to clarify possible unclear issues and diverging answers. In the interviews a so-called SWOT Analysis was used to evaluate the **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats involved in the Action Plan covering the following issues:

- Strong points of the Action Plan and its realization (implementation structure, resources (human and financial)
- Weak points
- External supporting factors
- External impeding factors
- Priorities for the future.

The results of the SWOT analysis are presented in chapter 5.

Focus groups
The focus groups were held with five stakeholders from different backgrounds, who proved to have thorough inside knowledge on the various topics of the actions. There were two focus groups. One to check and fine tune information from preliminary findings and to discuss erratic answers from the questionnaires and interviews. The second focus group aimed on the new Drug Action Plan and tuned in on recommendations and priorities for the future.

The results of the questionnaires, interviews and focus groups are integrated in chapter 5, 6 and 7: SWOT, Discussion of findings and Recommendations.

4. Findings from the questionnaires

In this chapter we present the findings from the questionnaires, which were completed by twelve governmental and NGO stakeholders. The results were analysed and integrated in the framework of the mid-term evaluation. The balance sheet in annex 3 gives a detailed overview of the progress reported for the period from 2005 to 2009 and the current state of affairs of the implementation of the 2005-2009 Drug Action Plan. The balance sheet follows the structure of the National Drug Action Plan presenting the actions divided over two 'pillars', i.e. demand reduction and supply reduction, and four transversal axes, i.e. risk, damage and nuisance reduction, research and information, international relations and coordination mechanisms.

The respondents were also asked to give follow-up recommendation on the actions. These recommendations can also be found in detail in the balance sheet in annex 3 and are discussed in chapter 5 together with the results of the interviews and focus groups.

Forty-five of the 55 actions (i.e. 82%) from the National Drug Action Plan 2004-2009 were executed and most of them were judged 'positive' by the stakeholders. Six actions (11%) were delayed and four actions (7%) suspended. The respondents emphasized the good collaboration between stakeholders and services and pleaded for more (human) resources and expansion of activities. It appears that most actions that were unsuccessful or not going at all at the time of the mid-term evaluation finally didn't improve.

Pillar one: Demand reduction
Demand reduction aims to enhance the efficiency and efficacy of primary prevention and information campaigns aiming at different target groups; to enhance the diversity, capacity and accessibility of prevention and treatment services nationwide (including the introduction of controlled administration of drugs).

The planned prevention actions have been conducted successfully and are highly appreciated by the stakeholders. To consolidate this and to be able to expand activities more (human) resources are required according to the stakeholders. Some aspects such as the involvement of schools and geographical spreading could be improved upon.

In the field of out-patient and in-patient structures stakeholders appreciate the improved collaboration of networks and judge most actions as successful. Here they also plead for further development and more resources to expand activities. The creation of a therapeutic structure for dual diagnosis has still not been realised. Substitution treatment should be monitored more thoroughly and improvement of legislative and surveillance instruments is needed.

Most reintegration actions in the field of housing have been accomplished and are highly appreciated. Stakeholders plead for expansion and diversification of actions. The 'Transitions' project on temporary housing for abstinent drug users has not been realized. One priority for the future is an expansion of after-care facilities. The action in the field of training and employment is still waiting for approval and has therefore not been realized.

Pillar two: Supply reduction
Main aims are to increase the efficacy of actions in the field of supply reduction; the improvement of the knowledge base upon which the policy measures against drug production and trafficking are taken, as well as the fight against money laundering and

organised crime; further development of regional and international co-operation are a priority.

Collaboration between organisations involved is judged as excellent and constructive. Capacity to control common routes of supply has been increased, but according to the stakeholders more resources are required. The integration of a narcotics file in 'POLIS' has not been fully implemented yet, but is still judged positively.

All planned actions targeted at the fight against organised crime and money laundering, trafficking and drug tourism have been conducted. Trans-border and trans-agency collaboration is judged as good. Further development and collaboration is needed.

The actions in the field of data collection and exchange of information for monitoring of (the quality of) illicit drugs have been executed, but need further improvement.

The actions directed at the support of drug users in prison have been carried out, but are judged quite differently by the various stakeholders from 'slightly positive' (ministerial stakeholders: operational, fitting demand) up to 'very poor' (NGO's). The programme covers prevention as well as harm reduction activities. NGO stakeholders state that the action is not sufficient. Stakeholders emphasize the importance of the development of supportive services after release from prison. They plead for diversification of services and increase of capacities. Syringe distribution programmes in prison need improvement.

Transversal axe one: Risk, damage and nuisance reduction
Risk, damage and nuisance reduction aims to enhance the capacity of low-threshold services and to make them complementary to the existing services. Another important aim is the reduction of drug related deaths and infectious diseases within the target groups.

The drug consumption room and day/night centre TOXIN is operational, but there is still no permanent accommodation. Some services of TOXIN cannot be fully implemented because there is no permanent accommodation. Furthermore expansion of these services to other cities is frustrated because some cities e.g. Esch refuse to give approval for implementation. The injecting room in TOXIN is judged as 'positive' by the stakeholders. It is functional and its capacity is seen as sufficient. The action aimed at asylum seekers is ongoing and also undertaken by other actors than JDH (Jugend- an Drogenhëllef, i.e. a low-threshold service for youth and drug users), e.g. by the Aids prevention centre. Medical prescription of heroin has not been realized. There is political consensus that this service should be available. A plan for medical prescription of heroin has been drafted by the Ministry of Health and was approved by all parties involved. The decision for implementation was postponed in order to build on the experiences of the injecting room.

The foreseen action in the techno scene has not been executed by the responsible stakeholder. The stakeholder states that the action has been cancelled because it did not fit with the target group of the drug counselling centre.

Transversal axe two: Research and information
Actions in the field of research and information are aiming at the development of the infrastructure and the means needed for research and collection of information. Aims are to frame drug-research into national and international networks; to improve the exchange of knowledge between researchers and policy makers; to improve the distribution of information to various target groups; to give special attention to the evaluation of the actions that have been undertaken.

The study for the EMCDDA on the prevalence of Hepatitis and HIV among drug users has been conducted and has resulted in useful recommendations. The draft of another study for the EMCDDA on the support of minor drug users has been finished. A third study for the EMCDDA on the public health costs of drug abuse has been conducted and was highly appreciated for the good results. A 'Rapid Assessment' study on the use of cocaine, alcohol and on gambling has not been conducted because of a lack of recourses. The same applies to a study on the link between family and social cohesion and psychosocial resources against addiction, violence and psychiatric disorders. The monitoring of the treatment demand (one of the five key indicators of the EMCDDA) has been consolidated and the results are highly appreciated. Some stakeholders state that the privacy of the clients' should be better protected. The data protocol and data base should be improved. The early warning system on synthetic drugs is functional and has been judged as 'positive'. The data flow to low threshold services can be improved upon.

Transversal axe three: International relations
Is a responsibility of the Ministry of Foreign Affairs and Immigration and has been included in the action plan on the level of coordination.

No remarks have been made here.

Transversal axe four: Coordination
The activities in the field of demand reduction are a responsibility of the Ministry of Health and are coordinated by a National Drug Coordinator; in the field of supply reduction and foreign affairs, the Ministries of Justice and Foreign Affairs and Immigration have their own responsibilities; the drug coordinator has an advisory role here and chairs a Groupe Interministériel Toxicomanie (GIT) in which all the relevant Ministries and other parties are represented.

The coordination is highly appreciated by the stakeholders. GIT functions well; there is a high level of collaboration, meetings are regular and frequent enough. According to some stakeholders GIT could improve its visibility, take more initiative and include more partners (from civil society).

5. Findings from the interviews (SWOT)

This chapter focuses on the results of the SWOT analysis. SWOT stands for the **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats involved in the Action Plan.

The following issues will be discussed in this chapter:

- Strong points of strategy document, realization (implementation structure, resources (human and financial)
- Weak points
- External supporting factors
- External impeding factors
- Priorities for the future.

Strong points of strategy document, realization (implementation structure, resources (human and financial)

There is general agreement between the experts interviewed that the National Drug Action Plan of Luxembourg (2005-2009) gives a good, well-structured general picture of the drug policy plans for the period covered by it, presenting an overview of all new programmes to be financed within this time frame. It is seen as a comprehensive policy paper, presenting a balanced approach covering all relevant areas: supply reduction, demand reduction (prevention and treatment) and harm reduction. It is emphasised that this is the first document in its kind in Luxembourg describing concrete actions (projects) in all areas facilitating overall drug policy coordination.

Relevant parties/stakeholders were consulted during the preparation period of the Action Plan (strictly differentiating between policy making and policy implementing level) resulting in a high level of commitment. On governmental / policy-making level an inter-ministerial drugs working group (GIT) was established in order to assure involvement and input from all Ministries with responsibilities in the drug policy field. On implementation level all stakeholders were invited to put forward concrete project ideas. This was done in bilateral consultations with individual stakeholders, in which they prioritised actions and reviewed the draft Action Plan. Besides this a working group on demand reduction (groupe chaine therapeutique) was set up to get input and create consensus for the Action Plan.

Several experts pointed out that the Drug Action Plan has also brought about a substantial increase of financial resources for drug policy, compared to other domains, e.g. psychiatry. Mention has been made of a considerable increase of human resources in treatment and care. The number of fte in the demand reduction sector (including harm reduction) has doubled in the past years (from around 40 to around 80).

The only exception seems to be acute psychiatric treatment in hospitals, where no new investments were reported. However, acute psychiatric services for young people were realised according to plan. The follow-up (housing) programme for clients after successful treatment (Action I.3.1.c, see annex 3) has still not been realised. The envisaged specialised treatment programme for dual diagnosis patients (Action I.2.1.2.b, see annex 3) has not been realised either. According to the CHNP this programme was not needed.

After-care/social rehabilitation (subsequent to in-patient treatment) is considered to have been developed well. The envisaged actions are reported as fully realised. Twenty five instead of the envisaged 12 treatment slots have been realised.

The Action Plan puts a strong emphasis on harm reduction. Harm reduction services have developed strongly in the period of the Drug Action Plan. Among others a night shelter

and an injecting room were opened. There is one facility available in the city of Luxembourg. The result has been assessed as working well though the accommodation is judged as insufficient, restricting the quality of services delivered.

All experts interviewed judged the cooperation between the different services, between the different fields (supply reduction, prevention, treatment and harm reduction) and between the field and the Ministries (in particular the Ministry of Health) as very positive, resulting in a supportive atmosphere among professionals. Several experts stressed the fact that the cooperation between police and drug health services is overall good. The cooperation between the different players in the supply reduction domain (police, customs, etc.) has improved in the past years.

Especially the cooperation in the health field (prevention, treatment and harm reduction) is seen as highly developed. The services are relatively well-tuned with each other with regards to target groups, opening hours, etc. There is mention of the need to improve case management. Though one respondent stated that this should not be done in a bureaucratic way but rather using a good 'coordination' model for referrals.

A number of experts mentioned that the positive atmosphere between stakeholders / services is one of 'favourable consent'. Different factors were mentioned as contributing to this atmosphere. There seems to be an overall agreement about the necessity and complementarity of the various approaches and services and a shared understanding on who is doing what (dividing territories). There is a consensus on objectives contributing to a smooth coordination of drug policy.

It often happens in smaller countries that there is rivalry between the services / programmes which frequently leads to a negative, mistrustful attitude toward each other. This is not the case in Luxembourg. According to some experts this has to be explained by the people working in the field. Another factor contributing to this might be the way of financing. In Luxembourg prevention, treatment and care services are not financed based on caseload (number of clients/patients, type of service provided, etc.) but each service receives a fixed (lump sum) budget to provide certain services.

Weak points

Regarding the weak points the picture is rather diverse. There is clearly less agreement among the interviewed experts, on this issue. The following points have been mentioned by several experts:

A weak point mentioned by a number of experts is that the Action Plan is a somewhat technical document. It is not much more than a list and description of concrete actions to be undertaken. It does not explain the general aims and specific objectives and the considerations and motives underlying the choices made. Especially for a layman it is unclear why certain choices have been made and why certain actions are prioritised. One example mentioned is the focus of the Action Plan on drugs and addiction / problematic use without clearly defining what substances and problems are covered by this. Implicitly it is evident that the focus is on illicit drugs. A clear, well-founded statement why licit drugs are not included is lacking. After all, there are good reasons to – at least partly – include problematic use of alcohol, as alcohol abuse frequently plays a considerable role in poly-drug use.

Mention is also made that it is not transparent which criteria are used to make certain choices, to give one field or action priority over others, but also why one organisation receives funding and why the other one does not.

The Action Plan does not always clearly define the criteria or indicators for determining whether an action has been accomplished. The progress of the various actions presented in the mid-term evaluation[2] can only be assessed in general terms because the statement 'accomplished' does not indicate what has been achieved. The interviewed experts differ substantially in their appreciation what has been achieved under a number of actions. In some cases a rather negative expert judgement of an 'accomplished' action can be explained by the fact that the result of the action is only temporary or has limited geographical coverage. The first is the case for drug prevention in foster homes and homes for children and youth (Action I.3.1.a, see table in annex 3), the latter is the case for the day / night centre for drug users / injecting room TOXIN (Action III.1.1.a, see table in annex 3).

Another remark was that it is not clear why a particular action has not been realised (e.g. in the case of the follow-up therapeutic programme of acute psychiatric treatment). The Action Plan also does not have a binding character. An organisation mentioned in the Action Plan as being responsible for the implementation of a particular action can decide not to do so, without any consequences.

Another weak point of the Action Plan mentioned is that actions are only funded as separate projects with clearly defined budgets. Long-term programmes – as for instance drug information / prevention programmes – face the risk of budget reductions in case of spending cuts presented in the annual drug policy budget.

An additional problem for universal prevention programmes is that these programmes are not exclusively aimed at illicit drugs, whereas the Action Plan is. Funding for universal prevention addressing alcohol and tobacco use is not covered by the Action Plan. Universal prevention programmes are funded by different Ministries, such as the Ministry of Health and the Ministry of Education. This adds to the funding problem just mentioned.

There are a number of statements that certain types of services are missing in the Action Plan or that the available / envisaged services are insufficient. The following services were reported as missing or insufficient in the Action Plan:

- Day programmes available for problematic drug users (offering a day structure).
- Programmes supporting the job perspective of drug users, e.g. programmes offering the possibility of part-time work.
- Housing programmes, either offering clients the possibility to live independently (e.g. after a period of in-patient treatment) or housing facilities offering social support. Now quite a number of drug users stay in hospital longer than is strictly medically required. Due to expensive housing costs (high rents) and a lack of possibilities to refer clients to adequate services it is difficult to find housing.
- Early intervention programmes for the age group 12 to 18 years. As a result many users enrol in treatment relatively late after several years of problem drug use (sometimes up to 10 years).
- Follow-up programmes both to treatment and imprisonment. This seems to be especially true for the most problematic users. Sometimes drug users go directly from therapy or prison to the injecting room and day / night centre (TOXIN).
- Basic medical care for problem drug users. The available services are judged as minimal and inadequate (medical problems of problem drug users are regularly not taken seriously / not carefully checked by the general health services).
- Prevention programmes. Despite different actions included in the Action Plan there has been no substantial new investment in this sector.

[2] Ministère de la Santé`, Bilan mi-parcours de l'état de progression de l'implémentation du plan d'action 2005 – 2009 en matière de lutte contre les drogues et les toxicomanies, Luxembourg 2007

- Prevention programmes. Despite different actions included in the Action Plan there has been no substantial new investment in this sector.
- Community police work. With regards to the police work the Action Plan only focuses on the measures taken against trafficking and dealing. No attention is paid to the police work in the community, e.g. serving public order by special neighbourhood police.

Besides these points interviewed experts have also mentioned a number of (problematic) issues which – though actually not considered to be weak points in the Action Plan – are still worth to be included in this policy assessment.

Several respondents pointed at the difficulty to find a balance between offering the care a client needs and taking over responsibility from the clients. Available services (especially low-threshold services) offer care and support among others by arranging a variety of things (medical care, housing, social security, etc.) without stimulating clients to take their own responsibility. The problem here is that it is very hard to establish in which cases this 'intensive care' is required – because the client is simply not able to do these things on his/her own – and in which cases a client should be stimulated to arrange things by him/herself.

Also the coordination of and control on prescribing psycho-pharmaceuticals is insufficient. Some patients receive prescriptions for psycho-pharmaceuticals from different doctors without (the possibility of) a check which – possibly interfering - medication they have been prescribed by other doctors. Mention has been made of a few doctors prescribing large amounts of psycho-pharmaceuticals including methadone without clear medical indication.

An interesting issue brought forward by some respondents is that the drug problem is a general problem of our (Western) societies. Drug use reflects a broad spectrum of socio-cultural factors. An Action Plan can help to do something about the problem but cannot solve a more general problem of society.

External supporting factors

When asked which external factors support the implementation of the Drug Action Plan the interviewed experts again showed broad agreement on a number of factors. Drug policy is generally seen as a politically relevant issue. It is an important issue on the political agenda and receives a great deal of support from the Minister (political support), the Ministry (policy maker support) and several politicians. There is a widely shared political consensus (including conservative, liberal and progressive parties) which steps are needed, including frequently highly disputed services injecting rooms and heroin prescription.

This support is reflected in the availability of sufficient financial resources. As mentioned above, the Drug Action Plan has brought about a strong increase of financial resources for drug policy measures.

The generally positive and supportive coverage of drug policy in the media is also named as an important external supporting factor. Overall the media have supported the drug policy plans, as presented in the Action Plan. The latter might also have had a positive influence on the attitude of the general public, which is also perceived as positive. There is substantial public commitment and a widely shared consensus how to tackle the drug problem. This consensus includes harm reduction measures – which in many countries are not well accepted by politicians, media and the general public. In Luxembourg increasing support for harm reduction services is reported.

The positive atmosphere and good cooperation between the stakeholders and organisations mentioned under strong points is enhanced by the short links between them. Being a small country is of advantage here offering the potential for effective and efficient cooperation between all involved stakeholders and organisations.

In conclusion, as stated by one of the interviewees: the general conditions for realising the Drug Action Plan are positive. The atmosphere of 'favourable consent' between stakeholders / services, the good cooperation and the broad consensus among stakeholders / services on priorities and division of tasks mentioned above, are important supporting factors.

External impeding factors

There is more agreement among the interviewed experts about the supporting external factors than about the impeding external factors. The picture for the latter is rather diverse.

Two financial issues have been mentioned by a number of experts. One is the impossibility of planning project budgets for a period longer than one (calendar) year. There is no budget attached to the Action Plan, assuring the funding of planned actions/programmes for the five years' period of the Action Plan. The budget for actions has to be secured in annual budgets (per calendar year), following the usual budget rules applied by the government in Luxembourg (in line with customary rules for public budgets in most of Western countries). This means that actions which run for a period exceeding one calendar year have to be presented in project plans following the calendar year.

The obligation to plan these activities in the format of calendar year projects has unfavourable consequences especially for longer-term activities, such as structural prevention programmes. It might hinder structural investment in human and other resources. Trained, experienced teachers require long-term investment. Stability and continuity contribute to efficiency.

However, this planning per year also has one clear advantage: each year the budget can be adapted to new priorities and needs.

One recurring issue are insufficient financial resources to realise all programmes presented in the Action Plan. This applies to demand and harm reduction (e.g. acute psychiatric treatment and low-threshold day and night centres) as well as supply reduction (criminal investigation capacity for work on trafficking and dealing cases). One expert stated that insufficient financial resources for expanding services has led in a particular case to avoiding publicity in order to generate less treatment demand.

Besides insufficient financial resources for the implementation of the planned actions some general conditions are impeding the effectiveness of services. This is especially true for social rehabilitation programmes where high rentals and a lack of job opportunities for the target group limit the success of programmes.

Another impeding factor mentioned by some experts is that the political decision making process is slow. It takes a long time to reach a decision, among others because the focus is on deciding by consensus. Reaching agreement on political decision making level and implementing the decision is sometimes difficult, especially if the decision involves national and local politics, field organisations and the general public. One example is the slow political decision making on (geographical) distribution of injecting rooms. Currently there is only one injecting room in Luxembourg City, resulting in a high concentration

(and visibility) of problem drug users in and around that location. Finding alternative locations – also outside Luxembourg City in Esch – proves to be very difficult and time consuming, as citizens living in the surroundings of envisaged locations are afraid of nuisance. In some cases local authorities are not very supportive when it comes to developing prevention, treatment and care services. They tend to see this work as the primary responsibility of the Ministry of Health.

Over-specialisation is seen as an unnecessary and undesirable development. It might stand in the way of effective and efficient treatment and care. It might result in an over-complex treatment and care system (taken into account the size of the country) and hinder the reflection and understanding of a complex problem.

The Schengen Agreement, which has resulted in the removal of systematic border controls between the participating countries, also brought a decrease of regular control on cross-border drug trafficking. According to some experts this is impeding effective control of drug trafficking and has caused an increase of the drug trafficking problem in Luxembourg.

Priorities for the future

The question what the priorities are for the new Drug Action Plan has presented a long and diverse list of issues. We have ranged the issues under the following headings:

- General issues regarding the new Drug Action Plan
- General issues regarding services / programmes
- Prevention / early detection
- Treatment / social rehabilitation
- Harm reduction
- Supply reduction.

General issues regarding the new Drug Action Plan

From the answers provided it can be concluded that there is no reason for major changes. The new Drug Action Plan should continue and further develop the comprehensive policy developed in the past years.

A number of general suggestions have been made to improve the Action Plan, such as a clear presentation of the general aims and objectives, the policy choices made and the motivation for making these choices, reflecting on the societal framework of the drugs problem. This would also give more transparency about the priorities and budget allocations. The Action Plan should clearly appoint organisations responsible for the realisation of certain actions or programmes. The new Action Plan should also reflect the long-term perspective, allowing continuous investment in certain fields.

The implementing services and organisations should again be consulted, when preparing a new Action Plan. Their input should be incorporated in the Action Plan. Experts appreciate it to discuss plans in a regular exchange with the Ministry, in working groups on certain issues and in bilateral exchanges with individual services and organisations. This exchange is seen as vital for defining details and fine-tuning actions in the new Action Plan. One repeatedly mentioned example of a working group is COCSIT, a group of representatives of all prevention, treatment and care facilities in Luxembourg, which meets every 6 weeks. It plays an important role in the process of finding consensus on priorities and preparing proposals for Ministry.

One suggestion made is to widen the scope of the Action Plan and to include also licit drugs besides illicit drugs, especially alcohol, since problem use of some illicit drugs (e.g. opiates and cocaine) often goes together with problem use of alcohol. Poly-drug use is a

widespread problem in Luxembourg. Experts also suggested including problematic (addiction-like) forms of computer / internet use and gaming. Addiction to / problem use of substances and computer applications share essential features. This should be addressed in the Action Plan by reflecting these common features in prevention and treatment actions.

The description of the actions should also describe the process of realisation, defining milestones and expected results, so that the process and the achievements can be monitored. The evaluation of the envisaged actions / programmes and feedback to the responsible services / organisations should be defined in the Action Plan.

Several experts stated that an increase of the budget is needed to allow sufficient services. However, better use of available resources and services (e.g. shortening the detoxification period in hospitals by offering adequate aftercare, but also treatment at an earlier stage) is another option mentioned.

General issues regarding services / programmes

Priorities regarding general issues of services or programmes reflect for an important part issues mentioned under the SWOT headings. The following points were made:

- The services offered to the clients should be more tailor-made, taking into account individual differences and specific needs.
- Over-specialisation of services should be reduced. Where possible, services should be integrated in broader facilities, since drug use is generally linked to other psycho-social problems.
- Cooperation between services should be supported by organising regular (one or two times per year) exchange meetings (e.g. a formal platform and a common training programme). These meetings will also be helpful to reach and maintain consensus and can be used for case-management.
- Case management is priority in order to increase effectiveness and efficiency of treatment.
- Treatment and care (harm reduction) should support own responsibility and independence of clients.
- At the same time drug services will have to accept that some clients will never be able to stop using drugs. This is one important prerequisite for offering adequate services to this target group.

Prevention / early detection

The following priorities were brought forward by the interviewed experts:

- Increasing the number of prevention programmes (including involvement of parents, school and other stakeholders).
- To target prevention programmes for specific (vulnerable) groups / settings. Examples are programmes for children of alcoholic parents and programmes targeted at juvenile homes.
- A study on the impact of an early start of cannabis use on the personal development.

Treatment / social rehabilitation

Treatment and social rehabilitation priorities for the next period include:

- Early detection and interventions at an early stage of (problem) drug use. This means among others more and better targeted outreach work, involvement of schools (requiring training of school staff) and support and information for parents.
- Introduction of flexible age limits for treatment services for minors to allow treatment for pupils above 18 (in cases where these young people are still at school).

- Improvement and expansion of social rehabilitation services, in particular support of housing and work. Regarding the first communities should be encouraged to take care of (financing) housing of (former) drug users. Due to the high rents it is very difficult for drug users to find a place to live. Concerning work, so-called work projects for drug users (part-time work allowing clients to spend their time in a meaningful way, to get used to work on a regular basis and to acquire some basic skills) would be important.

Harm reduction

Experts identified the following harm reduction priorities:

- Extension of the low-threshold services offered by TOXIN in Luxembourg City, e.g. extending opening hours (now: 15:00 till 22:00, plan: 09:00 till 22:00). This will have a positive effect on users and public security. Long-term aim is to offer a 24-hour's service.
- Improvement of the services of TOXIN. An important item is the realisation of the planned new accommodation and more professional support for the TOXIN staff, e.g. regarding their work with clients with psychiatric problems.
- Spreading injecting rooms geographically. In Luxembourg City a second injecting room besides TOXIN can help to de-concentrate the problem drug user population and reduce nuisance (for surroundings and users). For the same reason and for a better geographical coverage injecting rooms should also be available in Esch and in Ettelbruck.
- To examine aims and limits of low-threshold services. Low-threshold / harm reduction services are an important element of services for drug users, but could have more effect when one would choose a more motivating, activating approach.
- To enhance quality of substitution treatment by using generally applied guidelines, by implementing a national supervision and control system, with a national accreditation system for substitution treatment requiring specific training of involved doctors and offering social support to the clients.

Supply reduction

The following priorities were named for the supply reduction field:

- More personnel for criminal investigation of trafficking and dealing.
- A more intensive and regular cooperation with the police in neighbouring countries.
- Measures against the (illicit) market in legal medical drugs, e.g. investigations where these drugs come from (Luxembourg, neighbouring countries, internet)
- To promote community police work, i.e. police work in the community, e.g. ensuring public order and safety.

6. Discussion of findings

Overall the Drug Action Plan is assessed positively by the interviewed stakeholders, both as a policy paper and as regards its implementation. It is regarded as a comprehensive, balanced plan covering all relevant areas: supply reduction, demand reduction (prevention and treatment) and harm reduction. What is found missing is an explanation of the considerations and motives and the general aims underlying the choices made. It can be concluded from the questionnaires and interviews that there are no reasons for major changes.

The Action Plan is primarily health oriented. Demand and harm reduction are clearly more prominent in the Action Plan than supply reduction. Supply reduction, on the one hand, and demand and harm reduction, on the other hand, are separate tracks in the document. However, this separation is a common phenomenon in many countries which for an important part has to be explained by the different angles of the two key approaches of drug policy. Demand and harm reduction are primarily health oriented whereas the main aim of supply reduction is maintaining the drug laws. This different and partly even conflicting orientation translates into essentially different action packages.

The vast majority of the actions presented in the Action Plan is reported to have been accomplished (see table in annex 3). Already the midterm evaluation showed a positive picture of the achievements.[3] There are only some minor differences between the outcomes of the mid-term and the final evaluation. One interesting finding is that not much progress seems to have been made with the actions which were reported as not accomplished in the mid-term evaluation. The majority has still not been accomplished and has been suspended or even cancelled.

For some of the 'not accomplished' actions it is unclear why they have not been realised. This seems to be the case for the follow-up (housing) programme for clients after successful treatment (Action I.3.1.c, see annex 3). There is also the report that the envisaged specialised treatment programme for dual diagnosis patients (Action I.2.1.2.b, see annex 3) has not been realised because according the CHNP this programme was not needed. This brings up two issues. One is how to monitor in an effective and transparent way the implementation of the Action Plan (monitoring meetings). The second issue is the procedure for changing or even cancelling the implementation of envisaged actions.

Another point to take into consideration is that the judgement 'accomplished' in the mid-term evaluation does not indicate what exactly has been achieved. In the questionnaire used for this final evaluation we therefore have included questions to give opinion on the outcome, explain this opinion and to identify possible follow-up actions. The interviewed experts differed substantially in their judgment of the achievements made in a number of actions. The main difference seems to be that some respondents have higher expectations than others, viewing the glass half-empty whereas others view it as half-full (see also under weak points). One factor contributing to these differences of opinion is that the Action Plan does not (always) give clear criteria or indicators for determining whether an action is accomplished.

The substantial increase of financial resources brought about by the Drug Action Plan has resulted in new programmes and services in all fields (supply reduction, prevention, treatment and harm reduction). The most visible results are seen in the field of harm reduction (e.g. injecting room and night shelter), treatment (e.g. psychiatric care) and supply reduction (cooperation with neighbouring countries).

[3] Ministère de la Santé`, Bilan mi-parcours de l'état de progression de l'implémentation du plan d'action 2005 – 2009 en matière de lutte contre les drogues et les toxicomanies, Luxembourg 2007

In spite of this there are comments that the available resources are insufficient. The majority of the interviewed experts stated that an increase of budget is needed to create sufficient provisions for a number of actions. Certain services should be extended and/or turn in permanent provisions (see table in annex 3). A number of actions – while they are reported as been 'accomplished' – are still seen as insufficient. This can refer to limited availability (e.g. insufficient treatment slots), limited geographical coverage or provisional nature of a service.

However, in some cases a more efficient use of the available resources and services (e.g. shortening the detoxification period in hospitals by offering adequate aftercare but also treatment at an earlier stage) is mentioned as option.

Another issue regarding the financing system is that it does not allow planning project budgets for a period longer than one (calendar) year. This is seen as limitation for the planning and implementation of long-range programmes. Having to present these activities in the format of calendar year projects is seen as impeding structural investment in human and other resources and as efficiency loss (see under external impeding factors). On the other hand, an annual planning allows for adaptations of the original plan to changing needs.

One of the major strong points of the drug policy practice in Luxembourg is the good cooperation between the different services, between the different fields (supply reduction, prevention, treatment and harm reduction) and between the field and the Ministries (in particular the Ministry of Health). All interviewees make reference to this. (Investing in) cooperation was not included as specific action in the Action Plan, nor formally and financially supported by the Ministry. Cooperation covers two aspects: One is a discussion or exchange on general policy issues and service development. The other is coordination of individual treatment in which different services are involved (case management). One important aspect of case management is monitoring how clients move through different services, how the different elements of individual treatment are geared to one another.

According to some stakeholders the cooperation between services should be formalised and financially supported. In particular the development of a case management system requires financial support. A pilot project of case management (or a referent system, as the Luxembourgian stakeholders prefer to call it) is seen as a good start for developing an appropriate case management model.

The question is whether one should formalise the existing exchange on policy issues and service development by introducing mandatory meetings led by the Ministry. The existing platform (Cocsit) has been initiated by the services themselves. This bottom-up initiative, showing a high level of commitment of the services might have more potential and better results than a top-down approach forcing services to participate. For the time being it might be more appropriate to continue using the potential of the existing structure.

There is an overall agreement and shared understanding on priorities and division of tasks resulting in a smooth coordination and implementation of drug policy. Regular exchange between the stakeholders is a contributing factor. Asking all stakeholders to give input in the preparation stage of the Action Plan is another important factor here. This also contributes to a high level of commitment in the implementation.

Regarding the overall agreement the interviews showed a shared view among experts on strong points and on supporting factors. There was clearly less consensus on weak points and impeding factors. Quite a number of strong points and supporting factors seem to affect all stakeholders in the same way. This is an indication for a generally solid basis of drug policy making and implementation. Impeding factors and in particular the weak

points are more specific, affecting some services but not others. They seem less linked to general characteristics of the Action Plan.

The picture of favourable conditions for effective and efficient drug policy making is completed by the frequently mentioned atmosphere of 'favourable consent' between stakeholders / services and the absence of rivalry and envy between the services / programmes. Rivalry between services/programmes is rather common or even dominant in smaller countries, but does not play a noticeable role in Luxembourg. This might – partly – be explained by the chemistry between the people working in the field. Two financial factors might also play a role here. One is that the financing system for treatment and care services in Luxembourg is not based on number of clients and/or and services provided but on a fixed (lump sum) budget calculated on the basis of a work plan. The relative wealth of Luxembourg might be a second factor which helps to avoid competitive rivalry. Still, from the evaluator's view, it is rather unique to have such a good atmosphere in a small country. Compared with our work experiences in a number of smaller EU countries (long-term projects on drug service and policy issues in the Baltic States, Malta and Slovenia) the relationships between the stakeholders in the drugs field in Luxembourg are considerably harmonious. It can be assumed that this contributes to effective and efficient policy making and implementation.

One disadvantage of a strongly consensus-based policy is a time-consuming, slow political decision making process. This is especially true when a required agreement involves a substantial number of different stakeholders, e.g. national and local politics, field organisations and the general public, driven by different interests. One example is the slow political decision making on (geographical) spreading of drug consumption rooms (see under external impeding factors).

The priorities for the future named by the interviewed experts reflect – as can be expected – mainly what has been stated under weak points and impeding factors. We will reflect on the priorities below under recommendations. One remarkable detail is the priorities mentioned for treatment and social rehabilitation focus especially in the early and the late stages of the treatment process, i.e. early detection and interventions on the one hand and aftercare, social rehabilitation and harm reduction on the other hand. This can serve as orientation for future investments.

Taken into account the findings and discussion the following conclusions can be formulated with regards to the four main questions presented in chapter 3:

- ***Priorities***
  There is broad agreement between the interviewed stakeholders that the Action Plan appropriately addresses the priorities put forward by the stakeholders. Though the problem definitions and actions are presented rather briefly in general terms the actions are clearly enough defined to allow for implementation.
- ***Conditions***
  The conditions were favourable to realise the actions formulated in the Action Plan. This is true not only for the funding needed for the implementation but also for the organisational structure of services involved in the implementation. The Action Plan clearly defines which organisation is responsible for the implementation of each action. The cooperation between services and stakeholders is by itself working very well. Services/stakeholders take their responsibility and show a high level of commitment in the implementation of the Action Plan. The consensus on priorities and division of tasks supports a well-functioning coordination structure which is rather an autonomous initiative of the involved services / stakeholders than a structure imposed from above. This contributes to the well-functioning of the coordination structure.
- ***Results***
  The vast majority of the actions has been fully realised (45 of the 55 actions). Six actions are still in progress, four are suspended (see table in annex 3).

- ***Process***
  Stakeholders consider the process of policy formulation and implementation as overall well-managed. They appreciate to have had sufficient input.

7. Recommendations

Based on the findings presented in chapter 4 and 5 and the discussion in chapter 6 a number of recommendations can be made. We will start with some general issues and then focus on specific points.

General issues regarding the new Action Plan
Based on the generally positive judgement of the contents and implementation of the Drug Action Plan 2005-2009, it is clear that the new Drug Action Plan should continue and further develop the comprehensive drug policy developed in the past years.

The new Action Plan should maintain the following strong points of the previous one:
- A comprehensive policy paper covering all relevant areas
- Involving / consulting all stakeholders in the preparation and implementation of the Action plan
- Providing sufficient financial resources for all sectors: prevention, treatment and care/harm reduction and supply reduction
- The very positively judged cooperation between services was not an item in the previous Action Plan nor where there any financial means for it. It might be worth considering to include facilitating and further development of this cooperation in the new Action Plan.

For the new Drug Action Plan some general points should be taken into consideration. First of all the new Action Plan should include a brief but inclusive introduction serving a general outline for the reader. This introduction should refer to the envisaged general addiction strategy, which will serve as general framework for a number of different action plans, among which the drug action plan covering the field of illicit drugs. These different action plans will have to reflect the overlap between the fields of licit and illicit drugs (e.g. regarding poly-drug use and drug prevention). This introduction should include the following sections:
- General aims and specific objectives
- Scope of the Action Plan (what problems and substances are covered by it)
- Priorities in the different fields (supply, demand and harm reduction)
- Interrelations between the different fields and the different actions
- Linking (the outcomes of) each action to one or more of the specific objectives mentioned in the introduction
- Considerations and motives underlying the choices made.

This introduction can also serve as framework for the actions selected. It could be considered to state per action the criteria (linked to the introduction) by which this action has been selected. This can be done by explicitly linking (the outcomes of) every action to one or more of the specific objectives mentioned in the introduction.

To allow for a thorough monitoring and evaluation of the implementation it should be considered to define specific results for each action, maybe even to identify indicators – e.g. number of treatment slots and/or number of staff which will help to measure the results – and the so-called milestones (interim results). Specific objectives, results and milestones should be defined according the SMART criteria (specific, measurable, attainable, realistic and timely), as already partly done in the Dug Action Plan 2005-2009. Using a LogFrame (for an example see annex 4) for the Action Plan might be useful. This approach will help to monitor and evaluate the implementation and achievements of the Action Plan in an effective and transparent way.

Besides this quantitative measurement of achievements an assessment of the quality of the services provided should be taken into consideration. This would require a system of quality assurance applied to all prevention, treatment and harm reduction services. Such a system would involve a variety of elements, such as the formulation of quality criteria and standardised procedures, the development of checklists or protocols for different components of the work of the services and introducing supervision and/or intervision. The contracts between the Ministry and the services (the so-called conventions) should stipulate the required quality assurance measures. A first step could be a meeting organised by the Ministry of Health to make an inventory of quality measures already undertaken and to exchange experiences between services.

Regular monitoring discussions with all stakeholders might be useful to get a good picture of the present state of affairs and to plan / fine-tune next steps. Using the format of a SWOT analysis can help to run through the state of affairs of all actions in a systematic way and bring together relevant information on what goes well and where problems occur. This can be input for a discussion how to tackle eventual problems.

This monitoring could be included in the regular stakeholder meetings which are already taking place on an informal basis. Once every six months might be an appropriate frequency to allow for a response in a timely manner.

The monitoring discussions can also be used to consider and agree on adaptations or cancellation of certain actions. This can help to avoid a situation where decisions are taken without involvement of relevant stakeholders and without justification. This seemed to have been the case for two actions of the Action Plan 2005-2009 (see discussion chapter).

These two cases give the impression that actions can be cancelled by one stakeholder without further discussion, implying that the implementation of actions agreed upon in the Action Plan has no binding character. To avoid these problems, a covenant between the Ministry and the organisation appointed as responsible for an action, or at least a letter of intent – among others specifying how to act in case the realisation of an action is facing problems – should be considered. Another option would be a letter of intent by the organisation which is foreseen as implementing agency for a specific action. This letter of intent should state among others the preparedness of the organisation to realise a specific action (under the condition of funding as agreed in the Action Plan) and the obligation to report to the Ministry about any changes in the plans,

With regards to funding it is not our task to judge whether more financial resources are needed. However, joining one suggestion made by one of the experts interviewed, it is worth to consider a kind of efficiency check, to see if costs can be reduced. In some cases a more efficient use of the available resources and services (e.g. shortening the detoxification period in hospitals by offering adequate aftercare but also treatment at an earlier stage) might be an option.

One problem for universal prevention programmes is that these programmes are not exclusively aimed at illicit drugs, whereas the Action Plan is. The Action Plan does not fund universal prevention targeted at alcohol and tobacco use. This adds to the earlier mentioned problem that funding for universal prevention has to come from different Ministries (Health, Family, etc.) resulting in complicated procedures to get finances for universal prevention programmes.

One way to address this problem is to consider working with project plans instead of general universal prevention programmes, and giving the main responsibility per project to one particular Ministry (to avoid shared funding from different Ministries for one project).

General issues regarding services / programmes

A pilot project of case management or referent system[4] should be considered in order to try out different options of coordinating treatment for clients, who use the services of multiple organisations or change from one service to the other. This pilot should aim at formulating a protocol and guidelines for case management.

Regarding the exchange between services on policy issues and service development the best option might be to use the existing voluntary structure which has already been installed by the services themselves. According to all services involved this structure is working well. As long as this is the case it might be the most advantageous to use the potential of the existing commitment of the services. To replace this existing structure by mandatory meetings led by the Ministry – as proposed by some stakeholders – might weaken commitment. A more binding structure might still be put in place at a later stage in case the voluntary system does not work well anymore. For the time being the Ministry should consider a facilitating role, supporting where needed the existing structure and when needed, taking initiative to invite services for meetings.

Services are not always able to offer tailor-made programmes, taking into account the specific needs of clients. However, experts also mention the risk of over-specialisation of services. To reconcile these two points might seem like sailing between Scylla and Charybdis. However, it is good to realise that over-specialisation can in fact stand in the way of a tailor-made approach as can be taken from the above mentioned priority to introduce flexible age limits for treatment services for minors (see under Treatment / social rehabilitation in Priorities for the future). Specialised services for certain age groups can conflict with a tailor-made approach of individual clients exceeding a certain age limit.

To deal with the issue of over-specialisation of services an expert meeting could be organised to discuss and identify the problems for which specialisation is necessary and helpful and which issues can be dealt with by more general services. Where possible services should be integrated in broader facilities, because drug use is generally linked to other psycho-social problems. Within these services a more tailor-made approach is possible taking into account individual differences and specific needs.

A recurring issue in our talks with experts working in demand and harm reduction – which also played a prominent role in the focus group discussions – is the risk of 'over-caring' for clients, taking over responsibility and in doing so, hampering the client in taking his/her own responsibility and developing independence, which are key elements in social rehabilitation. Especially harm reduction services face the risk of over-caring as the physical and mental health problems of their target group are generally so serious that they require immediate and intense care measures to prevent further deterioration. Especially clients facing serious mental (and physical) health problems besides their drug use (comorbidity) have limited possibility to take their own responsibility. Therefore, it is very difficult in these cases to establish which tasks have to be done for the client and which tasks the client is able to carry out him/herself. There is no easy and clear-cut solution for the risk of over-caring. However, there are some suggestions that might help to deal with the issue.

One option is to discuss the issue in intervision sessions. Case discussions in a team where different staff members can exchange views how they deal with the issue can help to find ways to prevent or at least reduce over-caring for and over-identification with

[4] Experts in Luxembourg prefer the term 'referent system', referring to the referral of a client from one service to another

clients. Another option is to give clients certain tasks / responsibilities in the service centre. Finally, emphasising behavioural rules, treating others with respect, i.e. educating / training clients in social behaviour are important, not only within the service but also as element of social rehabilitation.

Prevention / early detection

One important priority for future drug prevention programmes, which emerged from the focus group discussions, is expanding the target group of drug prevention. Drug prevention should not only focus on young people, the actual target group of most prevention programmes, but also address / involve other stakeholders. There is general agreement that especially parents play a key role here. Key notions in our discussions how to do address / involve parents were:

- Support parents in their education efforts;
- Address their responsibility as parents;
- Inform parents about risk factors in the family;
- Discuss with parents how they can address substance use with their children;
- Discuss with parents how to deal with starting substance use of their children (including alcohol use).

To explore possibilities how to address and involve parents, an expert meeting or conference could be organised, offering the opportunity to discuss options like outreach work to families, awareness campaigns addressing the role of parents when faced with substance use among children and young people, etc.

Other stakeholders to be addressed by prevention programmes are owners and staff of pubs, discotheques, etc. school personnel and police. Priorities for these stakeholders are information and training sessions. There are good examples for training of bar and discotheque personnel on how to detect drug (and alcohol) (ab)use and how to avoid and handle cases of intoxication.

The Action Plan 2005 – 2009 included plans for research on prevention issues (see points III.2.1.b, III.2.1.c and III.2.1.e in Annex 3) which were not realised due to lack of funding. Stakeholders still see this research as relevant for developing appropriate prevention programmes. It should be considered to include these research plans in the new Action Plan.

Treatment / social rehabilitation

From the focus group discussions we have identified two key priorities with regards to treatment. The first priority is to develop a service which is regarded as the missing link between detoxification in hospital (one to three weeks) and aftercare / social rehabilitation: a so-called stabilisation programme of more or less three weeks, to offer clients the possibility to explore their future options. This would also help to avoid that clients stay in hospital for a longer period than required for their detoxification.

The second priority is the development of a case management system. A case manager or 'referent' can help the client to identify and enter appropriate treatment or care programmes, e.g. to plan the process from detoxification to follow-up steps like therapy or social rehabilitation. To establish such a system successfully, one could consider to introduce the condition that it is obligatory to have a referent (chosen with the client's consent) when a client decides to enter treatment (also including treatment abroad).

Harm reduction

In the field of harm reduction more low-threshold services (with a better geographical coverage) are required, like hostels or night shelters and programmes offering (straightforward and part-time) education and work opportunities, helping clients to spend their time in a meaningful way.

Municipalities should be stimulated to be more actively involved and take their responsibility in realising harm reduction services (drop-in centres, injecting rooms, etc.).

Supply reduction

The police needs more financial and human resources for targeted investigation work and development of community police work (with the focus on maintaining public order). A banning order to deny people causing public order problems or nuisance access to certain areas in the city might be a useful instrument to maintain public order. For more effective investigation work it should be considered to broaden the possibilities of protecting witnesses and undercover police work.

Annexes

Annex 1 - Questionnaire structure

1. What is the state of affairs now? Please mark the right answer in the table below.

Realised	
Not realised – still in progress	
Not realised – cancelled	
Not realised – other	

2. What is your personal judgment of the result/outcome? Pleas mark your global judgment of the result in the table below on the scale from 1 to 7 from excellent to poor.

	1	2	3	4	5	6	7	
EXELENT								POOR

Please give a short explanation in the table below

3. Are follow-up actions required? Please fill in the table below for Yes or no
   If yes shortly explain what actions and the relevance/priority
   If no shortly explain why not

	What actions?	What is the relevance/priority?
Yes:		

	Why not?
NO	

Annex 2 – Abbreviations

CePT	Centre de Prévention des Toxicomanies
CHNP	Centre Hospitalier Neuro-Psychiatrique
CNDS	Comité National de Défense Sociale asbl
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
GIT	Groupe Interministériel « Toxicomanie »
JDH	Fondation Jugend- an Drogenhëllef
MSF	Médecins Sans Frontières
OEDT	Observatoire Européen des Drogues et des Toxicomanies
PF OEDT	Point focal luxembourgeois de l'Observatoire Européen des Drogues et des Toxicomanies
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
SAP	Système d'Alerte Précoce

Annex 3 - Balance sheet National Drug Action Plan (2005 – 2009) of Luxembourg

Champ d' intervention	Questionnaire : actions	Commentaires	Exécution prévue	Mid-term evaluation	FINAL EVALUATION	FOLLOW UP
I. REDUCTION DE LA DEMANDE						
I.1 Prevention primaire						
I.1.1 Offre de formation	**I.1.1.a. CePT** Développement de l'offre de formation pour adultes	Il s'agit d'une activité déjà en cours. Les demandes de formation émanent essentiellement du domaine de l'école, des domaines péri- et extrascolaires, des services médicaux scolaires, du domaine de l'éducation institutionnalisée, des parents, du monde du travail, du domaine médical et des soins de santé, etc.	Continue	**ACCOMPLI** **Développé en fonction des moyens à disposition – Collaboration avec UNI Luxembourg.**	**DONE** **Structured multidisciplinary training program is appreciated by the stakeholders.**	**More resources required to expand activities.**
I.1.2.1 Prévention des toxicomanies dans l'enseignement préscolaire et primaire	**I.1.2.1.a. CePT** - Développement de projets de prévention chez les plus jeunes. -Initiation des projets, recherche de partenaires éventuels. -Elaboration de nouveaux matériels pédagogiques. -Formation de multiplicateurs. -Soirées thématiques pour les parents. - Formation du personnel de la Ligue luxembourgeoise de prévention et d'action médico-sociales (comme partenaire sur le terrain).	Pour être efficace le travail de prévention doit débuter dès le plus jeune âge, avant que les habitudes de vie néfastes ne soient prises, et doit s'étendre sur toute la durée de la scolarité. Il s'agit de développer les projets de prévention avec les premières classes de l'école préscolaire et primaire, pour former et accompagner le personnel enseignant en la matière, pour informer et impliquer les parents le plus précocement possible.	Continue	**ACCOMPLI** **Développé en fonction des moyens à disposition. Synergies avec Ecoles Santé.**	**DONE** **According to one stakeholder some parts (plus jeunes; partenaires) are not sufficiently achieved.**	**More (human) resources needed to expand activities. Other priorities: Increase involvement of schools and further development of materials.**

I.1.3.1 Prévention des dépendances dans les foyers d'accueil et homes pour enfants et jeunes	**I.1.3.1.a. CePT** -Développement d'un concept de prévention des toxicomanies dans les homes, foyers d'accueil et centres socio-éducatifs. -Contacts et échanges avec des institutions similaires d'autres pays. -Adaptation des projets existants à la situation nationale -Formation continue propre en la matière. -Initiation de projets concrets en la matière. -Formation continue spécifique pour le personnel des homes et centres socio-éducatifs, - Accompagnement. - Evaluation du projet.	La population cible constitue un groupe à risque. Depuis peu, la recherche étudie cette population de manière plus intensive, et souligne l'importance d'un travail préventif renforcé au sein de ce groupe-cible. Il apparaît également un besoin important en matière de formation des éducateurs, travailleurs sociaux et pédagogues dans ce domaine, ainsi qu'un besoin de communication et de collaboration avec les parents, éducateurs et puériculteurs. Cette activité est à développer conjointement avec l'activité I.2.1	Continue	**ACCOMPLI** **Développé en fonction des moyens à disposition : Projets avec le CSEE Dreiborn et le Groupe de Mondorf.**	**DONE** **According to one stakeholder only some temporary and small projects have been accomplished. Other stakeholders state that the action is achieved and appreciated.**	**More resources required to expand activities.**
I.1.4.1 Activités d'information, de formation et de prévention dans le monde du travail	**I.1.4.1.a. CePT** -Informations et formations pour le personnel, élaboration de projets de prévention primaire et secondaire au sein de l'entreprise.	Cette activité exige une collaboration étroite avec d'autres institutions actives dans le domaine de la prévention secondaire des toxicomanies, ainsi qu'avec les services de santé au travail fonctionnant auprès des entreprises.	Continue	**ACCOMPLI** **Développé en fonction des moyens à disposition : e.g. Demande de la Ville de Luxembourg.**	**DONE** **According to one stakeholder the action is only implemented in Luxembourg City. Follow-up is needed in other cities. Other stakeholders state that the action is achieved according to initial targets and is appreciated highly.**	**Expansion of activities is required.**

I.2 Offres de prise en charge						
I.2.1 Prise en charge non axée sur la prescription de substances psycho-actives. **I.2.1.1** Struct. ambulatoires :	**I.2.1.1.a. JDH** : Expansion de l'offre de parentalité. Création de synergies avec le réseau existant.	Diversification de l'offre et localisation du service sur un site approprié.	2006	**ACCOMPLI** 2006 **Elargissement de la convention avec le Ministère de la Santé.**	**DONE** **Although stakeholders judge the activities positive and state that services and collaboration of networks has been improved they also state that further expansion is needed and synergy should be further improved.**	**Further expansion and improvement of synergy, especially in the field of (supported) housing.**
	I.2.1.1.b MSF – Solidarité Jeunes en collaboration avec le parquet et les forces de l'ordre: Offre de formation et d'intervention modulaire pour primo-consommateurs et consommateurs occasionnels et leurs parents (modèle FreD)	Le projet est opérationnel.	2006	**ACCOMPLI** 2006 **Augmentation des ressources humaines via Convention MIN SAN**	**DONE** **Judged as very successful.**	**Increase human resources.**
I.2.1.2 Struct. résidentielles :	**I.2.1.2.a CHNP** : Création d'une structure spécialisée pour adolescents en difficulté et mineurs toxicomanes		2006	**ACCOMPLI** **Ouverture de la structure en 2006**	**DONE** **The structure is operational and the available capacity is fully used but the services offered could be more specifically adapted to minors.**	**Second phase – therapeutic structure – is planned and waiting for approval from the ministry of health.**
	I.2.1.2.b CHNP : Création d'une structure thérapeutique pour personnes à double diagnostic	La population cible est constituée de personnes présentant conjointement un abus de produits psychoactifs et des troubles psychiatriques	2006	**EN SUSPENS**	**NOT REALISED** **According the CHNP this programme was not needed.**	**None**

	I.2.1.2.c CHNP : Création d'une structure thérapeutique « moyen terme »	Il s'agit d'une structure résidentielle intermédiaire destinée aux toxicomanes ayant subi un sevrage physique et disposés à élaborer un projet d'avenir permettant de les orienter vers des structures adaptées et/ou vers une autonomisation progressive.	2006	**ACCOMPLI** **Opérationnel depuis 2006**	**DONE** **There are long waiting lists, needs more capacity.**	**More resources required to expand activities.** **Creation of a structure for less motivated patients. Structure should be decentralised according to the CHNP strategy plan**
I.2.2 <u>Prise en charge axée sur la prescription de substances psychoactives.</u>	**I.2.2.a Ministère de la Santé** : Adaptation des modalités du traitement de substitution en accord avec les dispositions du règlement grand-ducal du 30 janvier 2002	Les modalités du traitement de substitution ont été déterminées par le r.g.-d. du 30 janvier 2002 dans le cadre du plan d'action 2000 – 2004. La mise en application des dispositions du r.g.-d. du 30/01/2002 a été entamée sous le plan d'action 2000 – 2004. Sont notamment visées la création d'un registre central de substitution, l'introduction d'un carnet à souche destiné exclusivement au traitement de substitution et la régularisation des médecins prescripteurs face à l'obligation de détention d'un agrément accordé par le Ministre de la Santé.	2006 2007 2006	**ACCOMPLI** **Introduction du carnet à souche spécial en 2006.** **ACCOMPLI** **Version finale du logiciel du registre et début de la phase test en 2007.** **ACCOMPLI** **Introduction des carnets à souche bleus en 2007.** **ACCOMPLI** **Obligation de notification des traitements de substitution par les médecins prescripteurs en 2002.**	**DONE** **(all 4 actions)** **Results appreciated as 'poor' by the stakeholders. The implementation and enforcement of legislative and surveillance instruments is still problematic. (Closer consultation with prescription actors is currently developed.)**	**Better control on prescription, implementation of legislative and surveillance instruments.**

I.3 Reintegration psycho-socio-professionnelle						
I.3.1 Logement	**I.3.1.a CNDS - NUETSEIL** Logement d'urgence (provisoire)	c.f action sous point **I.1**		**ACCOMPLI**	**DONE** **Highly appreciated but needs a fixed structure.**	**Decentralisation to North and South of Luxembourg.**
	I.3.1.b CHNP-CTM Logement supervisé modulé Consolidation et expansion des offres de logement CHNP-CTM (Rosport / Moersdorf)	Projet mis en place dans le cadre du plan d'action 2000 – 2004. L'expansion de l'offre de logements supervisés s'appuiera sur l'élaboration d'un concept global de l'offre post-cure en collaboration avec le CTM (CHNP) et la fondation JDH.	2006-2007	**ACCOMPLI** **Expansion de l'offre de logement supervise entre 2005 et 2007.** **ACCOMPLI** **Ouverture d'un deuxième site à Moersdorf en 2007 et élargissement de la convention avec le Ministère de la Santé en 2008.**	**DONE** **Positively judged** **DONE** **Positively judged**	**Increase of capacity is needed.**
	I.3.1.c JDH : Projet « Transitions » Transformation du foyer de post-cure Neudorf en une structure résidentielle de stabilisation et d'orientation.	Le foyer de post-cure JDH sera ouvert à une population plus ciblée (hommes toxico-dépendants abstinents ou substituées) nécessitant un hébergement (maison « dry ») et un suivi en vue d'une insertion sociale. Durée de séjour limité (transitions).	2006-2007	**EN COURS DANS LES DELAIS**	**NOT REALISED** **STILL IN PROGRESS.** **Should have been finished in 2007. After-care should get more attention.**	**Implementation of a project for a well defined target population as foreseen by the action plan.**
	I.3.1.d JDH : Aide au logement autonome Expansion de l'offre de logement sur le modèle du projet « niches » de la fondation JDH.	Une décentralisation de l'offre ainsi qu'une augmentation des moyens mis à disposition par le Ministère de la Santé.	2007	**ACCOMPLI** **Elargissement de la convention avec le Ministère de la Santé en 2007.**	**DONE** **Highly appreciated but waiting lists are too long.**	**Increase and diversification of capacities needed.**

I.3.2 Mesures de formation et de mise au travail	**I.3.2.a Stëmm vunn der Strooss** : Création d'une structure de jour offrant des possibilités de formation professionnelle et des occupations journalières (rémunérées) aux personnes souffrant d'une maladie de dépendance.	Le projet s'implantera en milieu rural et proposera des formations et occupations professionnelles adaptées aux différents degrés et champs de compétence des bénéficiaires. Une offre d'hébergement est prévue à moyen terme.	2008	**EN COURS HORS DELAIS** (LES PLANS SONT APPROUVES MAIS L'AUTORISATION DE BATIR FAISAIT DEFAUT au 31.12.2007). **Le projet à été retardé afin de pouvoir prendre en compte les inquiétudes de la population locale et en raison de difficultés issues du partage du site avec une autre partie.**	**NOT REALISED** **Still waiting for approval.**	**Extension of slots. Low-threshold work project for day structure and rehabilitation.**
II. REDUCTION DE L'OFFRE						
II.1 Réduction de l'offre et de la demande						
II.1.1 Coopération et coordination	**II.1.1.1** Groupe toxicomanie		Continu	**ACCOMPLI**	**DONE** **Highly appreciated because all stakeholders are represented and collaboration is excellent and constructive.**	**None**
	II.1.1.2 Groupe de suivi de la structure des salles d'injections		Continu	**ACOOMPLI**	**DONE** **Very positive judgement by stakeholders because of good collaboration between services.**	**A permanent and bigger accommodation has to be realised. Similar services should be realised in other cities.**
II.2 Sécurité publique						
II.2.1 Renforcer les moyens d'action	**II.2.1.1** Contrôle commun accru des voies d'approvisionnement (rail-route-air) par Police et Douanes	Examiner les modifications législatives nécessaires à une efficacité accrue et préparer un projet de loi afférent.	2005/06	**ACCOMPLI**	**DONE**	**More (human) resources required.**

II.2.2 Développement d'une base de données et détermination des modalités d'accès	**II.2.1.2** Intégration d'un fichier stupéfiants dans « POLIS » avec accès de lecture aux fichiers « police-douane » en simultané		2006-2007	**EN COURS HORS DELAIS**	**NOT REALISED STILL IN PROGRESS.** **Positively judged by stakeholders but not fully implemented yet.**	**Full implementation.**
II.3 Base de données informatisée en matière de trafic illicite de drogues						
II. 4 Lutte contre la criminalité organise						
II.4.1 Drogues illicites	**II.4.1.1** Transposition de la Décision-cadre 2004/757/JAI du 25 octobre 2004 concernant l'établissement des dispositions minimales relatives aux éléments constitutifs des infractions pénales et des sanctions applicables dans le domaine du trafic de drogues		2005/06	**ACCOMPLI**	**DONE** **Article 6 of the European directive must still be transposed. A bill has been submitted on April 20th 2007 under the number 5718.**	**According to one stakeholder the punishments foreseen by Luxembourg law in respect to article 5 of the European decision n° 2004/757/JAI are much too soft and should be reconsidered.**
	II.4.1.2 Mise en conformité de la législation nationale avec la réglementation communautaire:			**ACCOMPLI (13/02/2007)**	**DONE**	**None**
II.4.2 Produits précurseurs	**II.4.2.1** Règlement 111/2005 du 22.12.2004 fixant des règles pour la surveillance du commerce des précurseurs des drogues entre la Communauté et les pays-tiers; **II.4.2.2** Règlement (CE) 1277/2005 du 27 juillet 2005 **II.4.2.3** Décision-cadre 2004/757/JAI du 25 octobre 2004	Compétences du Ministère de la Santé, Ministère de la Justice et Ministère des Finances.	2005/06	**ACCOMPLI**	**DONE**	**Monitoring of enforcement.**

II.5 Améliorer les stratégies et procédures de collecte de données statistiques						
II.5.1 Stratégie de collecte de données en matière de qualité de drogues illicites	**II.5.1.1** Transposition du Système d'alerte précoce		2005/06	**ACCOMPLI**	**DONE**	**More structured seizure analysis protocols in order to increase quantity and quality of data on composition of substances available on the national market.**
II.5.2 Assurer les procédures de collecte de données statistiques aux fins des rapports aux organismes internationaux	**II.5.1.2** Participation à l'exercice législatif visé sous III.2.2 pour établir un réseau formel de transmission de données				**DONE**	**Needs further improvement.**
II.6 Instruments adéquats en matière de lutte contre le blanchiment d'argent						
II.6.1 Transposition des directives communautaires **II.6.2** Développement des échanges d'information au moyen du FIU Net **II.6.3** Augmentation des effectifs policiers affectés à la lutte contre le blanchiment			2007 continu	**ACCOMPLI** (3 directives anti-blanchiment) **ACCOMPLI**	**DONE** **Especially effective in the field of money laundering.**	**None**
II.7 Coopération trans-régionale et international						
II.7.1 Lutte contre le tourisme de la drogue – contrôle accru des voies d'approvisionnement (rail-route-air)	**II.7.1.1** Police/Douanes **II.7.1.2** Opérations Hazeldonk		2005-2009	**ACCOMPLI** (Hazeldonk et Traité de Prüm)	**DONE** **Good trans-border and trans-agency collaboration but the outcome of Hazeldonk operations is generally poor.**	**Maintain and further develop collaboration schemes.**

II.7.2 Lutte contre le trafic de drogues	**II.7.2.1** Police/Douanes	Examen des modifications législatives nécessaires à une efficacité accrue	2005-2009	**EN EXAMEN**	**DONE** **Good trans-border and trans-agency collaboration but the outcome of Hazeldonk operations is generally poor.**	**Maintain and further develop collaboration schemes.**
	II.7.2.2 Participation aux opérations coordonnées au niveau UE **II.7.2.3** Police/Douanes		2005-2009	**EN COURS**	**DONE** **Good trans-border and trans-agency collaboration but the outcome of Hazeldonk operations is generally poor.**	**Maintain and further develop collaboration schemes.**
II.7.3 Lutte contre le trafic de précurseurs	**II.7.3.1** Participation aux opérations coordonnées au niveau UE		2005-2009	**EN COURS**	**DONE** **Good trans-border and trans-agency collaboration but the outcome of Hazeldonk operations is generally poor.**	**Maintain and further develop collaboration schemes.**
II.8 Action préventive et de lutte contre la toxicomanie en prison						
II.8.1 Projet de prise en charge globale des personnes toxico-dépendantes en milieu carcéral	**II.8.1.1** Ministère de la Justice/Parquet Général **II.8.1.2** Evaluation finale du projet-pilote		2006	**ACCOMPLI** **(Programme fonctionnel et convention avec le CHNP pour prises en charge psychiatriques.)**	**DONE** **Judged by the stakeholders from slightly positive (ministerial stakeholders: operational, fitting demand) up to very poor (NGOs). The program covers drug prevention as well as harm reduction. NGO stakeholders state that the action is not sufficient.**	**Support after release from prison. Diversification of services. Increase of capacities. Improvement of syringes distribution programme in prison.**

III. AXES TRANSVERSAUX						
III.1. REDUCTION DES RISQUES, DOMMAGES ET NUISANCES						
III.1.1. Structure bas-seuil	**III.1.1.a Ministère de la Santé** : Consolidation et re-localisation du centre d'accueil jour/nuit pour toxicomanes à Luxembourg-Ville.	Le foyer TOXIN (CNDS) fonctionnent depuis décembre 2003 dans une structure-container à proximité de la gare ferroviaire de Luxembourg. Le projet visé concerne l'implantation de ces deux structures au sein d'un site définitif à Luxembourg-Ville.	2005 - 2009	**ACCOMPLI** **Triple augmentation des postes accordés par le Ministère de la Santé 2005 – 2007.**	**DONE** **The centre is operational and demand is increasing. There is still no permanent structure.**	**Permanent structure**
		Le projet de relocalisation du foyer TOXIN à pris du retard en raison du refus de la Ville de Luxembourg du site d'implantation « Rue de Hollerich » proposé par le Ministère de la Santé en 2005 et la mise en suspens de l'autorisation de bâtir pour le site « Rue du Dernier Sol ». Accord avec la Ville d'Esch/Alzette pour la construction d'un foyer comprenant également une salle de consommation supervisée	2006	**EN COURS HORS DELAIS**	**NOT REALISED** **STILL IN PROGRESS** **Results judged as 'poor' by the stakeholders. The service is hosted in a temporary accommodation. Plans for a new permanent structure have been finalised by the Ministry of Health in 2006. Until now the City authorities refrained from granting a construction permit. In the city of Esch there is still no approval for implementing the service.**	**Permanent accommodation needed.** **Full implementation of foreseen action.**
	III.1.1.b Ministère de la Santé : Création d'une salle d'injection pour personnes toxicomanes.	La première salle d'injection pour toxicomanes à implanter au sein du foyer TOXIN.	2005	**ACCOMPLI** **Ouverture en 2005**	**DONE** **Judged very positively by the stakeholders. The injecting room is functional and capacity well used.**	**Moving to a permanent accommodation and complementing injecting room with facilities for inhaling.**
	III.1.1.c JDH : Activités de réduction de risques pour consommateurs de drogues demandeurs d'asile.		2007	**ACCOMPLI**	**DONE** **This action is ongoing and also undertaken by other actors than JDH (e.g. Aids prevention centre).**	**Further development.**

III.1.2 Distribution de stupéfiants	**III.1.2.a Ministère de la Santé /JDH :** Mise en place d'un programme de distribution de certains stupéfiants sous contrôle médical.	Activités d'information et mise en réseau des institutions impliquées.	2007	**EN COURS HORS DELAIS** **Le GIT a donné son feu vert pour la planification du projet en 2007. Avis favorable conditionnel du collège médical en 2007. Finalisation du concept en avril 2008.**	**NOT REALISED** **STILL IN PROGRESS.** **Political consensus exists. Concept has been written by Ministry of Health and is approved by all involved parties. Decision to implement has been postponed in order to gain from experience of injecting room. Therefore the budget is not granted yet.**	**Prompt realisation**
III.1.3 Intervention en milieu festif	***III.1.3.a MSF - Solidarité Jeunes :*** Mission exploratoire en techno-scène	Evaluation des besoins en vue de développer des offres d'intervention adaptées pour une réduction des risques, dommages et nuisances.	p.a.	**EN SUSPENS**	**NOT REALISED** **Not executed by stakeholder. Cancelled on stakeholders own choice because it doesn't fit with the target group.**	**None**
III.2. Recherche et information						
III.2.1 Etudes/Enquêtes	**III.2.1.a PF OEDT / CRP-Santé** Recherche-Action - Prévalence et propagation des hépatites virales A,B,C et du HIV au sein de la population d'usagers problématiques de drogues d'acquisition illicite. Dépistage, vaccination HAV et HBV, orientation et réduction des risques et dommages	Ce projet de recherche a débuté en août 2003 sous l'ancien plan d'action et est financé par le FLTS. La finalisation du projet a eu lieu fin 2006	2006	**ACCOMPLI HORS DELAI** **Publication de l'étude en 2007. Retard en raison des délais non prévisibles pour l'octroi d'une autorisation de la part de CNPD.**	**DONE** **Much appreciated by the stakeholders: Highly usable results of national recommendations.**	**Implement remaining recommendations from the study.**

	III.2.1.b. PF OEDT /CRP-Santé Etude exploratoire sur les besoins en matière de prise en charge des mineurs usagers problématiques de drogues	Etude menée par le PF OEDT Proposition de concept existante	2005	**ACCOMPLI** 2005	**NOT REALISED** **STILL IN PROGRESS** **Concept existing but study not done because no financial resources available.**	
	III.2.1.c PF OEDT/CRP-Santé : Mise à jour de l'étude sur dépenses publiques en matière de politique anti-drogue	Etude menée par le PF OEDT	2007	**ACCOMPLI** 2007	**DONE** **Highly appreciated by the stakeholders: Good data, Methodology praised by EMCDDA.**	**Fine tuning and yearly update.**
	III.2.1.d CePT -Etude « rapid assessment » de la situation nationale en matière de la consommation de cocaïne, d'alcool et des jeux de hasard	Les thèmes retenus renvoient clairement à des préoccupations actuelles en termes de Santé Publique. Méthodologiquement l'étude repose sur la combinaison d'un recueil représentative de données et la technique de l'évaluation rapide de la situation observée.	2006	**EN SUSPENS** **(financement non accordé)**	**NOT REALISED** **STILL IN PROGRESS.** **Lack of resources.**	**Gather data in a more cost effective way by applying rapid assessment methodologies.**
	III.2.1.e CePT -Etude sur le lien entre la cohésion familiale et sociale et les ressources psychosociales cotre les addictions, la violence et les troubles psychiques	Les changements socio-économiques actuels induisent des remaniements en termes de repères familiaux et de fonctionnent social. L'étude s'intéresse aux facteurs et ressources qui peuvent avoir une influence sur des comportements tels que les addictions, la violence et les troubles psychiques tant au niveau de la population luxembourgeoise que dans les familles immigrées. Les résultats de l'étude serviront de base pour l'élaboration de nouvelles stratégies de prévention.	2006-2008	**EN SUSPENS** (financement non accordé)	**NOT REALISED**	**Gather data in a more cost effective way by applying rapid assessment methodologies.**

III.2.2 Système de monitoring épidémiologique	**III.2.2.a PF OEDT/CRP-Santé** Consolidation du système de monitoring des contacts institutionnels pour usage illicite de drogues. (RELIS)	Harmonisation de la méthodologie de documentation des contacts « drogues ». Les services spécialisés participent actuellement au dispositif RELIS sur base volontaire. Il s'agira de faire évoluer le dispositif vers un système de documentation et d'évaluation unique faisant partie intégrante des prestations des services concernés.	continu	**EN COURS DANS LES DELAIS**	**DONE** **Highly appreciated by the stakeholders: high level of data quantity and quality. Private data of clients can be better protected.**	**Redesign of data protocol and data base after a decade of RELIS surveillance. Inclusion of new data providers (now quasi-exhaustive national data sources' coverage).**
III.2.2 Système d'alerte précoce en matière de drogues synthétiques et de nouvelles tendances (SAP)	**III.2.2.a PF OEDT/CRP-Santé** **Ministère de la Santé** Consolidation du système SAP	Le GIT a arrêté une liste de correspondants permanents chargés de transmettre toute information relative aux drogues synthétiques et aux nouvelles tendances de consommation au coordinateur national drogues. La quantité d'information transmise est cependant jugée insuffisante afin de garantir un suivi et une prévention efficace. Il s'agira de légiférer en la matière afin de constituer un réseau formel de transmission de données et ce dans l'intérêt de la Santé Publique. Par ailleurs il conviendrait de légiférer en matière d'interventions au sein des milieux festifs (e.g. testing anonyme des pilules en circulation) afin de pouvoir disposer d'informations plus fiables sur la qualité des produits consommés.	2005.	**ACCOMPLI**	**DONE** **Although appreciated, data flow to low threshold services can be improved.**	**Improvement of data flow towards low threshold services. Improvement of protocols for substance analysis to increase quantity and quality of data on purity, composition and price of illegal substances found on the national market.**
III.2.3 Evaluation	**III.2.3.a** Evaluation du plan d'action drogues 2005 - 2009	Evaluation du niveau d'implantation et de l'impact	2009	**EN COURS DANS LES DELAIS**	**IN PROGRESS** ON SCHEDULE	

III.3. RELATIONS INTERNATIONALES	Compétence du Ministère des Affaires Etrangères et de l'Immigration. Inclus dans le plan d'action au niveau des mécanismes de coordination		
III.4. COORDINATION			
- Conférer au GIT un pouvoir d'initiative et le statut d'organe central de coordination en matière de stratégie et de plans d'action anti-drogues au niveau inter-compétence et sur le plan national. **ACCOMPLI**		**DONE** **Highly appreciated by the stakeholders.** **Reform of the GIT: more active, more visible, more effective, more partners.**	**Maintain high level collaboration.**
- Le GIT constituera le mécanisme de consultation et de concertation permettant de déboucher sur des positions communes dans les dossiers internationaux. Les aspects de relations internationales devront par ailleurs bénéficier d'un engagement plus soutenu. **ACCOMPLI**		**DONE** **Well appreciated by stakeholders.**	
- Les réunions du GIT devront être préparées par un bureau composé des délégués nationaux auprès du Groupe Horizontal Drogues (GHD) du Conseil de l'UE afin de garantir la cohérence entre la stratégie de l'UE et les interventions au niveau national. **ACCOMPLI**		**DONE**	
- L'ordre du jour devra contenir des points permanents tels que rapports sur la situation actuelle trans-piliers, dossiers européens, le système d'alerte précoce des drogues synthétiques, etc**. ACCOMPLI**		**DONE**	
- Les rapports des discussions et des décisions du GIT devront être obligatoirement transmis aux ministres compétents. **ACCOMPLI**		**DONE**	
- La fréquence des réunions du GIT devra être accrue afin d'assurer un suivi adéquat des dossiers en cours. **ACCOMPLI**		**DONE** **Meetings are regular and frequent enough.**	
- La cellule « coordination drogues » ainsi que le coordinateur national « drogues » de la Direction de la Santé devront être formellement investis d'un mandat reconnu au niveau national et disposer de moyens suffisant pour mener à bien leurs tâches. **EN COURS**		**DONE**	

STATE OF EXECUTION (12/2007)

MID-TERM 2007

Etat d'exécution (10/2007)	Nombre de mesures	(%)	
Accomplies dans les délais	37	67%	**82% Accomplies ou en cours dans les délais**
En cours dans les délais	7	13%	
Accomplies hors délais	1	2%	**18% hors délais ou suspendues (Raisons cf. grille)**
En cours hors délais	6	11%	
En suspens	4	7%	
TOTAL	55	100 %	

FINAL 2009

Etat d'exécution (10/2007)	Nombre de mesures	(%)	
DONE	44	80%	**82% Done or on schedule**
IN PROGRESS - ON SCHEDULE	1	2%	
			18% Delayed or suspended
NOT REALISED – STILL IN PROGRESS	6	11%	
EN SUSPENS	4	7%	
TOTAL	55	100 %	

Annex 4: Logical framework matrixes (Log Frame)

A LogFrame Matrix is used to plan, monitor and evaluate a project or programme. The LogFrame is a tool, which helps to organize, coordinate and perform activities in a project or programme. The LogFrame is constructed on four levels: overall objectives, specific objectives, results and activities.

The highest level is the **overall objective**. Overall objectives describe the general goals of the programme: e.g. improving the health situation of a target group that is not reached by social and health services.

This overall objective can be broken up in a number of **project purposes**. Specific objectives might be used to enlarge the reach of a service among the target group, to reduce unhealthy behaviour in the target group, to train staff to reach the target group, etc.

The specific objectives can be translated in **results** of the project or programme, e.g. the concrete outputs or improvements to be achieved, e.g. that more individuals from the target group make use of social and health services, that less health problems (e.g. HIV infection) occur among the target group and that staff is sufficiently trained to reach the target group.

Finally, to achieve these results **activities** have to be undertaken that are appropriate to achieve these results. This could be e.g. outreach work or peer support. Other activities might be training of peers and outreach workers.

For each of the four levels there is a separate row in the LogFrame.

	Intervention Logic	**Objectively verifiable indicators of achievement**	**Sources and means of verification**	**Assumptions**
Overall objectives	What is the overall broader objective to which the project will contribute?	What are the key indicators related to the overall objective?	What are the sources of information for these indicators?	
Project Purpose	What are the specific objectives which the project shall achieve?	What are the quantitative or qualitative indicators showing whether and to what extent the project's specific objectives are achieved?	What are the sources of information that exist or can be collected? What are the methods required to get this information?	What are the factors and conditions not under the direct control of the project which are necessary to achieve these objectives? What risks have to be considered?
Expected Results	What are the concrete outputs envisaged to achieve the specific objectives? What are the envisaged effects and benefits of the project? What improvements and changes will be produced by the project?	What are the indicators to measure whether and to what extent the project achieves the envisaged results and effects?	What are the sources of information for these indicators?	What external factors and conditions must be realised to obtain the expected outputs and results on schedule?

Activities	What are the key activities to be carried out and in what sequence in order to produce the expected results?	Means: What are the means required to implement these activities, eg personnel, equipment, training, studies, supplies, operational facilities, etc	What are the sources of information about project progress?	What preconditions are required before the project starts? What conditions outside of the project's direct control have to be present for the implementation of the planned activities?

(source: The European Commission's Delegation to India, Bhutan, Nepal and the Maldives http://www.delind.cec.eu.int/en/csn/civil_society/eccp/eccp-logical_framework.xls)

Each LogFrame has four columns. In the first column you find the **intervention logic**, i.e. descriptions of the overall objective, specific objectives, results and activities.

In the second column you define **(objectively verifiable) indicators** for the objectives, results and activities. What are key indicators for the overall objective; what are SMART (Specific, Measurable, Appropriate, Realistic and Time-bound) indicators measuring the realisation of the specific objectives; what are SMART indicators measuring the achievement of the envisaged results; what are the means required to implement the activities (human resources, equipment, training, etc.).

Sources and means of verification clearly specify the means and the sources of information that tells us something about the indicator. We need to consider what information has to be collected, how it will / can be collected (method), who will be responsible and the frequency with which the information should be provided.

Assumptions refer to **risk factors** (what might prevent objectives from being achieved) and **supportive factors** (conditions that must be met or are helpful in order for project objectives to be achieved).

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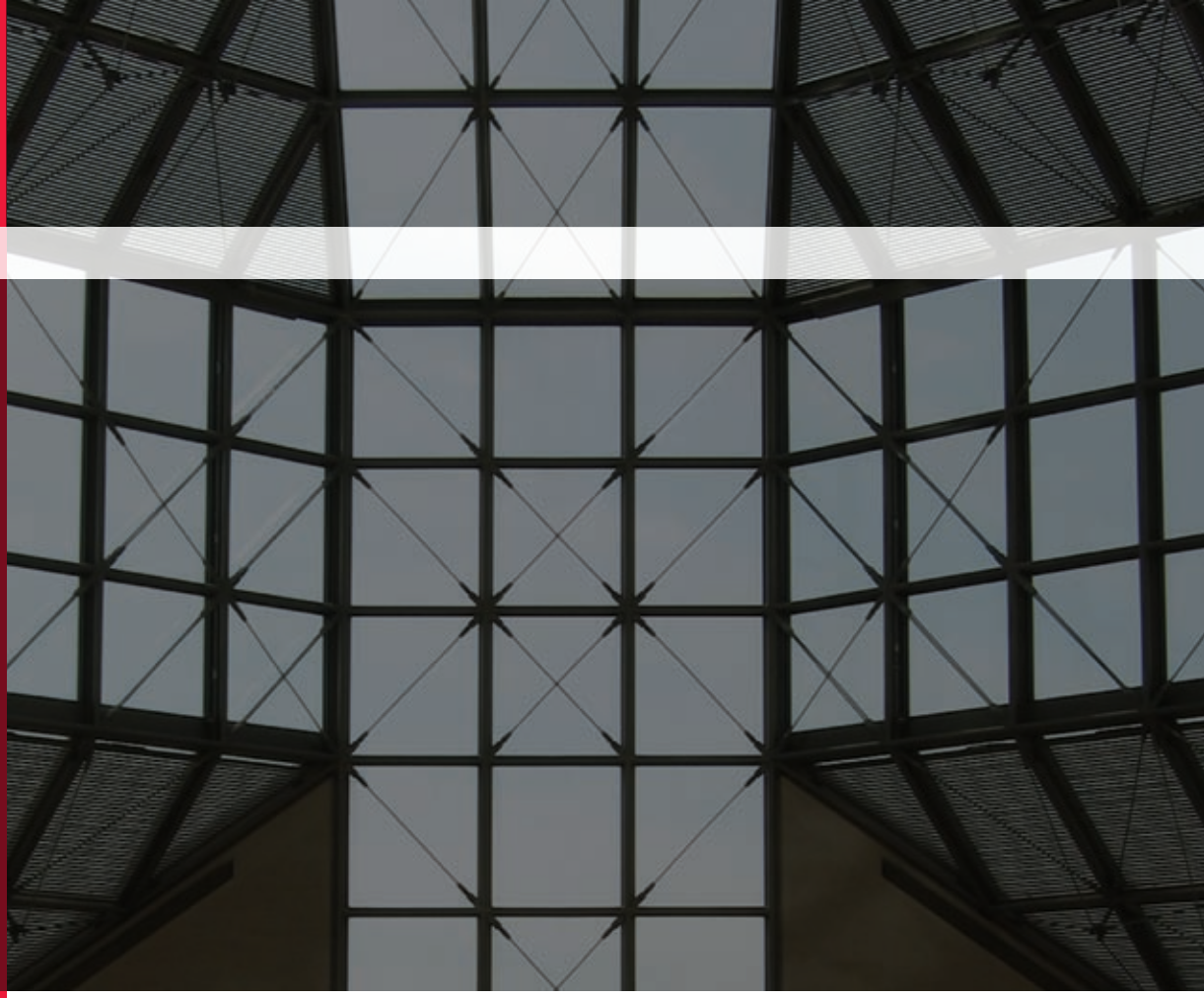

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