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GRAND-DUCHÉ DU LUXEMBOURG

2011 **National Drug Report** (2010 data)

Grand Duchy of Luxembourg

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

NATIONAL DRUG REPORT
EDITION 2011

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L'ETAT DU PHENOMENE DE LA DROGUE AU GRAND-DUCHE DE LUXEMBOURG

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

EDITION 2011

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SUMMARY

ABBREVIATIONS

AST	Service d'Action Socio-Thérapeutique
CATF	Chemical Action Task Force
CePT	Centre de Prévention des Toxicomanies
CAS	Commission d'admission et de surveillance (CHDP)
CFSP	Common Foreign and Security Policy
CHNP	Centre Hospitalier Neuro-Psychiatrique
CICAD	Inter-American Drug Abuse Control Commission
CMO	Comprehensive Multidisciplinary Outline (UN)
CND	Commission on Narcotic Drug
CNDS	Comité National de Défense Sociale
CNER	Comité National d'Ethique de Recherche
CNPD	Commission Nationale de Protection des Données
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
CPOS	Centre de Psychologie et d'Orientation Scolaire
CRP-HT	Centre de Recherche Public - Henri Tudor
CRP-Santé	Centre de Recherche Public - Santé
CTM	Centre Thérapeutique de Manternach
DEA	Drug Enforcement Administration (United States)
EWS	Early Warning System on New Synthetic Drugs
GID	Groupe Interservices Drogue (de la Commission européenne)
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMEA	European Medicines Agency
EUROPOL	European Police Office
FBI	Federal Bureau of Investigation (United States)
FED	Fond Européen de Développement
FATF	Financial Action Task Force on Money Laundering
FEDER	Fond Européen de Développement Régional
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
HAT	Heroin Assisted Treatment
HDG	Horizontal Working Party on Drugs

Honlea	Heads of National Drug Law Enforcement Agencies
ICD	Interministerial Commission on Drugs
ICPO/INTERPOL	International Criminal Police Organization
ILO	International Labour Organization
INCB	International Narcotic Control Board
JDH	Fondation Jugend- an Drogenhëllef
LNS	Laboratoire National de Santé
MSF	Médecins Sans Frontières
NDLEA	National Drug Law Enforcement Administration (Nigeria)
NFP	National Focal Point of the EMCDDA
NIDA	National Institute on Drug Abuse (United States)
OAS	Organization of American States
OCDE	Organisation de Coopération et de Développement Economiques
OGD	Observatoire Géopolitique des Drogues
OLAF	European Anti-Fraud Office
ONDCP	Office of National Drug Control Policy of the White House (United States)
PECO	Pays d'Europe Centrale et Orientale
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
REITOX	European Information Network on Drugs and Drug Addiction
SADC	Southern African Development Community
SEPT	Semaine Européenne de Prévention des Toxicomanies
SID	Système d'Information Douanier
SIS	Système d'Information Schengen
SNJ	Service National de la Jeunesse
SPG	Système de Préférences Généralisées
SPJ	Service des Stupéfiants de la Police Judiciaire
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organization
WHO	World Health Organization
ZePF	Zentrum für Empirische Pädagogische Forschung – Universität Landau

AVANT–PROPOS

Le rapport 2011 sur l'état du phénomène de la drogue au Grand-Duché de Luxembourg (RELIS) vise à situer le contexte dans lequel s'inscrivent l'usage et le trafic illicites de drogues et les toxicomanies au niveau national en proposant une vue d'ensemble des évolutions historiques et des tendances actuellement observées en la matière.

Les experts suivants ont été consultés: Dr Arno Bache (Direction de la Santé), Andrée Colas et Sophie Hoffmann (Ministère de la Justice), Auguste Dicken (Administration des Douanes), Jean-Paul Juchem (CNS), Dr Ferdy Kasel (CHNP-BU-V), Dr Annette Mühe (CHL), Marc Bamberg (Police Judiciaire - Section Stupéfiants), Jean-Marie Schanck et Guy Reinart (Direction de la Santé), Steve Schmitz (Police Judiciaire – Criminalité organisée), Simone Schram et Linda Weis (Direction de la Santé), Robert Welter (Parquet), Dr S. Schneider et Dr M. Yegles (Laboratoire National de Santé) ainsi que les chargés de direction de l'ensemble des ONG spécialisées en matière de prise en charge.

FOREWORD

The 2011 edition of the national report on the state of the drugs problem in the Grand Duchy of Luxembourg aims to describe the framework in which drug use and drug trafficking evolve at the national level by providing a comprehensive overview of historical developments and recent trends.

Thanks are due to the following experts consulted in the framework of the 2011 edition of the report: Dr Arno Bache (Directorate of Health), Andrée Colas and Sophie Hoffmann (Ministry of Justice), Auguste Dicken (Customs Administration), J.-P. Juchem (CNS), Dr Ferdy Kasel (CHNP-BU-V), Dr Mühe (CHL), Marc Bamberg (Special Drug Department of the Judicial Police), J.-M. Schanck and Guy Reinart (Ministry of Health), Steve Schmitz (Judicial Police), Simone Schram and Linda Weis (Directorate of Health), Robert Welter (Public Prosecutor's Office), Dr S. Schneider and Dr M. Yegles (National Laboratory of Health LNS) as well as heads of all national specialised NGOs.

RESUME

RAPPORT NATIONAL SUR L'ETAT DU PHÉNOMÈNE DES DROGUES ET DES TOXICOMANIES AU GRAND-DUCHÉ DE LUXEMBOURG
(RELIS - Edition 2011)

Depuis sa création en 1994, le Point Focal Luxembourgeois (PFN) de l'Observatoire Européen des Drogues et des Toxicomanies (OEDT) maintient et développe le dispositif de surveillance épidémiologique en matière de drogues et de toxicomanies, connu sous le nom de Réseau Luxembourgeois d'Information sur les Stupéfiants et les Toxicomanies (RELIS).

RELIS repose sur une architecture d'information multisectoriel incluant les centres nationaux de traitement spécialisé ambulatoires et résidentiels, les centres de consultation, certains hôpitaux généraux, ainsi que les instances judiciaires et pénales compétentes.

Les efforts déployés depuis plus de 15 années ont permis de constituer une base de données nationale annuellement mise à jour, permettant notamment:

- de situer la prévalence, l'incidence et l'évolution de l'usage problématique de drogues illicites au niveau national;
- de servir de support scientifique et de base de données pour l'activité de recherche;
- d'évaluer les tendances nouvelles et l'impact de certaines interventions sur les comportements et caractéristiques de la population d'usagers problématiques de drogues (UPD) et de faciliter l'analyse des besoins et le processus décisionnel au niveau politique lors de la mise en place de plans d'action et de stratégies d'intervention en matière de lutte contre la toxicomanie.

Orientations politiques et budgétaires

Le gouvernement a confié la coordination des actions de réduction de la demande et des risques associés à la drogue et aux toxicomanies au Ministère de la Santé, ce qui a donné lieu à la désignation d'un Coordinateur National « Drogues » en 2000.

Le programme gouvernemental de 2009 a servi de cadre à l'élaboration de la troisième stratégie nationale et du plan d'action pluriannuel en matière de lutte contre les drogues et les addictions. **La stratégie et le plan d'action 2010-2014** s'appuient sur les priorités fixées par le Ministère de la Santé et sur une collaboration soutenue avec les acteurs de terrain. Afin d'optimiser son impact, le plan d'action actuellement en vigueur a également tenu compte des éléments pertinents issus des traités UE et CE, **de la stratégie anti-drogue 2005–2012** et du **plan d'action drogues 2009–2012 de l'UE**. L'objectif général de la stratégie et du plan d'action nationaux est de contribuer à atteindre un niveau élevé de protection en termes de Santé publique, de Sécurité publique et de cohésion sociale.

Une stratégie anti-drogue qui veut faire face aux défis actuels repose prioritairement sur **deux piliers**, à savoir la réduction de la demande et la réduction de l'offre ainsi que sur **quatre axes transversaux** : 1. la réduction des risques, dommages et nuisances, 2. la recherche et l'information, 3. les relations internationales et 4. les mécanismes de coordination. Le coordinateur national « drogues », en collaboration avec le Groupe Interministériel « Toxicomanies » (GIT), suit et ajuste les processus de mise en œuvre du plan d'action en matière de lutte contre les drogues et les addictions.

Le budget global du Ministère de la Santé alloué aux services et programmes du domaine des drogues et des toxicomanies, est passé de 1.270.169 EUR en 1999 à 8.635.867 EUR en 2010 ce qui équivaut à un taux de progression de 580%. En 2000, le nombre de postes ETP conventionnés par le Ministère de la Santé et alloués aux structures spécialisées issues du domaine des toxicomanies s'élevait à 30,75 ; il a atteint 87,25 ETP en 2010. De façon générale, les dépenses publiques en matière de lutte contre les drogues et les toxicomanies sont actuellement estimées à 38,5 millions EUR (Origer, 2010). Les dépenses allouées exclusivement aux traitements des problèmes liés à l'usage de drogues illicites représentaient 16,3 millions EUR en 2010.

Indicateurs épidémiologiques

En référence aux données de prévalence de 2009 (UNODC, 2011), le nombre global de personnes âgées de 15 à 64 ans ayant consommé au moins une drogue d'origine illicite au cours d'une année écoulée est estimé entre 149 et 272 millions. L'usage à caractère problématique de drogues illicites concerne 15 et 39 millions de personnes de la population mondiale dans cette même tranche d'âge.

Le cannabis reste de loin la drogue la plus consommée[1] au monde (125 à 203 millions de personnes équivalant à 2,8 – 4,5% de la population mondiale telle que définie) suivi des stimulants de type amphétamine (STA) [14 à 57 millions de personnes (0,3 – 1,3%)], incluant les usagers d'ecstasy (11 à 28 millions de personnes). Le nombre de consommateurs d'opiacés se situerait entre 12 et 21 millions de personnes. Mondialement un nombre estimé de 14,2 à 20,5 millions de personnes (0,3-0,4%) consomment de la cocaïne.

Au cours de la dernière décennie, les marchés ont présenté des signes de stabilisation, voire de régression, concernant la consommation d'opiacés, de cocaïne, de cannabis et de STA. Au sein de l'UE les dernières données de l'OEDT laissent entrevoir une tendance similaire à l'exception de l'accroissement de la consommation de cannabis surtout dans certains pays de l'Europe de l'Est et d'une popularité accrue de la cocaïne qui semble toutefois commencer à afficher une certaine stagnation. A l'échelle micro-géographique, le Grand-Duché de Luxembourg s'aligne sommairement sur les tendances au sein de l'UE, avec toutefois de variations locales en matière de prévalence plus ou moins prononcées et une tendance à la baisse du taux de prévalence générale de l'usage problématique de drogues d'origine illicite.

Prévalence en population générale au G.-D. de Luxembourg

Prévalence d'usagers de drogues au sein de la population scolaire

Des données comparables issues d'enquêtes scolaires menées entre 1992 et 2000 témoignaient d'un taux de prévalence « vie » (consommation au moins une fois au cours de la vie) croissant en ce qui concerne la consommation de drogues illicites, toutes catégories confondues. L'usage d'opiacés par les jeunes (16 à 20 ans) témoignait d'une prévalence basse. L'étude HBSC 2010 permettra une confrontation actualisée des données sérielles dans l'édition 2012 du présent rapport.

1 Les prévalences et taux de prévalence par produit se rapportent à la consommation au cours de l'année écoulée de personnes âgées de 15 à 64 ans.

Les premiers résultats, non encore validés au moment de la rédaction, de la dernière enquête nationale en milieu scolaire (HBSC - 2010), portant sur 9.878 élèves de l'enseignement secondaire âgés entre 12 et 18 années indiquent, en comparaison avec les données sérielles de 1999, qu'un taux moins élevé de jeunes rapportent l'usage antérieur (au cours de la vie) de l'ensemble des drogues illicites considérées à l'exception de la cocaïne qui affiche une hausse toutefois non significative. En analysant l'évolution entre 2006 et 2010 (HBSC – 2006), on observe une baisse très modeste de l'usage de cannabis, d'XTC, d'héroïne, de solvants et de champignons hallucinogènes; l'usage-vie d'autres substances psychoactives demeurant assez stable.

En ce qui concerne l'usage au cours des derniers 12 mois, on observe des tendances fort similaires. A souligner toutefois que la prévalence de consommation de cannabis au cours des derniers 12 mois et des derniers 30 jours semble s'être stabilisée entre 2006 et 2010. Par contre l'âge moyen lors de la première consommation de cannabis et de drogues illicites en général par les jeunes âgés de 12 à 18 ans a augmenté de plus au moins 6 mois depuis 2006. En 2010, 9.44% des jeunes questionnés ont rapporté une première consommation de cannabis avant l'âge de 15 ans alors que ce même taux était de 12.03% en 2006.

Prévalence de l'usage problématique de drogues (UPD)[2]

Contacts institutionnels et recours aux institutions sanitaires pour des problèmes liés aux drogues illicites

Le nombre d'UPD indexés par les institutions nationales en 2010 équivalait à 5.415[3] personnes (2002: 4.701).

A titre comparatif, on retiendra qu'en 2002, 2.383 personnes furent recensées par les **institutions de réduction de la demande** et 2.318 par les **instances de réduction de l'offre**. En 2010, ces mêmes instances ont recensé respectivement 2.653 et 2.762 personnes. Sommairement, le nombre de personnes entrées en contact avec des instances sanitaires et répressives a atteint un plateau entre 2002 et 2008 avec une première croissance du nombre de contacts au cours des années 2009/10. Cependant, lors de cette même période, le nombre de demandes de traitement a connu une tendance à la hausse alors que le nombre de contacts avec les forces de l'ordre a connu une baisse générale à l'exception de l'année 2010. La population générale âgée de 15 à 64 ans prise comme référence, la proportion des personnes entrées en contact avec des instances sanitaires ou répressives pour motifs d'usage de drogues, tout comme le taux de prévalence d'usagers problématiques de drogues, ont sensiblement diminué entre 2002 : (15,8/^{1000} habitants) et 2009 (14,7/^{1000} habitants). En 2010 cependant ce taux accuse une nette hausse, due exclusivement à une augmentation du nombre de personnes enregistrées par les forces répressives.

Caractéristiques socio-démographiques de la population nationale d'UPD

Le sex-ratio (M/F) de la population des UPD est actuellement de 4:1. Sur les dix dernières années on constate que la proportion de ressortissants étrangers parmi les UPD recensés a témoigné d'importantes fluctuations affichant cependant une tendance à la hausse à partir de 2003, qui s'est stabilisée depuis les 3 dernières années (+/- 51%). La population des non-luxembourgeois(es) est principalement composée de citoyens d'origine portugaise dont la proportion (39% de l'ensemble des UPD non-luxembourgeois) est supérieure à celle observée au sein de la population générale (37%). Les UPD d'origine française et allemande occupent respectivement le deuxième (23%) et troisième (10%) rang. Les UPD d'origine italienne qui occupaient la troisième place au cours des neuf dernières années parmi les personnes interpellées pour infraction(s) à la législation nationale sur les stupéfiants, ne représentent plus que 2% en 2010 (rang 7).

2 Le terme 'UPD' sera utilisé pour désigner des 'Usagers problématiques de drogues d'acquisition illicite' tout au long du présent rapport.

3 Dans ce recensement les comptages multiples sont inclus ce qui signifie qu'une personne donnée a pu être indexée deux fois ou plus si on tient compte de l'ensemble des institutions spécialisées établies sur le territoire national. Dès lors, ce chiffre ne représente pas la prévalence (la taille) effective de la population d'UPD au niveau national (qui elle, se détermine par des méthodologies différentes).

L'âge moyen des usagers recensés est passé de 28 ans et 4 mois en 1995 à 31 ans et 7 mois en 2010. L'âge moyen des UPD masculins a augmenté plus rapidement que celui des femmes. L'écart entre les usagers les plus jeunes et les plus âgés s'est stabilisé récemment. L'augmentation dans la classe d'âge de 40 années et plus des UPD et une diminution des UPD âgés de moins de 30 années, tendance observée au cours dernières années, ne s'observe plus. L'âge moyen des UPD luxembourgeois est inférieur à celui des UPD non-luxembourgeois. On retiendra également l'accroissement significatif de l'âge moyen des victimes de **surdoses mortelles** jusqu'en 2008 (accroissement léger en 2010 comparé aux données de 2009) et une proportion croissante de mineurs parmi les prévenus pour infraction(s) STUP in 2010 (9% ; 2009 :6%). A souligner enfin que les UPD ont tendance à entrer en traitement de façon plus précoce, ce qui pourrait être dû à une offre de prise en charge actuelle plus diversifiée.

Prévalence de l'usage problématique de drogues (UPD) et tendances de consommation

En référence aux données les plus récentes (Origer, 2009)[4], la prévalence et le taux de prévalence UPD actuels sont estimés respectivement à 2.470 personnes (I.C. (95%) : 2.089 - 3.199) et 7,67 par mille personnes issues de la population nationale âgée entre 15 et 64 années. De l'analyse des données sérielles de 1997 à 2007 ressort que la prévalence absolue et les taux de prévalence de l'usage problématique de drogues HRC ont connu une hausse marquée jusqu'en 2000, s'engageant ensuite sur un plateau de stabilisation pour afficher une tendance à la baisse à partir de 2003. Cette même tendance s'observe pour l'usage problématique d'héroïne pris séparément (2007 : 1.900 UPDs : 5,90 $/^{1000}$). Toutefois, la prévalence absolue et le taux de prévalence de l'usage intraveineux (UID) au sein de la population âgée entre 15 et 64 années a légèrement augmenté en comparaison à la situation observée vers la fin du 20^{ième} siècle.

L'usage intraveineux d'opiacés associé à une **polyconsommation généralisée** constitue de loin le comportement le plus observé au sein des UPD répertoriés par le réseau institutionnel. Le ratio entre usagers intraveineux et non-intraveineux s'est stabilisé à 2 :1 en 2010. La prévalence de l'usage de cocaïne en tant que drogue préférentielle affiche une tendance discontinue à la baisse depuis 2006. En 2010, et sur base des données disponibles, la prévalence de l'usage de cocaïne n'a pas augmenté en comparaison aux données de 2009.

Le nombre de personnes en contact avec le réseau institutionnel spécialisé pour usage (préférentiel) de **cannabis** représente actuellement 8% (diminution sensible). Les substances de **type amphétamines et ecstasy** sont faiblement représentées, ce qui toutefois ne renseigne nullement sur la prévalence de leur usage en population générale étant donné que les données RELIS portent sur l'ensemble des usagers problématiques actuels et ne recensent dès lors pas la totalité des usagers récréationnels. Le taux de **polytoxicomanie** (76% en 2010) s'est stabilisé à un niveau élevé après avoir atteint un niveau record de 92% en 2004.

Offres de traitement des toxicomanies

Les structures spécialisées en matière de traitement des toxicomanies sont soumises à l'obligation de disposer d'un agrément à accorder par le Ministre de la Santé et sont pour la plupart conventionnées par l'Etat. Ces deux mécanismes permettent, en association avec d'autres instruments, d'une part le contrôle de qualité et de l'autre le financement ou le cofinancement des structures visées.

Le nombre de patients adultes en traitement ambulatoire et résidentiel tend à diminuer, alors que le nombre de patients mineurs en ambulatoire affiche une hausse. Toutefois, la hausse la plus significative entre 2008 et 2010 concernait le nombre de demandeurs de traitement de substitution ainsi que le nombre de contacts avec l'ensemble des structures d'accueil à bas-seuil (2010 : 140.093). Tous centres et services de traitement

4 Téléchargeable sur http://www.relis.lu

confondus, 4.7% des clients ont formulé leur première demande d'aide en 2010. Une tendance qui semble se confirmer est une baisse de la proportion patients en traitement de substitution âgés de moins de 25 ans et une hausse au niveau de celle regroupant les personnes âgées 40 ans et plus.

Morbidité et mortalité liées à la consommation illicite de drogues

En 2010, la prévalence des cas VIH/Sida au sein de la population d'UPD a augmenté légèrement. Cependant **l'infection au VHC (hépatite C)** témoigne d'une nette diminution depuis 2009.

Selon les données les plus récentes, la proportion moyenne d'usagers intraveineux de drogues parmi les personnes nouvellement infectées par le VIH, accuse une légère tendance à la hausse. Entre 2004 et 2008, cette même proportion a évoluée dans des marges allant de 7% à 14% alors qu'en 2009 elle a diminué fortement pour atteindre 3.1% et pour augmenter à nouveau en 2010 (6,4%). Le taux d'infection VIH parmi les usagers intraveineux se situe actuellement autour de 8%. L'étude Origer et Removille (2007)[5], basée sur une méthodologie de dépistage sérologique, avait permis de confirmer une prévalence VHC élevée au sein de la population des UPD et UID, et ce, plus particulièrement en milieu carcéral.

La concrétisation des plans d'action consécutifs a été accompagnée d'une baisse discontinue mais tangible du taux de **décès par surdosage** au Grand-Duché de Luxembourg (12 cas en 2010). L'indicateur de mortalité lié aux drogues illicites doit toutefois être considéré avec précaution car il existe un nombre de facteurs externes influençant de façon importante son évolution, comme par exemple le vieillissement global des consommateurs d'opiacés, des variations importantes dans la pureté des drogues, une polyconsommation de drogues généralisée incluant la consommation non thérapeutique de médicaments délivrés sur ordonnance et présentant des effets d'interactions dangereuses si liée à la consommation de substances illicites.

Exprimée en nombre de cas de surdose par rapport à la population générale du Grand-Duché de Luxembourg, cette proportion correspondait à 5.9 décès par surdose pour 100.000 habitants âgés entre 15 et 64 ans en 2000 (2007 : 5.67). En 2010, 3,5 surdoses aiguës pour 100.000 habitants ont été enregistrées, représentant une tendance décroissante. Les données médico-légales de 1992 à 2010 confirment que la quasi-totalité des décès impliquaient la consommation d'héroïne dans un contexte de polyconsommation.

Pour les victimes, il s'agissait pour 2010 seulement d'hommes (100%) dont l'âge moyen au moment du décès a connu une hausse discontinue mais sensible sur les dernières seize années (1992 : 28,4 années et 2010 : 31 années). Bien que la moyenne d'âge ait augmenté, le nombre de victimes âgées de moins de 20 ans est resté relativement stable. Aucune victime mineure d'âge n'a été rapportée en 2010.

Une majorité confirmée de 83% (57%) de victimes était de nationalité luxembourgeoise ce qui représente une augmentation considérable comparée aux années précédentes. Sur toute la durée d'observation, les citoyens portugais occupaient la deuxième place suivis de l'Italie et de la France. L'écrasante majorité des personnes décédées sont connues par les forces de l'ordre en raison de leurs carrières d'usagers. En ce qui concerne le lieu de décès, depuis 2004 approximativement 50% des surdoses mortelles ont eu lieu au domicile de la victime, suivi par les lieux publiques.

5 Article associé publié en 2010 :
Origer A, Schmit J.-C. Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. *J. Epidemiol Community Health* doi: 10.1136/jech.2009.101378

Conséquences sociales et mesures de réintégration

Les corollaires sociaux de l'usage de drogues et de la dépendance y associée sont multiples et se répercutent aux niveaux familial, professionnel, financier et légal. On constate à titre d'exemple que l'usage de drogues illicites ou l'abus d'alcool et/ou de médicaments psychotropes est prévalent dans plus de 63% des familles d'origine des UPD répertoriés.

Le niveau d'enseignement des derniers est pour la plupart faible et incomplet. La situation résidentielle des personnes répertoriées affiche toutefois une amélioration au regard des années précédentes. Si en 1995, 31% des usagers disposaient d'un logement stable, cette proportion se situe actuellement autour de 62%, ce qui est en partie le mérite d'une série de projets d'aide au logement pour personnes dépendantes mis en place dans le cadre des plans d'action « drogues ». Les chiffres les plus récents tendent cependant à confirmer que même si l'offre en logements encadrés pour la population visée continue à être développée, la demande pour ce genre de logements s'est accrue également sur la toile de fond de la situation économique des dernières années.

Le taux de chômage (69%) tend à stagner. Cependant, la proportion d'UPD professionnellement actifs présentant une situation d'emploi stable a sensiblement diminué les trois dernières années, ce qui doit également être apprécié à la lumière des paramètres économiques actuels.

Mesures de réduction des risques

Le **nombre de contacts enregistrés par les structures d'accueil bas-seuil** a connu un accroissement remarquable lors de la dernière décennie (2005 : 47.739 / 2010: 140.093). La proportion de nouveaux clients admis dans ces structures est à la hausse. La diversification et la décentralisation de ces services sont essentiellement à l'origine de cette évolution. Environ 50% des clients appartiennent à la classe d'âge 25-34 ans et 40% ont 35 ans ou plus. Entre 50 et 60% des clients sont d'origine luxembourgeoise.

Depuis la mise en place du **programme national d'échange de seringues**, on notait une augmentation continue du nombre de seringues stériles distribuées jusqu'en 2005 et une décroissance assez marquée depuis lors avec cependant une nouvelle tendance à la hausse depuis 2008 (2010: 308.350 / 1996 : 76.259). Le taux global de retour de seringues usées se situe actuellement à 96% Un nombre croissant d'injecteurs se procurent leurs seringues auprès de structures spécialisées suivies des pharmacies et des distributeurs automatiques.

Indicateurs de réduction de l'offre[6]

Saisies de substances illicites au niveau national

D'importantes variations au niveau de l'évolution des **quantités saisies** s'observent depuis le début des années 90 et ceci pour presque tous les types de produits. Une analyse longitudinale indique une tendance générale à la baisse[7] des quantités d'héroïne, de cocaïne et une augmentation discontinue de résine de cannabis. Comparé à la situation observée en 2000, on note une hausse des saisies d'herbe de cannabis. Les quantités saisies de cocaïne sont hautement variables depuis le début des années quatre-vingt-dix.

6 Sauf indication contraire, les données présentées se rapportent à l'année 2010. A défaut d'autres indications, les données entre parenthèses se rapportent à l'année 2009.

7 Les drogues en transit exclues ; uniquement les quantités destinées au marché national ont été retenues.

Le nombre de saisies est resté stable, à l'exception du cannabis (résine et herbe : 167 saisies en 1994 et 947 saisies en 2010) qui affiche une hausse marquée. Le nombre de délinquants impliqués spécifiquement dans les saisies montre une tendance générale à la baisse. Par contre, le nombre total de personnes impliquées dans le trafic illicite de drogues témoigne d'une tendance constante à la hausse [(2010 : 2.530 (2000 :1.758) personnes)]. Une majorité confirmée de ces prévenus sont impliqués dans le trafic de cannabis et sont de nationalité étrangère.

Les saisies de STA sont restées modestes au cours des dernières années et aucune saisie de crack n'a été rapportée à ce jour par les instances répressives. Les quantités saisies de substances de type XTC sont restées assez stables entre 1996 et 2008 alors qu'elles affichaient une nette hausse en 2009 pour diminuer de nouveau en 2010.

Mesures judiciaires et pénales

Le nombre de **procès verbaux** pour motifs d'infraction à la loi modifiée de 1973 est passé de 764 en 1995 à 2.546 en 2010. En ce qui concerne le nombre respectif de **prévenus**, on note une évolution semblable. En 2010 furent enregistrées 229 **arrestations** (2006 : 225) pour motifs d'infraction à la loi modifiée de 1973.

La population des prévenus se compose de 85% d'hommes, proportion qui variait entre 79% et 89% durant les dix dernières années. 808 prévenus nouveaux ont été enregistrés en 2003 ; 949 en 2010. Même si le **pourcentage de prévenus mineurs** (< 18 ans) a connu une tendance à la hausse entre 1994 (4.9%) et 2000 (8.7%), les données de 2009 témoignent d'une diminution nette (6.3%). Cependant en 2010 le pourcentage de prévenus mineurs a de nouveau augmenté (9.2%). L'héroïne et la cocaïne sont les principales substances impliquées dans les premières infractions. Les données statistiques fournies par l'administration pénitentiaire pour l'année 2009 font état de 927 (892) nouvelles entrées au CPL dont 232 (25.02%) pour infraction(s) à la loi du 19 février 1973 (Code : DELIT-STUP); une proportion qui représentait 42,6% en 1996.

Disponibilité et qualité des drogues illicites au niveau national

La production nationale de drogues illicites est jugée très limitée en termes de quantité et qualité. En 2010, aucun laboratoire clandestin de drogues n'a été démantelé. Selon les données fournies par la Police Judiciaire et par l'ensemble des unités décentralisées de la Police Grand-Ducale (sections de recherche), la grande majorité des drogues illicites consommées au Grand-Duché de Luxembourg sont originaires des Pays-Bas (production de cannabis et transit d'autres drogues) suivis de la Belgique (production d'ecstasy et d'amphétamines) et du Maroc (production de cannabis). L'importation de cocaïne depuis l'Amérique latine se fait souvent par le sud de l'Europe (Espagne, Portugal) pour être acheminée ensuite via la France, la Suisse, l'Autriche et l'Allemagne en direction des Pays-Bas, tandis que l'héroïne suit toujours la route des Balkans (Roumanie et Bulgarie) ou des dérivés de celle-ci (Pologne, Turquie, Bélarusse) et le pays producteur principal reste l'Afghanistan. Jusqu'aux années quatre-vingt-dix, la majorité des personnes impliquées dans le trafic illicite de cannabis ont été des consommateurs qui se sont procurés de faibles quantités de drogues, notamment aux Pays-Bas, dans le but d'une consommation personnelle et éventuellement d'une distribution au sein d'un réseau local restreint.

Au cours des dernières années des réseaux de distribution mieux organisés ont vu le jour sur le plan national. L'expansion de ces réseaux plus structurés a contribué à une hausse sensible de la disponibilité de drogues, particulièrement en ce qui concerne l'offre de cocaïne et de cannabis. Les nouvelles drogues synthétiques (Legal Highs) sont à surveiller de façon rapprochée et les indicateurs actuellement disponibles ne permettent pas de leur attribuer une prévalence élevée à ce jour. Un phénomène plus récent consiste par ailleurs dans le fait que les groupements ethniques ont davantage tendance à interagir et à se concerter au niveau de l'organisation de la vente de la drogue, tandis qu'auparavant, aucune filière criminelle ne cherchait le contact avec les autres groupes. Par ailleurs, ils œuvrent à délocaliser leurs points de vente vers des endroits moins visibles à la police, tels qu'appartements privés ou cafés. La proportion de trafiquants de drogues non-

luxembourgeois a augmenté jusqu'en 2005 pour ensuite diminuer sensiblement, bien que les trafiquants de drogues de nationalité étrangère représentent toujours 62,7% (60% en 2007).

Au vu de la position géographique du Luxembourg, la Police Grand-Ducale travaille en étroite collaboration avec ses pays voisins et les Pays-Bas. Dans le cadre d'accords de coopération policière internationale, des opérations à grande échelle sont régulièrement organisées afin de lutter contre le trafic de drogues. Dans le cadre de ces opérations, la Police met en place un dispositif de surveillance, d'observation et d'interpellation afin de combattre les flux illicites de stupéfiants en provenance des Pays-Bas et les phénomènes de trafic et de consommation régionale de stupéfiants. Aussi, le nombre d'arrestations de personnes originaires du Maghreb mais de nationalité néerlandaise a augmenté (filières dites « Road Runners »).

Depuis 2006, **la pureté** de l'héroïne jouit d'une certaine stabilité alors que lors des quatre dernières années, la cocaïne affiche une tendance à la baisse bien qu'en 2010 une légère augmentation ait été observée. Toutefois, il s'agira de suivre attentivement les variations importantes au niveau des puretés minimales et maximales et plus particulièrement les concentrations de THC dans différentes variétés de cannabis ayant atteint des taux maximaux historiques mais à ce jour exceptionnels ayant dépassés les 40% en 2009. D'autres phénomènes particulièrement inquiétants représentent l'apparition de nouvelles drogues de synthèse dont les effets et risques potentiels associés sont encore largement inconnus au moment de leur apparition, ainsi que la présence accrue d'adultérants dans les drogues illicites et notamment la lévamisole dans la cocaïne de rue.

Les prix de rue de l'héroïne et de la cocaïne connaissent des marges très importantes. Pour ce qui est du cannabis et de ses dérivés, on retient une stabilisation des prix au cours des dernières six années.

Consistance des indicateurs

Les indicateurs de réduction de la demande s'alignent sur les données de la réduction de l'offre (voir fig. 4.4). Les indicateurs indirects de la prévalence d'UPD reflètent les tendances documentées par des études approfondies, à l'exception des statistiques du nombre d'admissions en structures d'accueil à bas-seuil depuis 2000 ainsi que le nombre de surdoses mortelles entre 2005 et 2007. Ces tendances sont à attribuer respectivement à l'augmentation de la capacité d'offres des structures à bas-seuil et à un meilleur accès aux mesures de réduction de risques au niveau national ainsi qu'aux changements significatifs dans les domaines des offres et de consommation.

Ainsi, ces deux indicateurs semblent être influencés par des facteurs externes ne permettant pas de conclure à une augmentation de la prévalence des UPD et ne sont ainsi pas en contradiction avec une stabilisation générale de la prévalence de l'usage problématique de drogues au Grand-Duché de Luxembourg.

Le nombre de prévenus pour infractions à la législation nationale sur les stupéfiants s'était également stabilisé entre 1999 et 2009, alors qu'on y observe un accroissement sensible pour l'année 2010. Cette évolution récente semble en partie attribuable à une activité accrue des forces répressives, notamment dans la capitale aux alentours des offres bas-seuil en raison d'un accroissement des activités de ventes illégales de drogues. Dès lors, il s'agira de suivre ce paramètre de façon rapprochée en 2012 avant de pouvoir en tirer des conclusions.

Le nombre de cas de surdoses mortelles aux drogues illicites avait atteint un pic marginal en 2007 pour redescendre de façon sensible depuis lors.

SUMMARY

ANNUAL NATIONAL REPORT ON THE STATE OF THE DRUGS PROBLEM
(Edition 2011)

Drug policy: legislation, strategies and economic analysis

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

The 2009 governmental programme has set the framework for the elaboration of the third national strategy and action plan (2010-2014) for the fight against drugs and addictions. **The national strategy and action plan 2010-2014** relies upon the priorities of the Ministry of Health and a sustained collaboration with field actors and civil society. In order to optimise its impact, the new action plan has taken into account relevant issues from EU and EC treaties, **the EU anti drugs strategy 2005-2012** and the **EU drugs action plan 2009-2012**. The general aim of the national strategy and action plan is to contribute to a high level of protection in terms of public health, public security and social cohesion.

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

The **global budget of the Ministry of Health** granted to drug demand reduction related services and programs went up from 1,270,169 EUR in 1999 to 8,635,867.- EUR in 2010, thus witnessing a progression rate of 580%. Overall public expenditures in the field of drug demand and drug supply reduction per year are currently estimated at 38,500,000.- EUR (Origer, 2010). Expenditures exclusively allocated to drug related treatment reached 16,320,606.- EUR in 2010.

Epidemiological Indicators

Globally, UNODC[8] estimates that, in 2009, between 149 and 272 million people (3.3 to 6.1% of the population aged 15-64) used illicit substances at least once in 2008. Globally, cannabis users comprise the largest number of illicit drug users (125 - 203 million people). Based on global estimates of the number of cannabis, opiate, cocaine and ATS users, it is estimated that there were between 15 and 39 million problem drug users in the world in 2009.

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

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

National drug prevalence in the general population

Drug prevalence in school population and in general population

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

First, not yet validated data by the time of writing, of the latest national school survey (HBSC - 2010), including some 9,878 pupils aged 12 to 18 years, seem to reveal a decrease in life-time use of all retained illicit drugs compared to the situation observed in 1999 (HBSC - 1999) with the sole exception of cocaine use showing a (non significant) increase. Between 2006 (HBSC – 2006) and 2010, one observes a very weak increase in cannabis, XTC, heroin, solvents and magic mushrooms use; trends for other psychoactive substances remaining fairly stable.

As far as the use of illicit drugs during the last 12 months is concerned, similar trends do appear. To stress, however, that cannabis use during last 12 months and last 30 days seems to have stabilised since 2006. Also, the mean age at first use of cannabis and illicit drugs in general has increased (+/- 6 months) between 2006 and 2010. In 2010, 9.44% of youngsters aged 15 years reported first cannabis before having reached 15 years, whereas this same proportion figured 12.03% in 2006.

National prevalence of problem drug use (PDU)

Data on institutional contacts and drug treatment demands

The annual **number of PDU contacts** indexed by national institutions figured 5,415[9] in 2010 (2002: 4,701).

2,383 users have been indexed by national specialised drug demand reduction agencies and 2,318 drug law offenders by supply reduction agencies in 2002. In 2010 the same agencies have indexed 2,653 and 2,762 persons respectively. Overall the number of persons showing drug-related contacts with DR or SR agencies has reached a plateau between 2002 and 2008 and showed signs of increase in 2009 and 2010. During the referred period, however, the number of drug treatment demands constantly increased in contrast to the number of contacts with law enforcement agencies, with the notable exception of 2010. Referred to the general population aged 15-64, the proportion of persons in contact with DR or SR agencies for drug related matters, likewise PDU prevalence rates, has been generally decreasing between 2002 (15,8/^{1000} inhabitants) and 2009 (14,7/^{1000} inhabitants). In 2010, however, this rate shows a sensible increase exclusively due to an marginally high number of drug law offenders indexed by law enforcement agencies.

Socio-demographic profile of PDU

The **male/female ratio** of the PDU population currently sets at 4:1. Over the last decade the proportion of indexed non-native PDU has been showing strong variations but a clearly increasing trend since 2003 and signs of stabilisation over the last 3 years (+/-51%). The population of non-native drug users largely consists of Portuguese nationals (39% of total number of non-native PDU), representing a proportion that is higher than the one observed in general population (37%). Citizens of French and German origins occupy the second (23%) and third (10%) rank respectively. Italian citizens, who occupied the third place in non-natives drug law offenders over the last 9-years, only represented 2% in 2010 (rank 7).

9 In this figure double counting is included meaning that a given person could have been indexed twice and more by different institutions. It is thus not representing the actual prevalence, which has to be assessed by other methods.

The **mean age** of indexed PDU has been evolving from 28 years and 4 months in 1995 to 31 years and 7 months in 2010. The mean age of male PDU has been increasing faster than for females. The gap between youngest and oldest PDU has been stabilised in recent years, after years of increase as one observed a long-term increase of the population of PDU aged 40 years and more and a sensitive decrease in PDU aged less than 30 years. The mean age of native PDU is consistently lower than the one observed for non-natives. Worth mentioning is also the significant increase of the average age of overdose victims until 2008 (slight increase in 2010 compared to 2009 data) and an increasing proportion of minors among drug law offenders in 2010 (2010: 9%; 2009: 6%).

Problem drug use prevalence and consume trends

National data are provided by serial prevalence studies on PDU aged between 15 and 64 years performed in 1997, 1999, 2000 and 2007 data (Origer, 2009)[10]. The estimation performed on 2007 data provides an absolute prevalence of problem drug users (PDU) of 2,470 persons (C.I. (95%): 2,089 to 3,199). In terms of prevalence rates estimates for the same age categories, 7.67 out of 1,000 habitants aged between 15 and 64 years show problem drug use. According to available serial data for the years 1997 to 2007, absolute prevalence and prevalence rates of PDU have been showing an increasing trend until 2000. After a brief plateau, a decrease has been observed from 2003 onwards. A similar evolution occurred also for problem heroin use (2007: 1,900 PDU: 5,90/1000). Absolute prevalence of intravenous drug use (IDU)[11] has slightly increased compared with the situation observed at the end of the 20th century and so did the IDU prevalence rate in the national population aged 15 to 64 years. New data from the 2010 serial prevalence study will be available in 2012.

Injecting heroin use associated to **poly-drug use** has been reported being the most common consume pattern in PDU. The ratio of injecting opiates use to the inhalation mode has reached 2:1 in 2010. The prevalence of the use of cocaine as primary drug increased until 2006 and from there on discontinuously decreased. In 2010, the prevalence of problem cocaine use did not significantly increase compared to 2009.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use currently represents 8% (sensitive decrease). **Amphetamine** type substances and ecstasy related treatment demands are only weakly represented, which, however, does not inform on their prevalence in general population as RELIS data refer to PDU and not to the overall population of recreational drug users. The proportion of **poly-drug use** (76% in 2010) has stabilised at high level.

Drug-related treatment

The number of adult out- and in-patient clients tends to decrease, while out-patient minor treatment demanders have been continually increasing. The most remarkable increases between 2008 and 2010 have been observed in substitution treatment demanders and in the number of contacts in low threshold facilities (2010: 140,093 contacts). 4.7% of respondents are first treatment demanders, all treatment centres included. A confirmed trend has to be seen in the decrease of the proportion of substitution patients aged less than 25 years and the increase of the proportion of patients aged 40 years and more.

Health correlates and responses to consequences

The **HIV/AIDS prevalence**[12] in PDU has been slightly increasing in 2010 while the **infection of HCV (hepatitis C)** has been showing a clear decrease since 2009. Data from the National Laboratory of Retrovirology suggest a long term and discontinuous decreasing tendency of the average proportion of IDU

10 Downloadable at http://www.relis.lu

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

12 Related article published in 2010:
Origer A, Schmit J.-C. Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. *J. Epidemiol Community Health* doi: 10.1136/jech.2009.101378

in newly diagnosed HIV cases. From 2004 to 2008 this proportion has been varying between 7 and 14 % and fell down to 3.1% in 2009, to increase in 2010 to 6.4%. HIV infection rates in IDU situate around 8 percent, which stands for an increase, after years of stability.

The implementation of the 2005-2009 and 2010-2014 action plans has been accompanied by a significant yet discontinuous, overall decrease of **overdose cases** in the Grand-Duchy of Luxembourg (2010: 12 cases).

In terms of number of overdose cases in the general population of the Grand-Duchy of Luxembourg, this proportion figured 1.76 overdose deaths per 100,000 inhabitants aged 15 to 64 years in 2005 (2000: 5.9 cases per 100,000 inhabitants). In 2010, 3.5 (2007: 5.67) acute OD cases per 100,000 inhabitants were registered, which stands for a decreasing tendency. Forensic data from 1992 to 2010 show that the most frequently involved substance in drug-related death is heroin, followed by methadone and cocaine consumed in a polyuse context. All victims were male (100%) in 2010 and their mean age at the moment of death shows a discontinued increase over the past 16 years (in 1992: 28.4 years and in 2010: 31 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years has remained relatively unchanged. No underage victims were reported in 2010.

As regards nationality of overdose victims, 83% (57%) were natives, representing a considerable increase compared to previous years.

Social correlates and social reintegration

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

The educational levels of PDU are low and mostly incomplete. The **residential status** of the latter has improved over the last years. In 1995, 31% of the users reported stable accommodation; currently the same proportion situates 62%. This improvement is partly due to various accommodation and housing offers for addicted people set up in the framework of the drug action plan. Recent figures tend to confirm that although specialised accommodation offers have been further developed, the current economic situation has created an even higher demand for this type of housing.

The **unemployment rate** (69%) tends to plateau. However, the proportion of professionally active respondents reporting a stable job situation (e.g. long term contract) has sensibly decreased over the 3 last years, which should also be put in the context of the current economic parameters.

Harm reduction activities

The **number of contacts** indexed by national low threshold agencies has increased dramatically over the last ten years (2010: 140.093 / 2005: 47,739), and so has the number of syringes distributed by the same agencies. The proportion of **new clients** within low threshold settings is on the increase. Approximately 50% of clients are aged between 25 and 34 years, and 40% of clients aged 35 and more is observed. 56% (56%) of clients are natives.

The number of **syringes** distributed in the framework of the national needle exchange programme (2010: 308,350 / 1996: 76,259), stabilised in 2005 and has been decreasing from 2006 onwards. A new upward trend was observed in 2009/2010. Return rates of used syringes have been increasing during the referred period and reached 96% in 2010. An increasing majority of injectors (46%) procure their syringes in specialised agencies followed by pharmacies and automatic dispensers.

Law enforcement indicators[13]

Seizures of illicit substances at the national level

Great variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analysis from 2000 onwards indicates a general decreasing tendency of heroin and cocaine seizures, whereas cannabis resin seizures[14] are showing a discontinuous increase. Quantities of herbal cannabis seized have increased compared to the situation observed in year 2000. Cocaine seizures (quantity) are highly variable since the beginning of the nineties.

The number of seizures did not show significant variations during the same period, with the exception of cannabis (resin and herbal products) going up significantly. Markedly, the number of cannabis seizures has risen from 167 to 947 between 1994 and 2010. Also, the number of offenders involved in seizures has been showing an overall decreasing trend. The total **number of persons** involved in traffic has followed a constant upward trend [2000: 1,758 (2010: 2,530) persons]. A confirmed majority of offenders involved in cannabis traffic are natives.

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

Drug law offenders and prison sentences

The **number of police records** for presumed offences against the modified drug law of 1973 went from 764 in 1995 to 2,546 in 2010. A similar evolution has been observed with regard to the **number of drug law offenders**. In 2010, 229 **arrests** (225 in 2006) for presumed drug offences have been reported.

The population of drug law offenders is composed of 85% **males**; a proportion that has been varying between 79% and 89% during the past decade. 808 **first drug law offenders** were reported in 2003 and 949 in 2010. Also the **percentage of minors** (< 18 years) among drug law offenders, having increased between 1994 (4.9%) to 2000 (8.7%), shows a clear decrease confirmed by 2009 data (6.3%). In 2010 however, the percentage of minors among drug law offenders increased again (9.2%). Heroin and cocaine are the main drugs involved in registered first drug offences.

Since 1998, **non-natives** (53% in 2010) have been representing the majority of drug law offenders (52-68%). 38% (34%) of the registered cases were **first drug law offenders**. National **prison data** of 2010 refer to 927 (892) new admissions of which 232 (25.02%) were related to drug law offences; a proportion that represented 42.6% in 1996.

Profile of the national drug market

The national manufactoring and cultivation of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2010 no clandestine drug-manufacturing laboratory has been dismantled at the national level. According to observational data provided by the Judicial Police and all decentralised national police units, a majority of illicit drugs consumed in the G.-D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). Cocaine found on the national market is originating from Latin America and mostly transits South of Europe (Spain, Portugal) to reach the Netherlands via France, Switzerland, Austria and Germany. Heroin follows the main Balkan route and its derivate (Poland, Turkey, Belorussia).

13 If not specified, data refer to 2010. Figures in brackets refer to 2009 if not otherwise specified.
14 Non–transit drugs destined to the national market

In recent years more organised distribution networks have been developing nationally. The expansion of these structured distribution networks by criminal associations thus contributed to a significant increase in drug availability, and particular in the supply of cocaine and cannabis. "Legal highs" are closely monitored and available indicators show a yet low prevalence. More recently different ethnic groups have created synergies in drug distribution and traffic, whereas previously these groups have been operating separately. Moreover, it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible for police as for instance private flats, bars or motorway rest areas in order to meet their clients halfway and sell them gross quantities. The proportion of non-natives involved in drug trafficking has been increasing until 2005 and has since then been decreasing quite sensibly although non-native drug traffickers represent 62.7% (60% in 2007).

Over the last 6 years, **purity** of heroin has remained fairly stable whereas average potency of cocaine is on the decrease for the last 4 years, with a slight increase for 2010. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (35- 40%) in cannabis resin products seized in Luxembourg in recent years. **Prices** show broad ranges for heroin and cocaine. Cannabis and derivates, however, have known certain stability during the last 6 years as far as street retail prices are concerned.

Most Relevant Trends

All indicators included, a decrease in PDU prevalence rates has been observed over recent years although results from latest prevalence studies suggest that IDU prevalence has slightly increased. Over the last decade an increasing number of PDU entered treatment or use low threshold offers and fewer come in contact with law enforcement agencies (exception 2010).

Injecting opiate use, combined with polyuse, is the predominant PDU pattern. However, overall quality of street drugs decreased, which resulted in an overall increase of polydrug use. The number of acute drug deaths went down to 12 cases in 2010 (27 cases in 2007).

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

There is also great concern about infectious diseases in drug users and in particularly IDU. HIV rates in PDU were low and stable from 2000 to 2008, but show an increasing tendency for 2009 and 2010. Hepatitis C has been increasing continuously from 2000 to 2008, to decrease again in 2009 and 2010. Latest research results based on serological testing (Origer & Removille, 2009) suggested HCV infection rates over 70% and even higher prevalence rates in prison populations in 2007.

The national drug market is led by more aggressive selling techniques and distribution strategies due to improved collaboration between criminal groups of different ethnic origins previously operating independently. A tendency to move selling points to locations or settings less visible for police as for instance private flats or bars is also observed in this context. Attention has finally to be paid to the striking differences in maximum and minimum purities of street drugs as well as to a historically high maximum concentration of THC (over 40%) in cannabis samples seized over the last years. Heroin purity has remained fairly stable, but cocaine purity and MDMA purity in XTC-like products has been decreasing over the last 10 years. In 2010 however, MDMA purity peaked since its first seizure.

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

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

Consistency between Indicators

Demand reduction indicators are consistent with supply reduction data (see fig. 4.4). Indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies except for admission statistics in low threshold drug agencies from 2000 onwards and the number of fatal overdoses between 2005 and 2007. These trends are respectively to be linked to an increase in capacities of low threshold offers and better access to harm reduction measures at the national level and significant changes in supply and consume patterns.

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

The number of drug law offenders has also stabilised between 1999 and 2009 but shows a peak in 2010. This recent evolution might be partly explained by the fact that law enforcement agencies increased their presence and interventions, notably in the vicinity of the supervised drug injection and low threshold facilities in order to fight increased drug deal activities. Next years trends of this particular indicator have to be interpreted in the light of further contextual data.

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

PART A:
NEW DEVELOPMENTS AND TRENDS

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

INTRODUCTION

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

The governmental programme 2009[15], foresees to further develop the national drugs action plan and specifically refers to the decentralisation of care and harm reduction structures, to further improve surveillance mechanisms in drug substitution treatment, to the creation of a heroin assisted treatment programme and to the extension of post–therapeutic offers. Further efforts are to be invested in effectiveness and efficiency evaluations of drug treatment offers and services.

The 2010 – 2014 national action plan on drugs and addictions built upon the outcome of the external evaluation of the national drug strategy and action plan 2005-2009 performed by the Trimbos Instituut[16] (NL) in 2009.

GENERAL LEGAL FRAMEWORK[17]

Drug legislation and recent drug-related laws

The basic national drug law, namely: 'Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie[18]' regulates both, the selling of controlled medicaments and the fight against drug addiction and dates back to the 19 February 1973. It has been last amended by the law of 27 April 2001[19]. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of treatment and harm reduction measures, namely, drug substitution treatment, needle exchange and shooting galleries (state accredited and, in addition to article 13 of the Grand ducal decree of 30 January 2002 (see below), Heroin Assisted Treatment (HAT).

No new law related to drugs or precursors has been voted in 2010.

15 Gov. Declaration of 2009, http://www.gouvernement.lu/gouvernement/programme-2009/programme-2009/index.html
16 Trimbos Instituut (2009). Evaluation of the national drug action plan (2005-2009) of Luxembourg, Utrecht. Available at : http://www.ms.public.lu/fr/activites/medecine-sociale-toxicomanie/index.html
17 Legal texts prevail on selectively produced summaries. The integral national legislation on drugs and drug addiction is available under: http://www.emcdda.europa.eu/eldd
18 Official gazette A 1973, p.319
19 Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001)

Grand Ducal Decrees

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

- Grand ducal decree of 4 **March 1974** regarding certain toxic substances
- Grand ducal decree of 20 **March 1974** regarding certain psychotropic substances
- Grand ducal decree of 26 **March 1974** establishing the list of controlled narcotics
- Grand ducal decree of 8 **May 1993** regarding commerce of narcotics and psychotropic substances
- Grand ducal decree of 2 **February 1995** regarding the production and distribution of certain substances used in the illicit production of narcotics and psychotropic substances
- Grand ducal decree of 6 **February 1997** regarding substances listed in schedules III and IV of the UN Convention on psychotropic substances of 21 February 1971.
- Grand ducal decree of **30 January 2004** modifying the grand ducal decree of 2 February 1995[20]
- Grand ducal decree of **13 February 2007** on the surveillance and commerce of drug precursors[21]

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

CHANGES IN 2010: The grand ducal decree of September 30, 2010[22] modifies the annex of the grand ducal decree of 20 March 1974 on certain psychotropic substances by putting *MEPHEDRONE (4-MMC or 4-méthylmethcathinone)* under national control.

Laws implementation

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

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

The modified 1973 law essentially remains a repressive law, towards drug consumers as well as dealers. Even though the 1973 law does not specifically provide for alternative measures to prison for drug-addicted law offenders, the following options exist.

In accordance with article 23 of the 1973 law, cases involving personal use of drugs (individually or in a group) and/or cases involving offences against article 8 of the 1973 law are dropped if the offender, before the illegal use was disclosed, undertook treatment for drug addiction. Moreover, the public prosecutor can offer the offender the option of voluntary treatment of his/her addiction.

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

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

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

22 Règlement grand-ducal du 30 septembre 2010 modifiant le règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes Official gazette A 2010, p. 2998 (Adoption: 30/09/2010, Entry in force: 06/10/2010).

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

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

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

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

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

The law of 27 April 2001[23] modifying the basic drug law of 19 February 1973 by decriminalising cannabis use, and enhancing the differentiation of penalties according to the type of drug offences and the nature of controlled substances involved and the grand ducal decree of 30 January 2002[24] on substitution treatment, have largely contributed to increase the congruity between drug legislations and prosecution routines. Also, current drug legislation and prosecution policies put higher priority on drug dealing and trafficking than on drug consumption and promote harm and risk reduction measures. The creation of a national supervised drug consumption room is a sound example of this holistic approach.

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

NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

Coordination mechanisms

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

At the national level, the coordination among the competent ministries takes place in the *Inter-ministerial Commission on Drugs* (ICD), chaired by the national drugs coordinator. The ICD is composed of official delegates from involved governmental departments and constitutes the top advisory level with respect to

23 Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001) See also ELDD
24 Official gazette A 2002, p.232 (Adoption: 30/01/2002, Entry in force: 12/02/2002) See also ELDD

coordination and orientation of actions. Both, the ICD and the Ministry of Health are responsible for the implementation of national drugs strategies and action plans. The ICD, has an advisory role and addresses issues ranging from illicit drug use to alcohol use and prescription drugs under the general heading of addictive behaviour and its consequences.

The National Drug Coordinator is also the head of the national delegation within the Horizontal Drugs Group (EU Council) and the national permanent correspondent within the Pompidou Group (Council of Europe). Furthermore, he has been nominated chair of the national substitution treatment surveillance commission in 2010 and is member of the national AIDS surveillance commission.

National plan and strategy

Having taken into consideration the EU drugs strategy 2005-2012, the EU drugs action plan 2009-2012, the national strategy and drugs action plan are meant to contribute to a high level of health protection, public security and social cohesion and rely on two policy pillars, namely supply reduction and demand reduction. More precisely, it is designed to contribute to reduce initiation of drug use, to develop and maintain diversity and quality in care and treatment offers, to tangibly reduce drug use prevalence in the general population as well as health and social damage generated by illicit drug use and drug trafficking.

Furthermore the 2010-2014 national action plan[25] includes, in addition to international cooperation and research, information, evaluation (retained by the EU action plan), two more cross-cutting themes: coordination and harm, risk and nuisance reduction. Luxembourg considers the latter two activity fields to be essential and of transversal nature.

The new governmental drugs strategy builds upon a more holistic approach than the previous ones. It addresses addictive behaviour as a whole and not only illicit drugs and drug addiction. Thus alcohol, tobacco and psychotropic pharmaceutics dependence as well as addictive behaviour not associated with substance use are now an integral part of an unique strategy. Specific action plans have been conceived or are currently under preparation in order to integrate the framework of a global national policy on addictions.

Operational objectives are as follows:

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

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

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

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

Implementation of policies and strategies

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

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

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

Evaluation of policies and strategies

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

Beside efforts made by all involved actors and networks, the positive outcome has also to be related to the considerable increase of the budgetary means allocated to the fight against drug addiction. An increase of almost 300% of the budget invested by the Ministry of Health in drug demand reduction occurred between 2000 and 2010.

Budgetary means invested allowed to increase resources in terms of primary prevention, to extend admission capacities of low threshold services, to increase the number of post-therapeutic offers, to further regionalize ambulatory treatment offers, to improve technical control measures related to substitution treatment, to reduce risks and damages, especially related to synthetic drugs and the transmission of certain infectious diseases, endemic to the population of PDU, to reduce the rate of drug overdoses and finally to promote research activities in the field.

Over the last 10 years the concept of implementation follow-up, evaluation and external evaluation strategies have gained in importance in the field of drugs and drug addiction. In the beginning of 2010, the Minister of Health jointly with the National Drug Coordinator has presented the new drug strategy and action plan 2010 – 2014. The referred action plan is based on the evaluation outcome of previous action plans and the assessment of current and future needs. In this context and for the first time nationally, a final external output and progress evaluation of the national drug strategy and action plan 2005-2009 has been performed (Trimbos Instituut)[26] in 2009.

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

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

In implementing the evaluation the following guiding principles were applied:

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

The evaluation report also lists a set of recommendations regarding the new National Drug Action Plan, the coordination structure and the policy-making process. Main results and recommendations were presented in the 2010 edition of the national drugs report. In addition to the recommendations of previously referred

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

to working groups, the final output of the external evaluation exercise has been serving the National Drug Coordinator and the Interministerial Commission on Drugs to elaborate the new national drugs action plan 2010-2014.

Other drug policy developments: Initiatives in Parliament and civil society

Drug-related parliamentary questions submitted during the reporting period mainly addressed the use and availability of mephedrone and the use of cannabis in research.

No projects or propositions of law in relation with drugs or drug addiction were introduced in 2010 and no specific Parliamentary debates or initiatives in the field of illicit drugs are to be reported.

Special topics addressed by the GIT in 2010 were:
- regulatory means to prohibit the selling and use of substances able to reduce levels of drug concentration in urine or blood of drug users and thus to distort test results;
- the spread of shisha smoking;
- substitution treatment and diacetylmorphine assisted treatment;
- the phenomenon of research or designer drugs and their diversion. Creation of new legal instruments to fight the phenomenon of "legal highs". Regulation of selling and confiscation of psychoactive substances not yet controlled.

ECONOMIC ANALYSIS[27]

Public expenditures

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

- Budget lines may be generic (legal & illegal drugs), aggregated (addiction prevention), over inclusive (social solidarity) or unidentifiable (others),
- Apportionment of budgets may not be provided,
- Difference between provisional budget, voted budget and final expenditure (provisional budget often more detailed than voted budget),
- Expenditures may be annual, multiannual, unique, ordinary, extraordinary, etc. If they occur during the study reference year, they should be included even though they might give a biased picture of average or routine expenditures, especially when they are important (e.g. investments in real estate)[28],
- In terms of follow-up: budget lines may be restructured, integrated or divided over time,
- In the field of public health, expenditures may result from direct state financing or social security reimbursement,
- Lack of clarity due to national mixed (Multi-ministries) financing (e.g. Public research Centres – multi projects' financing) or national & EU & International shared financing,
- Eligibility of cooperation projects vs. variability of yearly contributions,
- Assessment of impact of general education and educational interventions (e.g.) on DDR impossible.

27 See related chapter in Part B

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

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

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

Methodology

In the 2010 edition of the present report an overall estimation of direct public expenditures in 2009 compared to 1999 has been presented. Main results of these comparative studies are summarised in table 1.4. As overall estimations of public expenditures are not feasible on a yearly basis, the objective of the present analysis is to assess exclusively direct public health expenditures for the fight against drugs and drug addiction (drug-related prevention and treatment costs). The constituent concepts are defined as follows:

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

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

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

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

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

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

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

Main data sources:
- Laws and projects of law regarding the budget of revenues and expenditures of state
- Annual ministerial activity reports
- Activity reports of specialised agencies
- State conventions with NGOs
- Annual financial statements of specialised NGOs
- Statistical outputs and financial breakdowns of the CNS

Main reference documents:

Ministère des Finances (2010). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.
Ministère de la Santé (2011). Rapport d'activités 2010, Ministère de la Santé, Luxembourg.
Ministère de la Santé (2005). Stratégie et plan d'action national en matière de lutte contre les drogues et les toxicomanies 2005 – 2009. Ministère de la Santé. Luxembourg.
Ministère de la Santé (2009). Stratégie et plan d'action national en matière de lutte contre les drogues et les dépendances 2010 – 2014. Ministère de la Santé. Luxembourg.
Origer, A. (2002b). Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies. Séries de recherche n°4, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.
Origer, A. (2010). Update of direct economic costs of national drug policies in 2009. National Report on the state of the drugs problem in the Grand Duchy of Luxembourg. Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

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

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

Tab. 1.1 National estimates of labelled and non-labelled public drug demand reduction expenditures (Data year: 2010)

7.	Ministry of Justice	S7.2/12.370 0.30 TOX PROGRAMME: Care and treatment programme for drug addicts in prison	820.000-	Extracted from the national state budget 2010
10-11	Ministry of Education [...]	S 11.4 12.301 08.30 Drugs prevention campaigns in schools	2,000.-	Extracted from the national state budget 2010
14	Ministry of Health	S 14.0 12.000.05.00 Fees for National Drug Substitution treatment commission	0.-	Extracted from the national state budget 2010
		S 14.1/33.013 05.23 – 33.015 05.23 Staff and operational costs of specialised drug agencies conventionned by state (25/40% non specialised)	7,548,226.-	Idem
		S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	537,000.-	Idem
		S 14.2 12.301 05.20/12.801 05.20 Toxicological surveillance of drug addicts	150,000.-	Idem
14.1	Directorate of Health	S 14.1/33.014 05.23 Staff and operational costs of drug related activities of the National Aids counselling Centre	201,449.-	25% of total budget of the centre: average proportion of PLWHIV/AIDS infected via IDU in clients
17	Ministry of Social Security*	S 17.2 Staff, operational and mission costs for agents in charge of drug treatment referral abroad	80,000.-	Estimation by MSS based on analysis of work/mission/ career
22	Ministry of Public Works	Maintenance work on/in buildings occupied by specialised NGOs (not covered by other budgets)	25.000.-	Extracted from the national state budget 2010

* Ministry of Social Security (Health expenditures)
HIV/AIDS treatment (IDU related infections and health costs)
For HIV/AIDS treatment rates the following calculation formula has been applied:
- A: Total number of registered PLW HIV/AIDS infected via IDU (diagnosis reporting) (status: alive) (if available: Total number of PLWHIV/AIDS infected via IDU X mortality rate of target population) (higher precision (if available): Total number of PLW HIV/AIDS in treatment during year X that might be provided directly by central social security department)
- B: Average cost of HIV/AIDS treatment/ year
- Total cost of PLW HIV/AIDS IDU Treatment = A X B

NON LABELLED EXPENSES			
HEALTH/SOCIAL INSURANCE			
	A. Substitution treatment		
	Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (net patients' contribution excluded)	327,451.-	Detailed breakdown by the National Health Insurance Funds
	Reimbursement of pharmacies fees generated by substitution medication preparation /delivery	48,835.-	Detailed breakdown by the National Health Insurance Funds
	Reimbursement of medical counselling costs related to substitution prescriptions	234,796.-	Number of substitution prescriptions X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)
	B. Inpatient hospital drug treatment		2010 data
	Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification)	3,001,734.-	ICD-10, F11, F12, F14, F15, F16,F18, and F19 hospital episodes X average cost per episode (adjusted CNS data)
	Medical counselling costs associated to hospital treatment episodes	201,855.-	Number of medical consultations X reimbursed fees according to duration of stay
	C. Drug treatment abroad		
	Reimbursement of drug treatment costs abroad/ e.g. residential therapy or therapeutic offer unavailable in Luxembourg	1,428,800.-	Year-adjusted breakdown provided by CNS
	D. Inpatient therapeutic treatment extra-hospital	797.705.-	Institution specific budget of 2001 adjusted for salary costs and inflation
	E. Drug treatment costs subsidised by Min. Health	105,755.-	Budgetary section 14.0.34.011: Breakdown of real costs generated by drug treatment not covered by the CNS
	F. Cost of HIV/AIDS treatment provided to patients infected via IDU	576.000.-	Number of HIV/AIDS patients infected via IDU x yearly average cost of HIV/AIDS treatment X reimbursable proportion
	G. Estimation of state revenue loss from low renting prices for real estates provided to specialised NGOs	234,000.-	Yearly sum of differences between paid rent and market value rent.

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

Ministry / Department	Budget / Expense (EUR)	COFOG 1	COFOG 2	SECTOR
01 Ministry of Foreign Affairs and Immigration	**21,400.-**	Gf01	Gf0101	S1312
07 Ministry of Justice	**17,057,430.-**	Gf03 Gf03 Gf03 Gf03	Gf0306 Gf0303 Gf0304 Gf0301	S1312 S1312 S1312 S1312
12/13 Ministry of Family, Social Solidarity and Youth	**37,700.-**	Gf10 Gf10	Gf01010 Gf01004	S1312 S1312
14 Ministry of Health *14.1 Directorate of Health* *14.2 Public Health Laboratory*	**491,341.-**	Gf07 Gf07	Gf0704 Gf0702	S1312 S1312
17 Ministry of Social Security *Health / Social insurance* A. Substitution treatment B. Inpatient hospital drug treatment C. Drug treatment abroad D. Drug treatment costs (Min. Health) E. Drug treatment costs subsidised by Min. Health F. Cost of HIV/AIDS treatment provided to patients infected via IDU G. Estimation of state revenue loss from low renting prices for real estates provided to specialised NGOs	**7,258,805.-**	Gf07 Gf07 Gf07 Gf07 Gf07	Gf0704 Gf0701 Gf0702 Gf0703 Gf0706	S1312 S1312 S1314 S1314 S1314
TOTAL B	**24,866,676.-**			
TOTAL A+B	**38,438,483.-**			

Tab. 1.3 Comparative analysis of drug demand reduction costs in Luxembourg 1999 vs. 2009 /2010 (EUR)

	1999	2009	2010	Progression rate 1999-2010	Progression rate 2009-2010
Total expenditure	6,903,203.-	15,458,853.-	16,320,606.-	136 %	6%
Expenditure per inhabitant	16.-	31.-	32.-	100 %	0.3%
Expenditure per PDU	2,937.-	6,209.-	6,607.-	125 %	6.4%
Percentage of GNP	0.03	0.04	0.04		
Percentage of state budget	0.15	0.17	0.19		

Source: Origer 2002, PF OEDT, REITOX report 2009

Tab. 1.4 Comparative analysis of overall direct drug-related public expenditures in Luxembourg 1999-2009 according to various indicators (EUR) (Origer 2002, 2010)

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

Budget

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

Fig. 1.1 Annual budget of the Ministry of Health allocated to drug demand reduction activities 2000 - 2011

	2000	2005	2011
Budget (EUR)	2,066,000.-	6,196,000.-	8,321,620.-
Cumulative progression rate	Reference year	200%	303%

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

Fig. 1.2 Annual progression of the budget of the Ministry of Health and human resources allocated to drug-related activities 2004 - 2011

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

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

Funding arrangements

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

The funding of drug action plan is subject to an annual budgetary decisions process. Specific local projects designed by non-governmental actors requiring external financial support are generally submitted to respective ministries or to other national funding sources (Fund Against Drug Trafficking, Foundations, private funds, etc.) or international bodies (EU, EMCDDA, etc.).

Social costs

Origer (2002) assessed **the direct economic costs of policies and interventions in the field of illicit drug** use referred to year 1999 (see www.relis.lu). An update of the Origer 2002 study has been performed according to data for 2007 and results have been presented in the 2008 edition of the national report.

In July 2006, the STATEC (Central service of statistics and economical studies) published **a study estimating the economic impact of the illegal drugs related activities in Luxembourg** over the period 1999 to 2004 (Statec, 2006). The study was carried out within the framework of a European project intended to improve the comparability and the coverage of national accounting. Results were presented in the 2009 edition of the national report.

National media coverage of drug-related issues

Relation with the media is an indispensable tool in communications strategies aiming at informing a broad public by providing up-to-date and reliable data on the numerous topics related to drugs and drug use. In 2010 the NFP performed an in-depth analysis of national written media base on an exhaustive press review and focusing on thematic areas touched upon and frequency of appearance. Of 454 articles on drug related matters, 90% were published by the most read national daily newspaper. Most represented topics in order of importance are: national short news, international short news and doping in sports. Table 1.3 summarizes main results and covers the period from August 2009 to July 2010.

Fig. 1.3 National coverage of written media[29] regarding drug-related topics from August 2009 to July 2010

Paper/magazine / Topic	1	2	3	4	5	6	7	8	9	10	11	12	13	TOT	%
SR, law enforcement														**111**	**24**
National short news item (arrests, seizures)	66											2	9	77	
Court news (convictions, sentences)	7													7	
National drug scene (perquisitions, etc)	15												4	19	
Prison related topics	3				1								1	5	
Road safety	2												1	3	
Research														**4**	**1**
Statec, Ceps/Instead	4													3	
Substances and addiction														**48**	**11**
Addictions in general	1													1	
Cannabis							1							1	
Medicaments	1													1	
Doping	40												2	42	
Mephedrone						2							1	3	
Campaigns, prevention, laws														**45**	**9.91**
Drugs in general	6			1	1			1					1	10	
Alcohol	4				1									5	
Tobacco	12												4	16	
Infectious diseases	7												5	12	
Others						1							1	2	
Specialised drug agencies														**49**	**11**
NGOs	5	1				1							1	8	
TOXIN / Drug injection room	7	2	1	2	7	2	11		2	1	1	1	4	41	
EMCDDA National Focal point														**7**	**1.54**
Activities and publications	3					2							2	7	
Ministry of Health , Government, Parliament														**28**	**6**
EU drugs strategy and action plans	2	2	2	1	1	1	1				1		1	12	
Health Commission, Questions to government, Interministerial Groups on Drugs	10				1								1	12	
Heroin Assisted Treatment	1													1	
Substitution treatment		1			1	1								3	

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

External relations														**159**	**35**
Organised crime/ trans-border cooperation	5												4	9	
International Organisations	1													1	
Afghanistan	2												1	3	
Mexico	23												5	28	
HIV	14													14	
International short news	54												50	104	
Miscellaneous														**3**	**0,66**
Readers letters	3													3	
TOTAL	**298**	**6**	**3**	**5**	**12**	**10**	**13**	**1**	**2**	**1**	**2**	**3**	**98**	**454**	**100**
PERCENTAGE	**66**	**1.32**	**0.66**	**1**	**2.64**	**2.2**	**2.86**	**0.22**	**0.44**	**0.22**	**0.44**	**0.66**	**21.59**		**100**

Source: NFP 2010

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

INTRODUCTION

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

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

Prevalence estimations on drug use in the general population are based on data collected in more (e.g. schools) or less (general population: age group 15-64 years) targeted and representative samples of the national overall population. According to the most recent surveys, cannabis and derivates are by far the most common illicitly used psychoactive substances in the national population followed by Amphetamine Type Stimulants (ATS). Cannabis use in youngsters has been stabilizing over recent years but still shows the highest prevalence regardless considered age categories, whereas the prevalence of other psychoactive drugs varies according to age and data collection setting factors. Recent data from the latest HBSC study 2010 are briefly addressed in the summary.

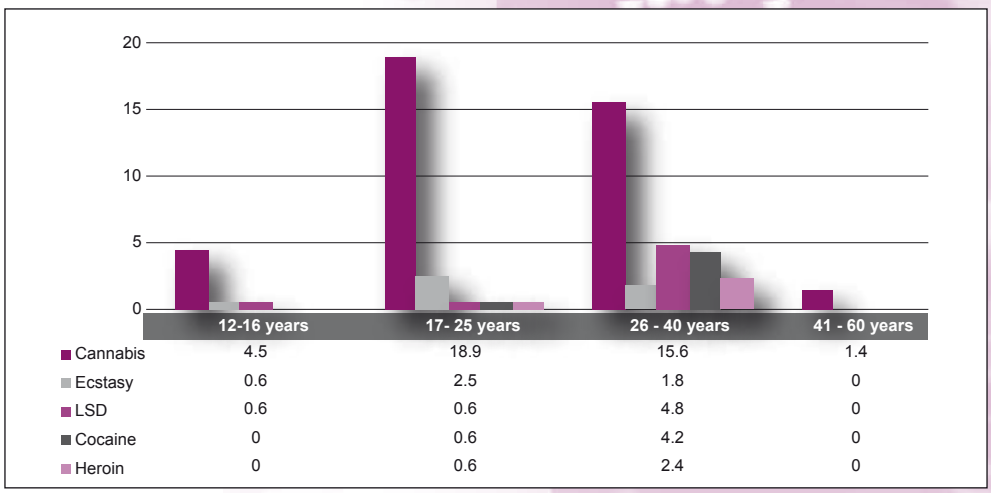
DRUG USE IN THE GENERAL POPULATION

To date, no national, large-scale (representative) general population survey on drug use has been conduced. Several community or targeted population surveys however allow estimating current prevalence.
A primary prevention pilot project at community level was launched by the CePT in 1995. In 2000, 13 council districts participated in this project. In the framework of this project a non-representative survey on drug use in the general population (reference 1: "Fischer 1999 study") was conducted.

REFERENCE 1.	Fischer U. CH. & Krieger W. (1999). Suchtpräventioun an der Gemeng – Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg. **EN:** Drug prevention at the communal level
Year of data collection	1998
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	7 council districts of the Grand Duchy of Luxembourg
Age range	12-60 years
Data coll. Procedure	Anonymous self-administrated questionnaires
Sample size	667 valid cases

Source: Fischer 1999

Fig. 2.1 Lifetime prevalence according to age (valid %) (Fischer 1999)

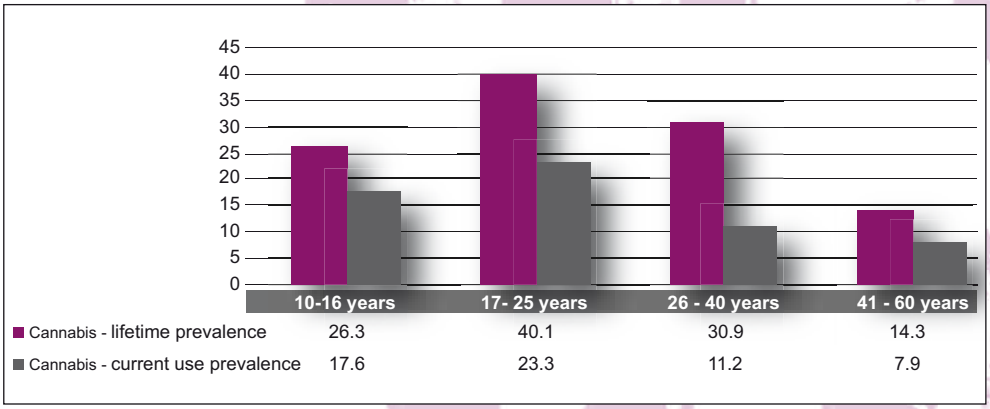


A second survey organized by the CePT was published in 2000 ("Fischer 2000 study"). Even though cannabis consumption was the main subject of the study, several other substances have been taken into account. The samples have been drawn on the one hand from a cinema visitor's population in Luxembourg City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

REFERENCE 2.1 Fischer U. CH. (2000) Cannabis in Luxemburg – Eine Analyse der aktuellen Situation, CePT, Luxembourg.
EN.: Cannabis in Luxembourg

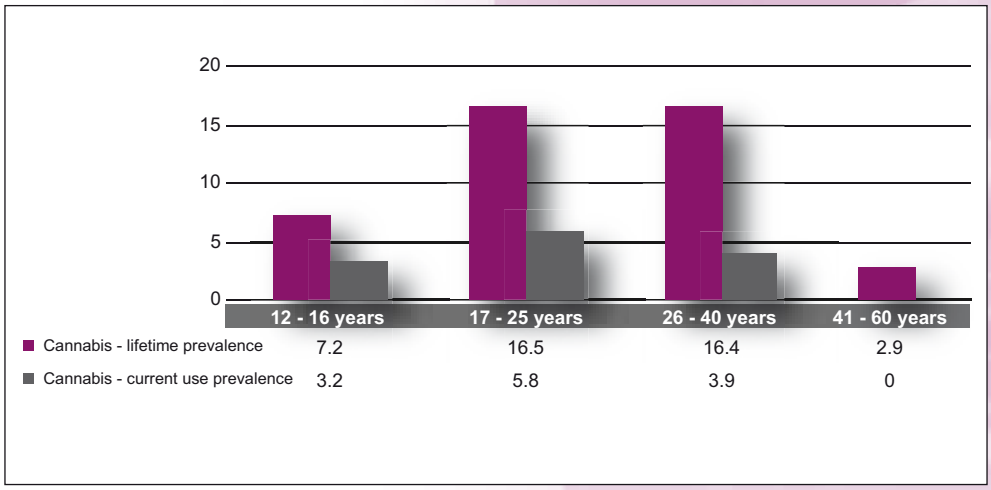
Year of data collection	1999
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	Cinemas in Luxembourg-City
Age range	15-64 years
Data coll. Procedure	On-site interviews
Sample size	991 valid cases
Sampling procedure	Random sampling of cinema customers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

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



REFERENCE 2.2	Fischer U. CH. (2000) Cannabis in Luxemburg – Eine Analyse der aktuellen Situation, CePT, Luxembourg. **EN.:** Cannabis in Luxembourg
Year of data collection	1999
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	6 district councils
Age range	12 to 60 years
Data coll. Procedure	Mail questionnaire
Sample size	486 valid cases
Sampling procedure	Random sampling
Response rate	27.7%

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



Regarding **lifetime prevalence**, the Fischer 1999 study revealed that youngsters from the age group 17 to 25 (18.9 %) are most vulnerable to cannabis consumption. The Fischer 2000 study reported 40.1% of lifetime prevalence concerning cannabis use (cinema sample). Discussions are currently held with the Ministry of Health to collaborate in a general study on health behaviour in general population in order to include items on drug use. This study may be conduced given required financial means are granted.

DRUG USE IN THE SCHOOL AND YOUTH POPULATION

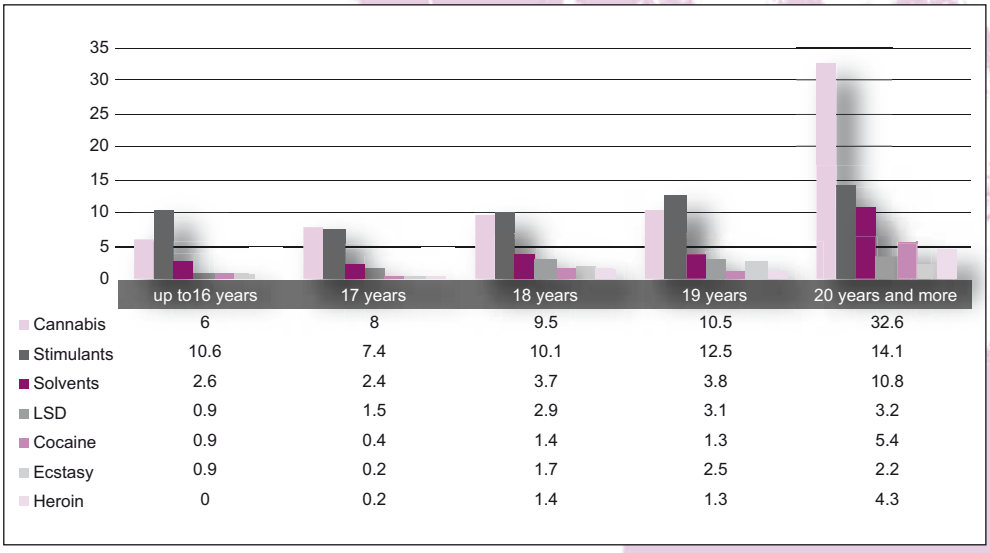
National school surveys may be divided in **two categories**. A first category refers exclusively to drug prevalence surveys in schools; the second refers to cross-sectional surveys combining data collection in school settings and other youth environments.

SURVEYS: CATEGORY 1

REFERENCE 1 **Matheis J. et al.** (1995) 'Schüler an Drogen', IEES, Luxembourg.
EN.: Students and Drugs

Year of data collection	1992
Single/repeated study	Repeated study 1983 – 92
Context	Public Health
Area covered	Nation wide
Type of school	5th years of all types of secondary school classes at the national level
Age range	16-20 years (AGE ENTERING 5TH CLASS)
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	1,341

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



	up to16 years	17 years	18 years	19 years	20 years and more
Cannabis	6	8	9.5	10.5	32.6
Stimulants	10.6	7.4	10.1	12.5	14.1
Solvents	2.6	2.4	3.7	3.8	10.8
LSD	0.9	1.5	2.9	3.1	3.2
Cocaine	0.9	0.4	1.4	1.3	5.4
Ecstasy	0.9	0.2	1.7	2.5	2.2
Heroin	0	0.2	1.4	1.3	4.3

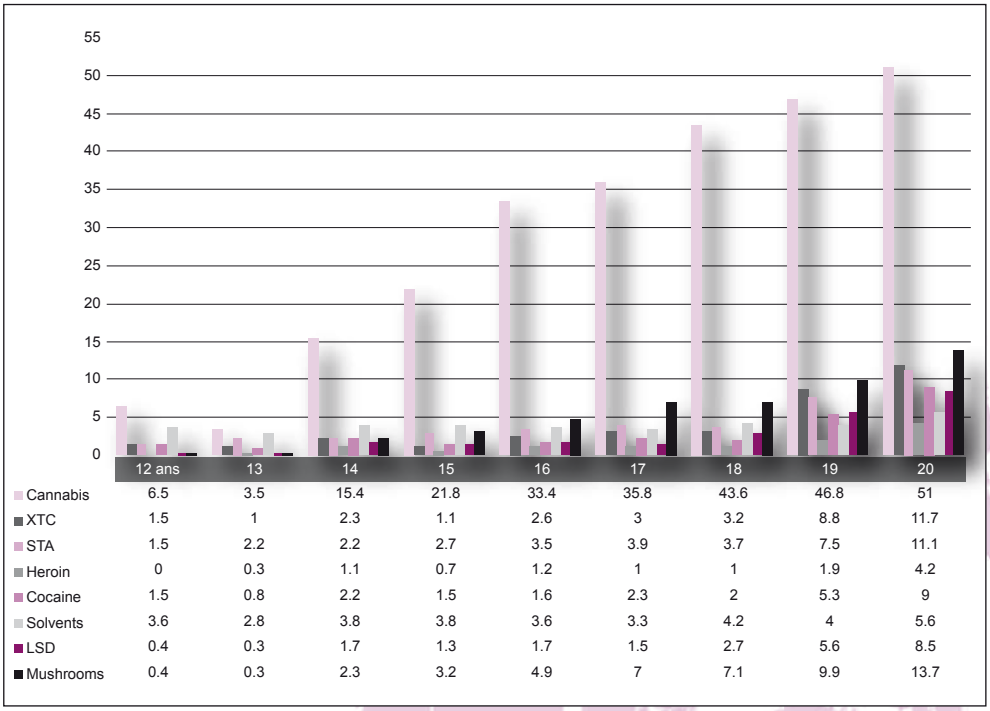
REFERENCE 2	**Dickes P. et al.** (1996), La consommation de drogues légales et illégales des élèves des 6ième de l'enseignement secondaire et des 8ième de l'enseignement secondaire technique, CEPS/INSTEAD. Luxembourg. **EN.:** The use of licit and illicit drugs by students in 6th and 8th classes of national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

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

Source: Dickes 1996

REFERENCE 3	**Das Wohlbefinden der Jugend – HBSC Studie** (2000), Ministère de l'Education Nationale de la Jeunesse et des Sports, Direction de la Santé, Luxembourg. **EN.:** Health and Health Behaviour in School aged Children
Year of data collection	1999
Single/repeated study	Repeated study (intended each 4 years)
Context	Health and Health Behaviour among Young People – WHO cross-national study
Area covered	Nation wide, representative
Type of school	Secondary schools
Age range	12-21 years
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	7,347
Response rate (M,F,T)	97%

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



	12 ans	13	14	15	16	17	18	19	20
Cannabis	6.5	3.5	15.4	21.8	33.4	35.8	43.6	46.8	51
XTC	1.5	1	2.3	1.1	2.6	3	3.2	8.8	11.7
STA	1.5	2.2	2.2	2.7	3.5	3.9	3.7	7.5	11.1
Heroin	0	0.3	1.1	0.7	1.2	1	1	1.9	4.2
Cocaine	1.5	0.8	2.2	1.5	1.6	2.3	2	5.3	9
Solvents	3.6	2.8	3.8	3.8	3.6	3.3	4.2	4	5.6
LSD	0.4	0.3	1.7	1.3	1.7	1.5	2.7	5.6	8.5
Mushrooms	0.4	0.3	2.3	3.2	4.9	7	7.1	9.9	13.7

A comparison of the Matheis 1992 study and the HBSC 2000 study revealed that in 1992, 18.1% of secondary school students of 5th class in secondary school (16-20 years) declared having had contact with illegal drugs. In 2000, this proportion increased to 41.1%. The HBSC 2000 study reported a proportion of nearly 50% of youngsters aged 18 having consumed at least once in their life an illegal drug. However, the consumption of "hard" drugs is not widespread among youngsters. Approximately 4 to 5% of youngsters reported consumption of "hard" drugs, mostly due to experimenting, while a lower proportion effectively develops a related dependency.

It should be stressed that a new HBSC study referring to 2005/2006 data has been presented in 2008 (Ministry of Health, in press). The section on drug use in youngsters thus allows to updating a series of former data. A further HBSC wave has been performed in 2010. Respective data will be presented in the 2012 edition of the present report.

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

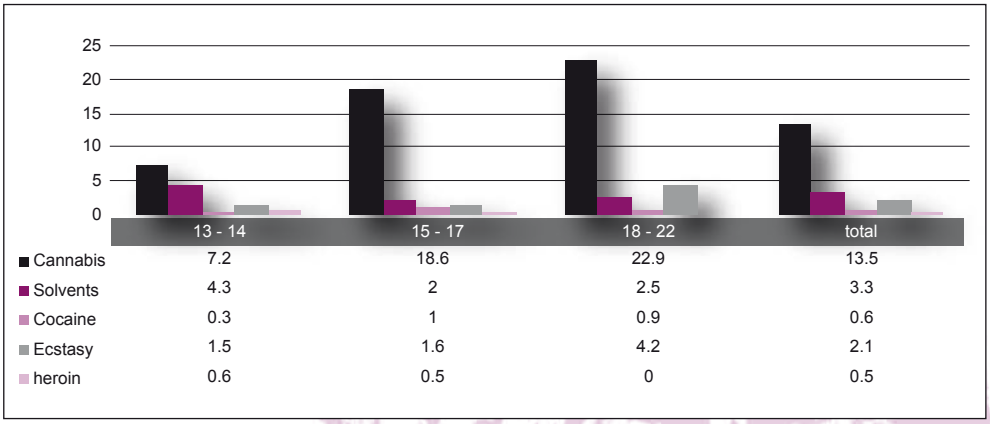
	HBSC 2002						HBSC 2005/2006					
	age 11		age 13		age 15		age 11		age 13		age 15	
	boy	girl	boy	girl	boy	girl	boy	girl	boy	girl	boy	girl
Tobacco												
ever smoked tobacco	-	-	39.4%	38.8%	59.6%	57.9%	13%	8%	34%	29%	57%	60%
at least once a week	0.5%	0%	9.2%	8%	24.7%	26.1%	2%	1%	6%	6%	17%*	21%*
daily smoking	0.5%	0%	5%	5.5%	20%	21%	1%	0%	4%	5%	13%	16%
Alcohol												
Drunkenness (proportions that reported having been drunk at least twice)	2.3% (11 and 12 years)	1.4% (11 and 12 years)	6% (HBSC 2006: 5.5%)		21,9% (HBSC 2006: 23.5%)		2%	1%	6%	5%	27%*	20%*
weekly drinking (proportions that reported drinking any alcohol at least every week)	-	-	17.1%	13.4%	37.7%	22.9%	4%*	2%*	9%	6%	30%*	19%*
Cannabis												
Lifetime use (at least once)	3.9%	0.2%	3.5%		21.8% (HBSC 2006: 23%)						25%	21%
Recent use – last 30 days – at least once											13%*	7%*
Cannabis use – in the last 12 months	3.8% (11 and 12 years)	0.6% (11 and 12 years)	3.5%		21.8% (HBSC 2006: 18%)						21%	16%

* indicates a significant gender difference ($p < 0.05$)

SURVEYS: CATEGORY 2

REFERENCE 4	**Meisch, P.** (1998), Les drogues de type ecstasy au Grand-duché de Luxembourg, CePT, Luxembourg. **EN:** Ecstasy type drugs in the G. D. of Luxembourg
Year of data collection	1997
Single/repeated study	Single
Context	Public Health – primary drug prevention
Area covered	Nation wide
Type of school	2nd and 6th years of classical (N: 311) and technical (N: 355) secondary schools
Age range	13-22 years (13-14: N347; 15-17: N193; 18-22: N118)
Data coll. Procedure	Self-administrated questionnaires
Sample size	666
Sampling frame	Schools participating in the "European 'Health-Schools' network
Response rate (M,F,T)	100%

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

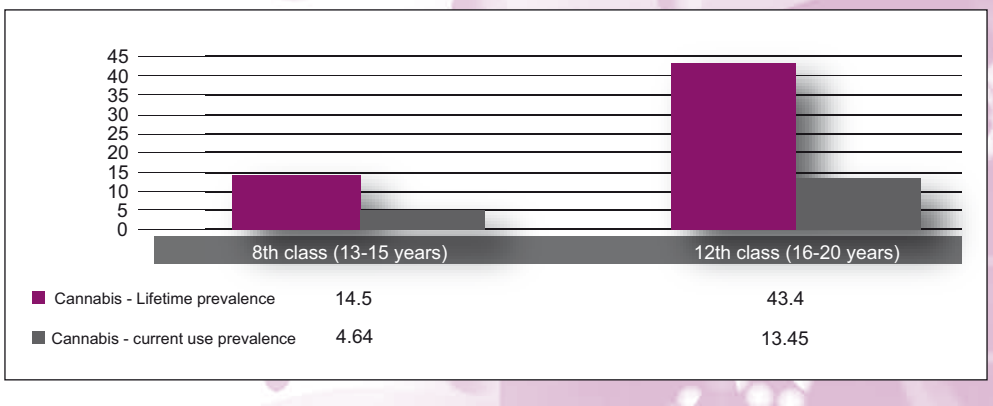


	13 - 14	15 - 17	18 - 22	total
Cannabis	7.2	18.6	22.9	13.5
Solvents	4.3	2	2.5	3.3
Cocaine	0.3	1	0.9	0.6
Ecstasy	1.5	1.6	4.2	2.1
heroin	0.6	0.5	0	0.5

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

Year of data collection	1999
Single/repeated study	Single
Context	Cannabis prevalence
Area covered	Nation wide
Type of school	2nd and 6th years of secondary schools
Age range	13-20 years
Data coll. Procedure	Self-administrated questionnaires
Sample size	562
Sampling frame	Schools selected on basis of their geographical situation (national representativity), exhaustive student sampling within the selected schools.
Response rate (M, F, T)	100%

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



SYNOPSIS OF MAIN COMPARABLE RESULTS AND OBSERVED TRENDS

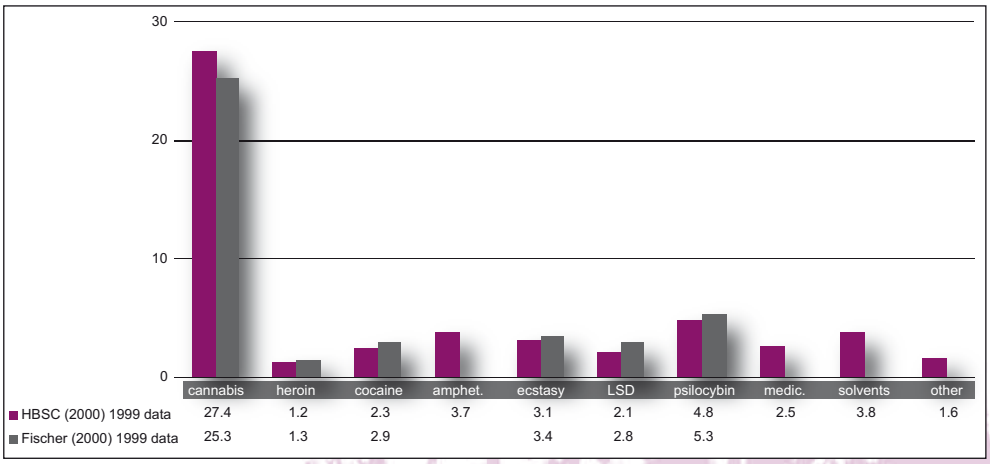
LIFETIME PREVALENCE: SCHOOL POPULATION:

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

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

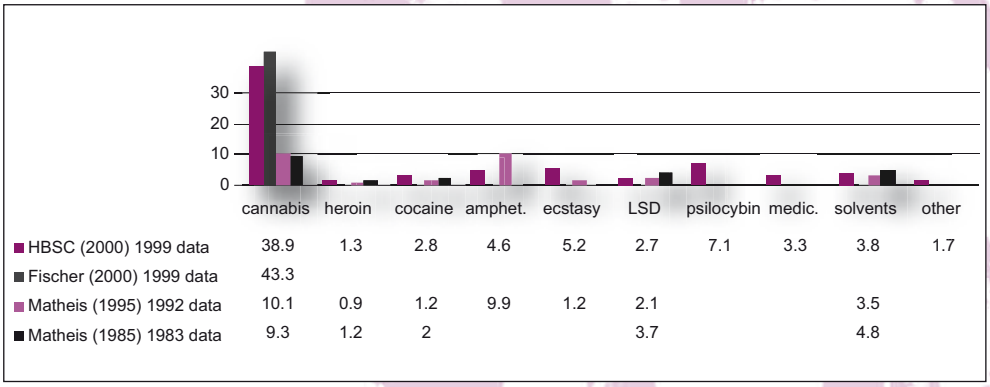
Regarding age group **13-14**, one should emphasise the increase of cannabis (9.7 - 10.5%) and cocaine (1.6 - 2%) lifetime prevalence. In age group **15-16** years, all prevalence rates show increasing figures since 1992 (cannabis: 27.7%, psilocybin: 4.1%). Compared with the latter group, age group **17-18**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

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



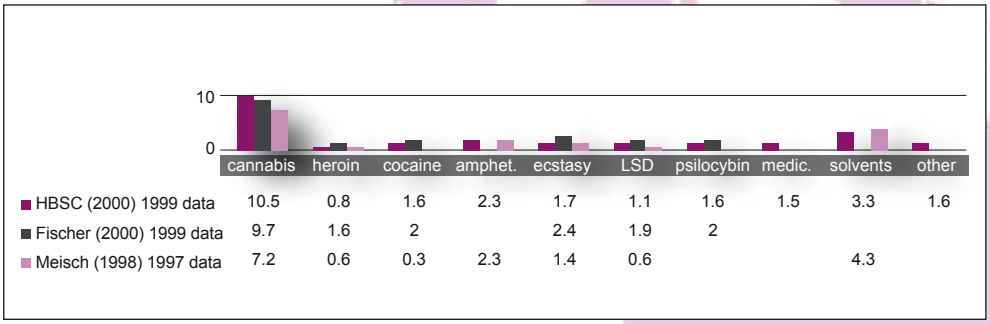
	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (2000) 1999 data	27.4	1.2	2.3	3.7	3.1	2.1	4.8	2.5	3.8	1.6
Fischer (2000) 1999 data	25.3	1.3	2.9		3.4	2.8	5.3			

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



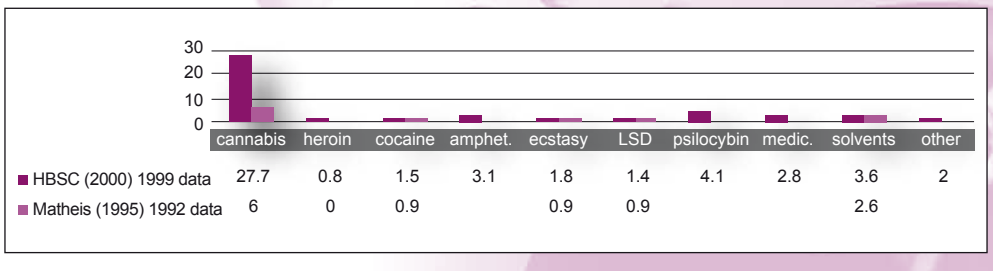
	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (2000) 1999 data	38.9	1.3	2.8	4.6	5.2	2.7	7.1	3.3	3.8	1.7
Fischer (2000) 1999 data	43.3									
Matheis (1995) 1992 data	10.1	0.9	1.2	9.9	1.2	2.1			3.5	
Matheis (1985) 1983 data	9.3	1.2	2			3.7			4.8	

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



	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (2000) 1999 data	10.5	0.8	1.6	2.3	1.7	1.1	1.6	1.5	3.3	1.6
Fischer (2000) 1999 data	9.7	1.6	2		2.4	1.9	2			
Meisch (1998) 1997 data	7.2	0.6	0.3	2.3	1.4	0.6			4.3	

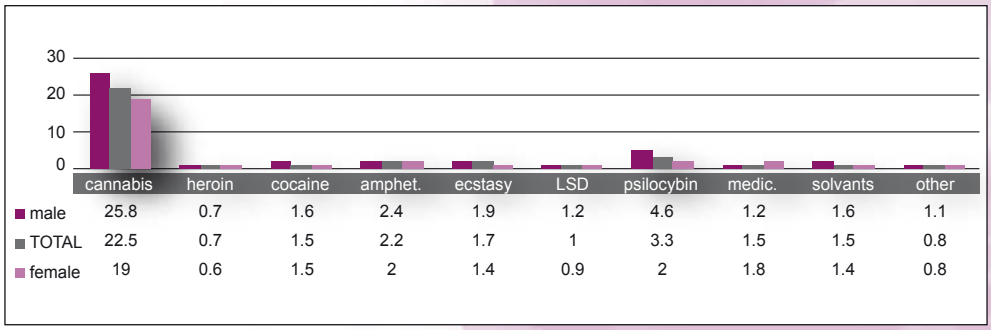
Fig. 2.11 : LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years



Last 12 Months Prevalence: School Population

The HBSC surveys (2000, 2006) provide last 12 months national prevalence figures in 12 to 20 years aged schoolchildren. Results mirror respective proportions of lifetime prevalence rates with particular emphasis on high cannabis (22.5%), psilocybin (3.3%) and amphetamines (2.2%) prevalence. Gender differences reflect the results of the lifetime prevalence surveys except for amphetamines use that is proportionally higher in females during the last 12 months. Medicaments use in females is more prevalent than in males.

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



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

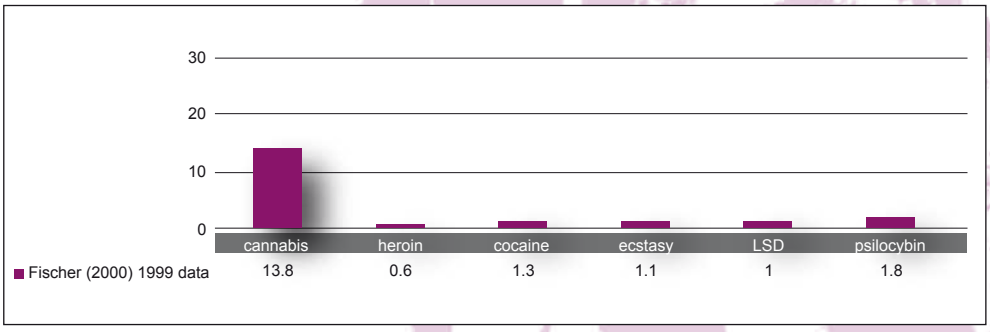
Tab. 2.2 HBSC 2002 and 2005/2006: Analysis according to age (last 12 months prevalence)

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

LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

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

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



DRUG USE AMONG TARGETED GROUPS

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

REFERENCE c.1	**Origer A., Removille N., (2007) Prévalence et propagation des hépatites virales A,B,C et du HIV au sein de la population problématique de drogues d'acquisition illicite, Point Focal OEDT / CRP-Santé. Luxembourg.** **EN:** Prevalence study on HIV, HCV, HBV and HAV in PDU in Luxembourg
Year	2007
Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence national PDU population
Area covered	In- and outpatient drug agencies and national prisons
Type sample	Random sampling during 8 months in 2005
Age range	> 17
Data coll. Procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES AND SEROLOGICAL TESTING
Sample size	366
Sampling frame	Random sampling
Response rate (M, F, T)	33.96%

MAIN RESULTS:

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

Furthermore, a study on *"Drug addiction in the working environment: Prevalence of use of psychoactive substances use and its relationship to high-risk occupation and stress"* (S. Krippler and F. Kittel, 2011)[30] has been published in April 2011. The aim of the study was to explore the prevalence of licit and illicit psychoactive substances use among employees aged between 18–39 years in the private sector in the G.D. of Luxembourg as well as its relationship to high risk occupations and other potential risk factors in occupational settings, (e.g. high-stress tasks). For this purpose, a self-administered questionnaire containing validated tools from the EMCDDA concerning street drugs, the AUDIT-C for alcohol use and the Siegrist Effort-Reward-Imbalance questionnaire on stress were distributed during occupational medical check-ups during June and July 2008. Alcohol, cigarettes, amphetamines, cocaine, heroin, ecstasy, LSD and psychotropic drugs use were investigated together with socio-demographic and professional factors. Among the 1358 respondents, 8.4% consumed illicit substances, cannabis accounting for 8.2%. High-risk occupations are significantly related to illegal substance use. Age (young), gender (men), smoking and family situation (bachelor living alone) show the same relationship. No effect was found for stress on illicit drug use while there was a significant effect on alcohol and prescription drug use in bivariate analysis only.

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

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

	Q10. Have you used cannabis yourself?			
	Yes – in past year	Yes – but more than one year ago	No, I have never used	Don't want to answer
LU	11	10	77	2
EU 27	14	12	72	2

	Q5. In certain countries some new substances that imitate the effects of illicit drugs are being sold as legal substances in the form of – for example – powders, tablets/pills or herbs. Have you ever used such substances?	
	No, I never used	Yes, I have used such substances
LU	93	7
EU 27	95	5

Source: Eurobarometer N°330

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

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

3. PREVENTION

INTRODUCTION

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

The present chapter provides a summary of recent universal and selective prevention measures undertaken at the national level. More detailed information and examples of good practice can be found in the EDDRA / Best practice database of the EMCDDA under: **http://www.emcdda.europa.eu/themes/best-practice/examples.**

The **national drugs action plan 2010- 2014** addresses primary prevention as a main intervention area. The priorities of the drug prevention action plan and the GIT as approved in 2010 are as follows:

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

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

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

The overall coordination of counselling, treatment and low threshold interventions is within the competence of the AST (Department of Directorate of Health, future division of Drug Addiction and Social Medicine) and the **national drug coordinator's office**. The AST has coordination and financial control missions (supervision of financial contract implementation of subsidised NGOs) in the field of drug addiction and psychiatry. Furthermore, the national drug coordinator is responsible for the conceptualisation and the implementation of activities included in **the drugs action plan 2010 - 2014** (see 1.1).

Direct drug prevention expenditures reached 672,000.- EUR in 2000 and 985,000.- EUR in 2010. These figures include staff and operating costs of agencies and ministerial department specialised [31] in drug prevention.

Training interventions in drug demand reduction are increasingly developed at the national level. The CePT publishes an annual training directory including training activities ranging from evaluation methodologies

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

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

A special department named 'Trampolin' has been set up within the CePT, to ensure the development of training activities and instruments covering national needs. Target groups are professionals from the educative, social, psychological and medical fields as well as parents and other interested stakeholders.

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

UNIVERSAL PREVENTION

School

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

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

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

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

As far as training activities are concerned, around 1,000 persons have participated in training sessions and conferences organized by the National Prevention Centre on Drug Addiction (CePT) during 2010, namely in the framework of the collaboration with the Service of Coordination of Research and of Pedagogical and Technological Innovations (SCRIPT) and the Luxembourg University, the City of Luxembourg, the national federation of School children' parents, the Police academy and specialised agencies.

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

A mobile interactive and prevention instrument called the 'Extra-Tour Sucht' and aiming to reach students aged 15 to 18 years in secondary school settings was further developed and adapted for instance to new trends such as shisha smoking. It was specifically designed for the Luxembourgish school settings by the German company KomPass. Interactive intervention modules are applied alternatively and allow for a participation of 60 pupils. Currently the following thematic sessions are proposed:

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

In 2009 the CePT jointly with the Ministry of Education published a brochure on cannabis specifically designed for teachers and other professionals from the educational sector called 'School **and cannabis – Recommendations for Education professionals'**. It includes epidemiological data, recommendations on early recognition, prevention and intervention means and information on existing networks: http://cept.lu/fr/projets/456-schule-a-cannabis-ein-leitfaden-fuer-das-schulpersonal.

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

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

Family

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

Active collaboration between the CePT and parent's association at each education level does exist. In 2001 CePT has released the so called **'prevention boxes'** including didactic material destined to potential multipliers as for instance teachers, parents and youth animators. The first prevention box, targeting 3 to 6 years old children has been released in September 2001. Due to its success, the 3-6 years prevention box will be reedited and a second one for children aged 11 to 15 years has been released in 2002. In 2004, seminars on the 'prevention boxes' took place in different communities participating in the project of addiction prevention in local communities. Also, the CePT collaborates with the Kannerschlass Foundation, in the framework of the project 'Parents' School'.

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

Community

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

Generally speaking, local and regional communities do rarely dispose of a comprehensive drug prevention strategy. Commonly, a given national agency initiates projects, defines the general intervention framework and seeks active collaboration with community authorities in order to meet local needs. The observed situation is mainly due to geographical parameters of the Grand Duchy. At present only one agency focuses on interventions in recreational settings, namely the CePT (community project [32]).
The CePT is continuously developing the project **'adventure circuit'**, an instrument for interactive and tangible drug prevention targeting general population. This itinerant exhibition has been prepared in 2004 by more than 40 volunteers who since then have fine-tuned and further developed the concept for national prevention tours. In 2008/2009 a performance tour was organised in Mondorf Group regions entitled 'The Quest of happiness'.

SELECTIVE PREVENTION IN AT–RISK GROUPS AND SETTINGS

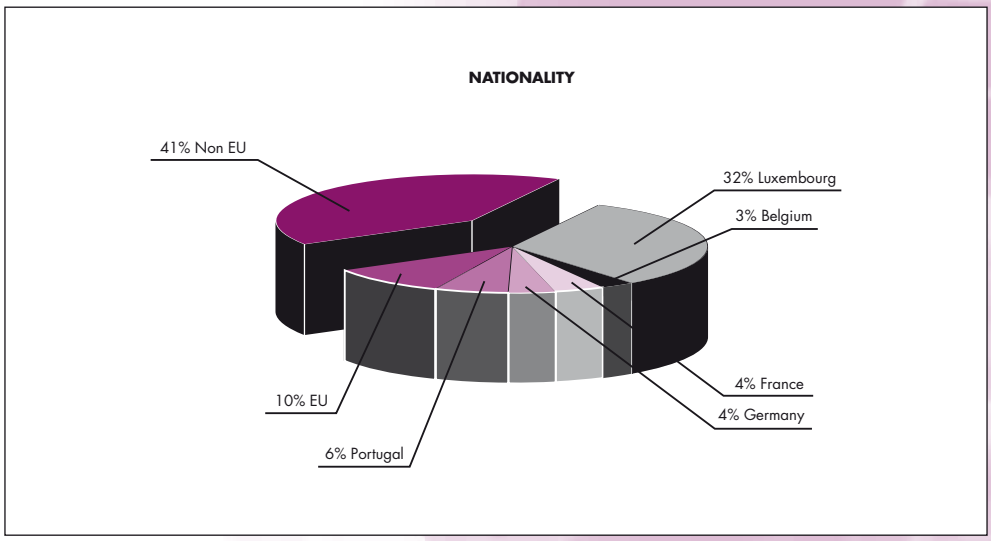
At-risk groups

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

32 In the beginning of 1995, a pilot project on community-based drug prevention has been launched by CePT. The main idea was to focus prevention activities on the very environment and daily life experiences of young people. Various demand reduction activities have been undertaken, either developed by CePT, SNJ and several youth centres, or initiated by the respective District Councils. 13 district councils and 150 volunteers are currently involved in the project. The funding of this community project is jointly ensured by the involved district councils, the EU (Drug Prevention Programme DG-V) and CePT.
The primary aim of the project is to improve communication skills on drugs, to increase participants' abilities in handling conflicts, stress and frustration (age range: 12 to 65 years) and to set up autonomous groups to continue implementing local prevention measures. In each participating municipality, prevention groups were composed of local volunteers who were asked to organise local drug-prevention activities related to their specific needs. Cornerstone concepts of the project are as follows: - Multidisciplinary drug prevention, - Tailor-made community solutions, - Health promotion with regard to risk and protective factors, - Holistic and systemic approach, - Target groups oriented, - Routine evaluation.

project called *'DIMPS'* (Intervention mobile for sexual health) in the framework of the national action plan on Aids 2006-2010. *DIMPS* is meant to inform on risk behaviour and provide free infectious disease testing in difficult-to-access populations, such as immigrants. Combined rapid tests for HIV and HCV are proposed as recommended by the Origer, Removille study (2007). Currently the *DIMPS* addresses low threshold drug agencies, gay meeting venues and immigration centres. The referred offer shows high acceptance and interest in the target groups. From 2009 to 2010, the *DIMPS* van registered 58 drives of 2 to 3 hours. At all, contact with 184 individuals has been made during this time and 212 counselling sessions have been held of an average time of 30 minutes. The clients are aged between 17 and 65 years with an average age of 32.7 years. Of 184 clients reported between 2009 and 2010, 66.8% were male and 33.2% were female.

Fig 3.1. Nationality of DIMPS clients 2009-2010



34.6% of DIMPS clients are drug users and 29.4% of all the clients are injecting their drugs. 44% of this population reported that they never made an HIV test at an earlier stage and 61% never submitted to a HVC test before.

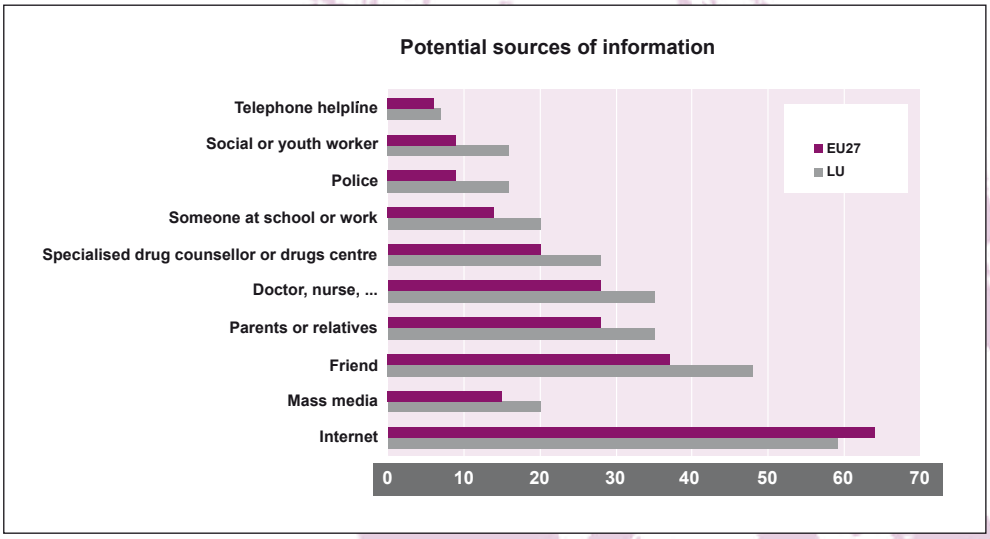
Moreover, the CePT introduced an EU project in the framework of the Grundtvig-Programme called *'Promotion of social and personal competences in socially unprivileged persons'* – PROSKILLS. Its objective is to elaborate didactic material for multipliers working in the field of the promotion of social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

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

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

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

Fig 3.2. Potential sources of information on illicit drugs and drug use



Source: Eurobarometer 330

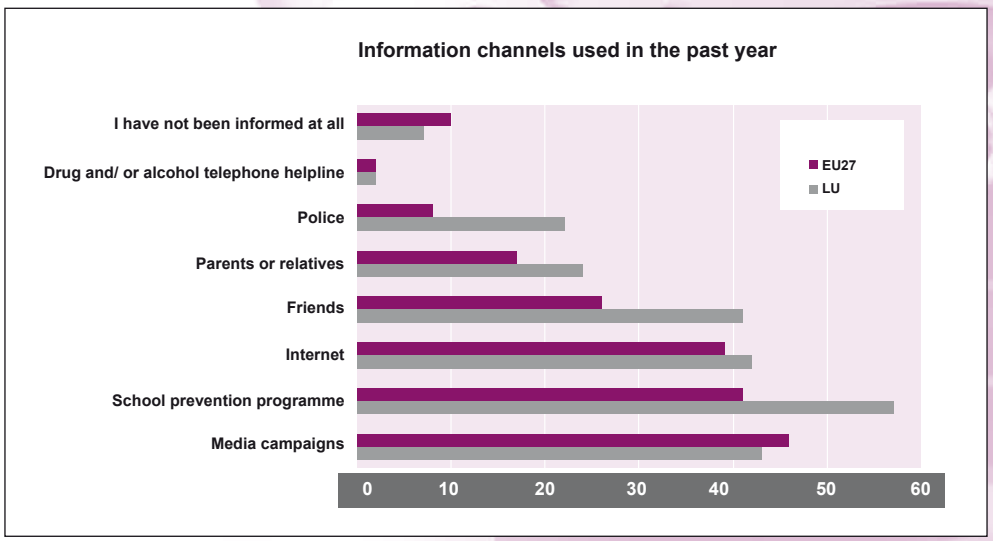
> *Information channels reaching youngsters in the past year*

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

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

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

Fig 3.3. Information channels used in the past year to be informed on the effects and risks of illicit drugs



Source: Eurobarometer 330

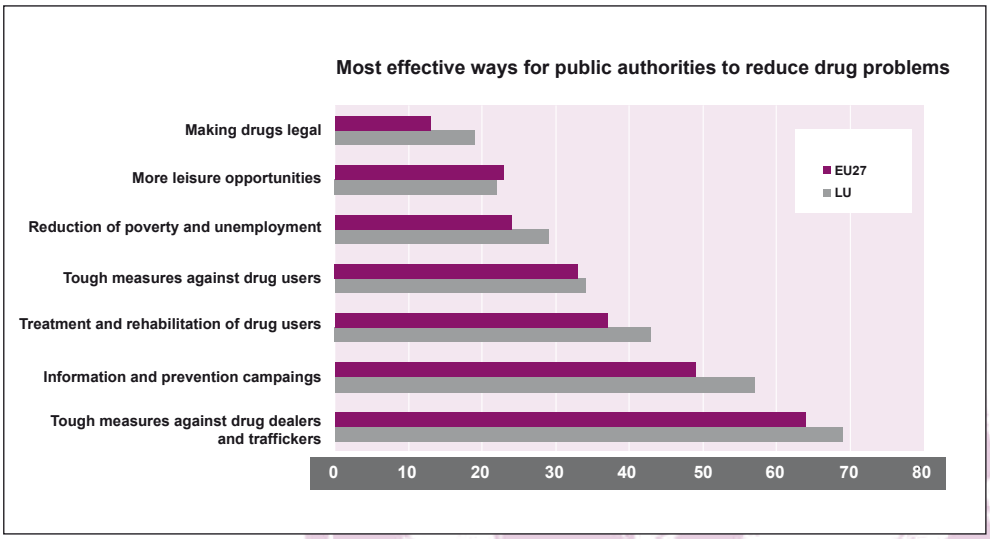
> How should drug problems be tackled?

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

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

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

Fig. 3.4: How should society's drug problems be tackled?



Source: Eurobarometer 330

At-risk families

Since 2003, the Youth-and Drughelp foundation (JDH) is running a parental project with the aim to provide psycho-social aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative capacities. This long term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. In 2010, the interventions concerned 96 parents as well as 50 children living with their parent(s) and 47 children, who don't live with their parent(s). An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

Moreover the CePT, in collaboration with JDH offers training courses for at risk mothers in order to build up their capacities as parent and improve mother-child relationship. (Project: O Mamm O Kanner, which was renamed "1- 2- 3 lass" "1-2-3 go!" in 2009.)

Recreational settings

Youngster do spend an important share of their time in leisure, recreational or social activities and numerous programmes in recreational settings take place at the community level, church and youth organisations or sport-oriented clubs. The latter are not necessarily drug specific and as such difficult to list exhaustively.

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

In this respect, the demand reduction activities organised by the 'Mondorf Group' (joint initiatives of border regions of France, Germany, Belgium and Luxembourg) jointly with the CePT and SNJ combine a non drug-centred approach with intercultural components in organising corporate leisure activities for youngsters from border countries based on the concept of 'adventure pedagogy'. The annual 'adventure weeks[33]' do fit in a broader programme named 'Adventure pedagogy and primary addiction prevention'. Those activities primarily aim to provide the opportunity to youngsters to experience group dynamics, conflict management, limit and risk assessment as well as the feeling of solidarity within a group of socially and culturally different people. The programme further aims at the reduction of risk factors and the enhancement of protection factors, by focussing on youngsters and their environment, rather than on drugs and addiction. Regional teams specialised in drug prevention meet in autonomous working and training groups and report activities to the Mondorf Group.

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

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

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

In the framework of the INTERREG IV Programme: Grande Région 2007-2013 Project 52 GR 3 3 100 the CePT participates in the project MAG-Net: http://cept.lu/fr/projets/442-mag-net - Promotion of well being and prevention of addictive behavior in school and recreational settings by youngsters and risk groups. The referred project includes the creation of a network of experts from Germany, France, Belgium and Luxembourg aiming to develop preventive measures for school, recreational and social settings. The duration of the project covers June 2009 to May 2012.

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

33 See EDDRA

Occupational settings

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

INDICATED PREVENTION

Children at risk with individually attributable risk factors

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

NATIONAL AND LOCAL CAMPAIGNS

Since September 2007, CePT has enlarged its offer of existing information (library, leaflets, brochures and homepage) by adding a telephone line, which is accessible every day from 9 am to 1 pm, as well as an electronic help-line (FRO NO). The redesign of the CePT homepage: www.cept.lu guarantees better access to information related to drugs and addictions.

Furthermore, leaflets on alcohol and cannabis and the latest one on psychotropic medications, informing the general public on effects of referred substances, their legal status, related risks, were diffused to a very broad national public. All these leaflets are available at http://cept.lu/fr/publications/cat_view/203-publications/30-substances-psychotropes-a-comportements-addictifs?limit=10&order=date&dir=ASC&start=10

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

The survey report concluded: *'In contrast to the alarming scene depicted by the media, our results show very localised and isolated occurrences of inhalant abuse in the Grand Duchy of Luxembourg. Furthermore, very few reports concern primary school pupils.*
Well intentioned dissemination of information and hazard warnings can easily backfire and, instead of preventing inhalant abuse, turn into a publicity stunt for these products. On the basis of our results of this poll we refrained from launching a widespread information campaign and decided to publish instead a fact sheet for professionals working with children and teenagers.'
In June 2009, CePT launched a new awareness raising campaign on what dependency actually is about. Without further explanation, yoyos with the inscription 'I make dependent', the phone number and the e-mail address of the national prevention centre were distributed next to the central railway station and in the pedestrian area of Luxembourg City. Additionally, newspaper articles with provocative questions on different consumption behaviours were published: Chocolate makes dependent? Cannabis makes dependent? Mobile phones make dependent? Alcohol makes dependent? Yoyos make dependent? The main objective of this campaign was to tackle interest of the general public, to motivate them to ask questions and to realise the versatility of the concept of addiction.

4. PROBLEM DRUG USE

INTRODUCTION

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

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

According to the latest serial and multi-methods prevalence study (Origer, 2010) performed in 2009, national prevalence of PDU situates at 2,470 persons (C.I. (95%): 2,089 to 3,199). A decreasing trend in PDU prevalence has been observed from 2003 onwards. A similar evolution occurred also for problem heroin use (2007: 1,900 PDU: 5,90/^{1000}). Although absolute prevalence of intravenous drug use (IDU) has slightly increased compared to the situation observed at the end of the 20th century, IDU prevalence rate in the national population aged 15 to 64 years shows an obvious decreasing trend over the referred period. Almost all indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies.

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDU. Low quality cocaine use in combination with heroin continues to be observed. Ecstasy-like substances and ATS are still popular even though seizure figures did suggest an inverse trend until 2010. Methamphetamine use in Luxembourg is very limited. The use of most 'new synthetic substances'[34] recently detected in other EU Member States has not been reported thus far with the exception of mephedrone seized in May 2010 in a secondary school. All indicators on cannabis use (problematic and recreational) have been on the increase for several years but tend to stabilise more recently. Cannabis showing high THC concentrations (in 2008 max: +/- 22% - in 2009 max: +/- 40% - in 2010 max: +/-21%) is increasingly found on the national market.

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

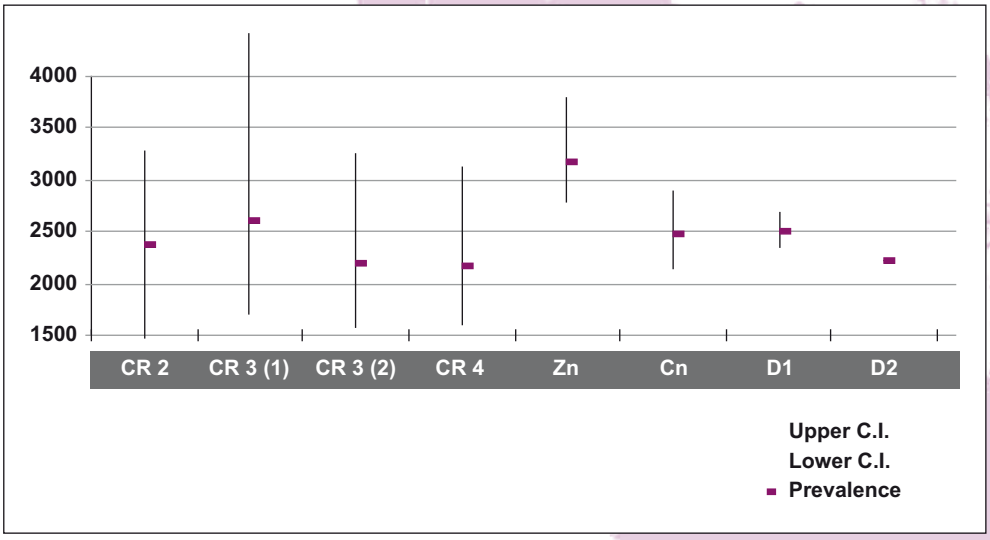
PREVALENCE AND INCIDENCE ESTIMATES OF PDU

NATIONAL PREVALENCE DATA

Data presented in the present chapter have been provided by serial drug prevalence study on PDU aged between 15 and 64 years performed on 1997, 1999, 2000 and most recently on 2003 and 2007 data (Origer, 2001, 2010) [35]. The latest, yet unpublished study, was performed in 2009 in the framework of the evaluation of the 2005-2009 national drug action plan. With this latest study based on 2007 data, it became possible to assess the evolution of PDU prevalence over the last decade knowing that applied methodologies and data sources referred to, during the same period, are highly comparable.

The research strategy relied on the methodological framework of the Luxembourgish Information System on Drugs and Drug Addiction (RELIS), set up in 1995 by the national focal point of the EMCDDA. RELIS stands for a nationwide multisectorial information network, including specialised drug treatment institutions, general hospitals, counselling centres and competent law enforcement agencies. As such, it provides for the most comprehensive and reliable data on problem drug users indexed by national institutions. In compliance with RELIS case definitions, the present study specifically aims at the prevalence estimation of problem use of illicitly acquired high risk drugs (HRC) in the national population aged 15 to 65 years.
The following methods have been applied: Case finding (CF), capture-recapture on 2, 3 and 4 sources (CR 2,3,4), truncated Poisson model associated to Zelterman's and Chao's estimators (tPm), and four different multiplier methods using data from law enforcement sources, drug mortality registers (D1,2,3) and treatment agencies (T).

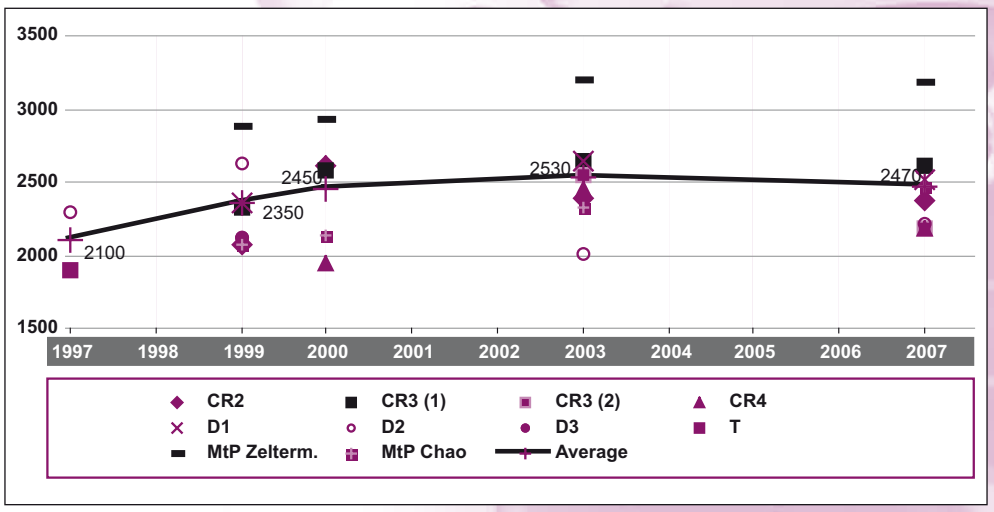
Fig 4.1. Absolute prevalence estimation of problem HRC drug use (2007)[36] and confidence intervals



35 Downloadable at http://www.relis.lu

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

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



Source: Origer, 2009

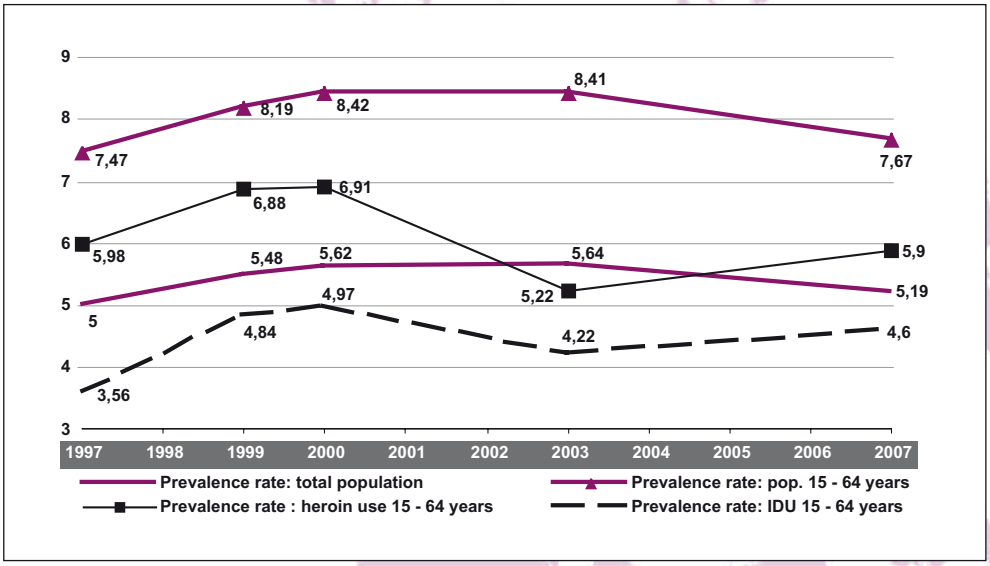
Tab. 4.1. Prevalence and prevalence rates according to selected sub-groups (1997 – 2007)

	1997	1999	2000	2003	2007
GENERAL POPULATION					
National population on 1st January	418,300	429,200	435,700	448,300	476,200
National population aged between 15 and 64 years on 1st January	281,100	287,100	291,000	300,800	322,000
HRC USERS IN CONTACT WITH THE NATIONAL INSTITUTIONAL NETWORK (low threshold agencies not included)					
Total number of indexed users (multiple counts excluded)	/	*887*	*986*	*1,065*	*1,200*
Number of drug treatment demanders in specialized institutions exclusively (Liberal GPs intervention excluded)	/	*317*	*372*	*582*	*756*
Number of drug law offenders exclusively (ad minima consume of HRC drug(s))		*378*	*365*	*375*	*373*
Numbers of drug treatment demanders AND drug law offenders	/	*192*	*249*	*108*	*71*
PROBLEM USE : HRC DRUGS					
Average prevalence	**2,100**	**2,350**	**2,450**	**2,530**	**2,470**
Average C.I.	p.d.	1,994 -2,758	1,933 - 3,126	2,144 - 3,290	2,089 - 3,199
Total prevalence rate	5 /1000	5.48 /1000	5.62 /1000	5.64 /1000	5.19 /1000
Total prevalence rate - age :15-64	7.47 /1000	8.19 /1000	8.42 /1000	8.41 /1000	7.67 /1000
PROBLEM USE : MAIN DRUG - HEROIN					
Prevalence heroin	**1,680**	**1,975**	**2,010**	**1,570**	**1,900**
Total prevalence rate - heroin	4.01/1000	4.60 /1000	4.61 /1000	3.50 /1000	3.99 /1000
Total prevalence rate - heroin - age :15-64	5.98 /1000	6.88 /1000	6.91 /1000	5.22 /1000	5.90 /1000

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

Source: Origer, 2009

Fig 4.3. PDU prevalence rates according to selected sub-groups (1997 – 2007) per 1,000 inhabitants aged 15-64 years



Source: Origer, 2009

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

According to serial data available for the period 1997 to 2007, absolute prevalence and prevalence rates of PDU-HRC have been showing an increasing trend until 2000. After a short stabilisation phase, a decreasing trend has been observed from 2003 onwards. A similar evolution occurred also for problem heroin use (2007: 1,900 PDU: 5,90/1000). Although absolute prevalence of intravenous drug use (IDU)[37] has slightly increased compared to the situation observed at the end of the 20th century, IDU prevalence rate in the national population aged 15 to 64 years shows an obvious decreasing trend over the referred period.

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

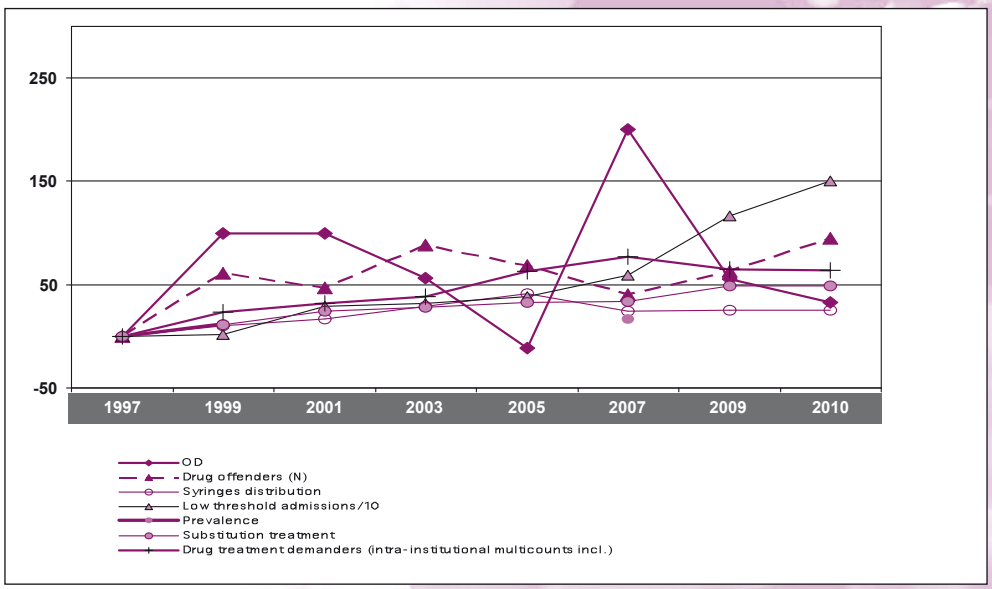
A further serial PDU prevalence study on 2009 data and based on the same methodology than previous ones is currently performed and results will be available by the beginning of 2012.

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

INDIRECT INDICATORS OF PDU PREVALENCE TRENDS

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

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



Source: Origer, 2010

Indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies except for admission statistics in low threshold drug agencies from 2000 onwards and the number of drug law offenders since 2008.

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

The number of drug law offenders has also stabilised between 1999 and 2009 but shows a peak in 2010. This recent evolution might be partly explained by the fact that law enforcement agencies increased their presence and interventions notably in the vicinity of the supervised drug injection and low threshold facilities in order to fight increased drug deal activities. Next years' trends of this particular indicator have to be interpreted in the light of this supplementary data.

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

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

A new research project has been launched in 2009 on the consolidation and validation of PDU estimates by indirect indicators. A correlation matrix including 18 indirect trend indicators has been conceived to follow-up trends and strength of association between these indicators and between PDU/IDU prevalence figures and the latter. First results will be available in the course of 2012.

LOCAL OR REGIONAL PREVALENCE STUDIES

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

CHARACTERISTICS OF INDEXED PDU

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

The **number of problem PDU** indexed by national institutions in 2010 figured 5,142 (2002: 4,701) (in this figure double counting is included meaning that a given person could have been indexed twice and more by different institutions. It is thus not representing the actual prevalence, which has to be assessed by other methods).

More precisely, 2,383 users have been indexed by national specialised drug demand reduction agencies and 2,318 drug law offenders by supply reduction agencies in 2002. In 2010 the same agencies have indexed 2,653 and 2,762 persons respectively.

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

	2000	2004	2008	2009	2010	TREND
Gender						
Male	*77%*	*78%*	*77%*	*83%*	*80%*	↘
Female	*23%*	*22%*	*23%*	*17%*	*20%*	↗
Nationality						
Natives	*54%*	*54%*	*48%*	*48%*	*49%*	
Non-natives	*46%*	*46%*	*52%*	*52%*	*51%*	
- of which						
Portuguese	*51%*	*58%*	*38%*	*49%*	*39%*	↘
French	*17%*	*11%*	*28%*	*16%*	*23%*	↗
Others	*32%*	*31%*	*34%*	*35%*	*38%*	
Mean age						
Male	*29Y4M*	*31Y2M*	*31Y8M*	*31Y9M*	*32Y4M*	↗
Female	*26Y10M*	*28Y4M*	*28Y5M*	*28Y3M*	*28Y9M*	↗
Total	*28Y9M*	*30Y6M*	*30Y11M*	*31Y2M*	*31Y7M*	↗
Primary drug						
Opiates	*84%*	*76%*	*72%*	*78%*	*81.6%*	↗
Cocaine	*7%*	*16%*	*17%*	*9%*	*9.5%*	
Others	*9%*	*8%*	*11%*	*13%*	*8.9%*	↘
Polydrug use	*87%*	*93%*	*89%*	*74%*	*76%*	↗
Primary opiates administration mode						
Iv	*56%*	*55%*	*45%*	*62%*	*59%*	↘
Non-iv	*44%*	*45%*	*55%*	*38%*	*41%*	↗
Infectious disease						
HIV	*4.3%*	*4%*	*4%*	*5%*	*6%*	
HCV	*40%*	*58%*	*65%*	*51%*	*52%*	

The male/female ratio of the PDU population is stable at 4:1. During the last ten years the proportion of indexed non-native PDU has shown strong variations but a clearly increasing tendency since 2003. The population of non-native drug users largely consists of Portuguese nationals, whose proportion is consistently higher than the one observed in general population. The remarkable and continuous increase of PDU of French origin over the last 8 years has been interrupted in 2009, but continues in 2010.

The mean age of indexed PDU evolved from 28 years and 4 months in 1995 to 31 years and 7 months in 2010. Mean age of male PDU has been increasing faster than for females. In general, the proportion of PDU aged more than 40 years has increased and the rate of users less than 30 years has been decreasing. In reference to years 2004 to 2010 a discontinuous decrease of minors in the overall PDU population has been observed in police data.

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

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

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDU. The proportion of **poly drug use** 76% has reached stabilisation after a record level in 2004 (93%). In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2010. The ratio of intravenous opiates consume to the inhalation mode is 2:1 in 2010. Provision of 'blowing paraphernalia' (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns. The prevalence of the use of cocaine as primary drug shows an increasing trend since 2000, but tends to stabilise in 2009 and 2010. Ecstasy-like substances and ATS use appears to be stable which however does not inform on prevalence in general population as RELIS data refer to PDU and not to the overall population of recreational drug users.

All indicators on cannabis use (problematic and recreational) have been showing a discontinuous increase for several years. The number of persons in contact with the national specialised network for (preferential) cannabis use shows, however, a sensitive decrease in 2010 (8%).

PDU show fairly stable infection rates of HIV (6%) between 2000 and 2010, whereas the HCV prevalence rate (52%) is high, although on the decrease for the last two years.

The **residential status** of indexed respondents has improved over the last years. In 1995, 31% of the users reported stable accommodation; currently the same proportion situates 62%. This improvement is partly due to various accommodation and housing offers for addicted people set up in the framework of the drug action plan.

The **unemployment rate** (69%) tends to plateau. However, the proportion of professionally active respondents reporting a stable job situation (e.g. long term contract) has sensibly decreased over the 3 last years, which should also be put in the context of the current economic crisis.

DATA ON PDU FROM NON–TREATMENT SOURCES

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

The ratio of male and female PDU is almost identical to PDU from treatment sources (80.9% male, 19.1% female offenders). Their mean age is 30.9 years, women being slightly younger than men (31.7 years for male 27.6 years and for female offenders).

46.1% of the offenders are natives and 53.9% are foreigners. Likewise 2009, most non-natives were Portuguese citizens (40.5%) followed by French native offenders (23%).

83.8% are recidivists (had more than one police record during their lifetime). 20.4% were arrested for dealing drugs, 44.1% are charged with illegal drug possession and 35.4% for other crimes related to drugs. Drug-law offenders (who are also problematic drug users) are mostly arrested for heroin and cocaine. A vast majority are reported polydrug users.

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

INTRODUCTION

Drug treatment is the 'use of specific medical and/or psychosocial techniques with the goal of reducing or abstaining from illegal drug use and thereby improving the general health of the client'.[38]

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

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

- **Outpatient treatment:** the patient receives drug treatment without staying overnight, pharmaceutically assisted or not [39];
- **Inpatient treatment:** the patient is staying overnight, pharmaceutically assisted or not (including detoxification);
- **Substitution treatment:** a type of medical treatment provided to opiate addicts primarily based on the delivery of a similar or identical substance to the drug normally used. Substitution treatment may be accompanied by psycho-social care;

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

DRUG TREATMENT STRATEGIES AND POLICY

In the mid seventies the cooperation between state and NGOs working in the social field has progressively gained structure. The first (financing) convention between the Ministry of Family and a series of NGOs, signed in 1975, was the starting point of what is known today as the "Conventionned sector". Over the years the collaboration schemes between State and NGOs evolved and were extended to the Public Health sector. In 1998 the so-called ASFT law [40] entered in force, regulating the relationship between State and private organisations working in the social, family and therapeutic fields.

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

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

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

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

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

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

TREATMENT SYSTEMS

ORGANISATION AND QUALITY INSURANCE

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

NGOs involved in drug treatment fall under the obligation of the above referred to 'ASFT' law (8/09/98) and the subsequent grand ducal decree of 10 December 1998[41], both regulating the relation (duties and rights) between State and NGOs or organisation providing psycho-medico-social and therapeutic care. The overall management of the referred agencies is ensured by a 'coordination platform' that includes a maximum of 3 members of the concerned institution and at least one representative from the competent ministry. All major decisions have to be approved by the coordination platform. All referred institutions work in close collaboration and have to be viewed as an interdependent therapeutic chain. A series of formal collaboration agreements have been signed in 2008 and 2009 between various agencies in order to insure rational use of resources and through-care. The 2010-2014 national drugs action plans foresees to further develop this synergy by creating a national network of unique reference persons for each drug treatment demander entering the specialised care system.

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

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

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

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

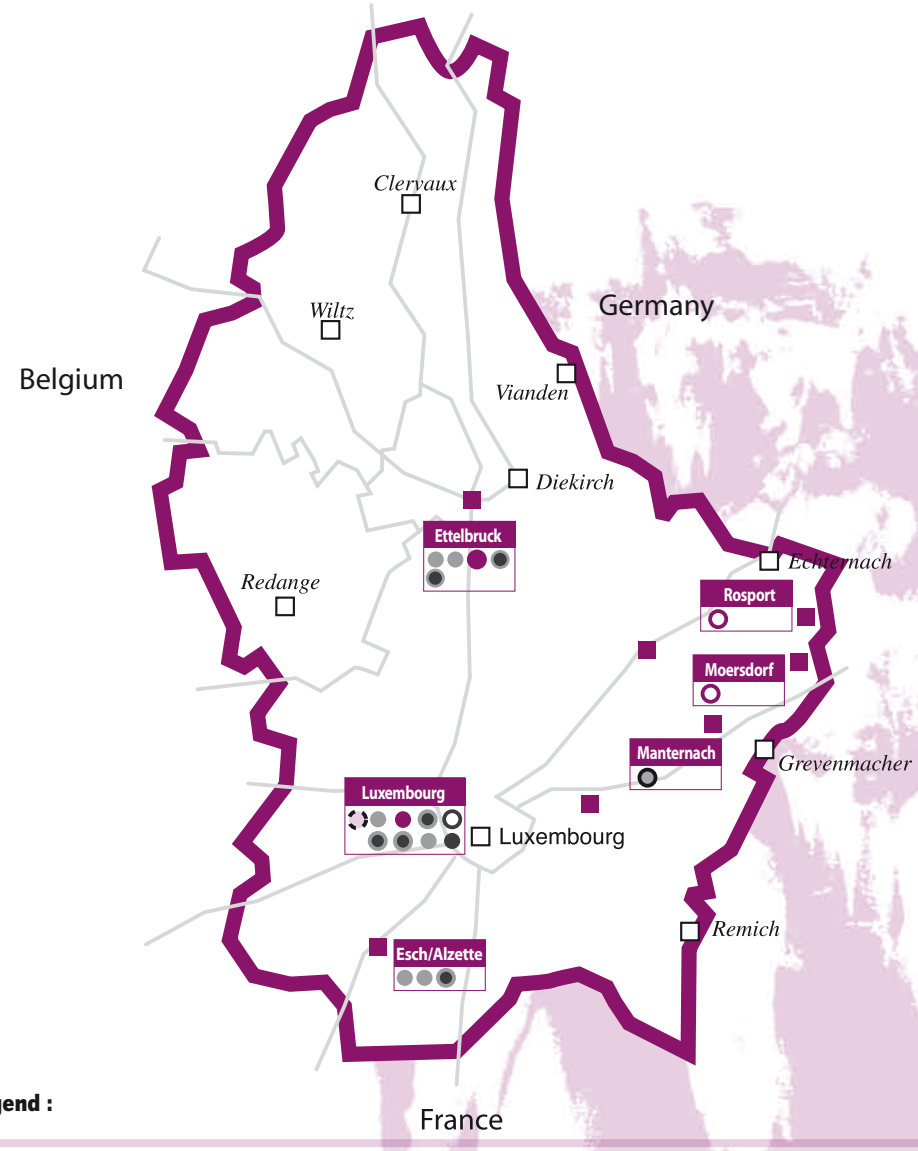
Table 5.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 2010. **Intra-institutional multiple counts** are excluded meaning that all treatment demanders indexed by a given agency are only indexed once by the referred agency during a reporting year. **Inter-institutional multiple counts** are not excluded since a given treatment demander may have contacted several national agencies during a given year. More detailed admission data, including low threshold agencies are provided in respective sub-chapters.

AVAILABILITY AND DIVERSIFICATION OF TREATMENT

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

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

Map 5.1 Geographical coverage of specialised drug agencies in the Grand Duchy of Luxembourg (status 2010))



Legend :

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

The following treatment typology is applied:

Outpatient: services and offers for adults

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

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

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

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

Outpatient: services and offers for minors

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

Outpatient: substitution treatment

Substitution treatment is currently defined as a medical assisted treatment with opioids' agonists and with antagonists (and antagonistic agonists). The objectives of substitution and maintenance treatment are manifold. They range from no-digressive dose, out-patient low threshold maintenance to abstinence oriented (digressive doses) rehabilitation offers. The primary goal is the psychosocial and medical stabilisation of the patient by replacing 'street' drugs by quality controlled substitution drugs. The further development and outcome of the treatment is assessed individually. Both components, condition of the patient and reduction of public nuisance are considered.

Substitution treatment is provided at the national level since 1989 (JDH). Until the beginning of 2001, however, there has been no **legal framework** regulating drug substitution treatment. The law of 27 April 2001 modifying the basic drug law of 19 February 1973 introduced a legal framework for substitution and maintenance treatment. The grand ducal decree of 30 January 2002[42] regulates the practical modalities of substitution. The referred law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of **substitution treatment licenses** granted to MDs and specialised agencies, the application of training requirements for prescribing MDs and adequate control mechanisms of **multiple prescriptions** (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a **structured and multidisciplinary substitution treatment programme** (JDH - mainly liquid oral methadone provided by specialised agencies) and **a lower threshold substitution treatment** offer provided by freelance state licensed MDs (MEPHENON®, METHADICT® and SUBUTEX®).

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

Until 2001 methadone and buprenorphine have been prescribed as part of a long-term treatment with a medium or long-term abstinence goal. There are, however, a series of cases in which substitution treatment has to be considered rather as a maintenance measure than an abstinence oriented therapeutic action. The grand-ducal decree of 30 January 2002 lists medicaments as well as preparations containing methadone (liquid oral form in programme and pill form in lower threshold prescription) and **buprenorphine** if the notice mentions substitution treatment as a possible therapeutic indication. Furthermore, **morphine-based (salts)** medications can be prescribed if the listed substances are deemed inadequate by medical authority. Finally, the decree allows for heroin prescription in the framework of a pilot project managed by the Directorate of Health. The **list of substitution substances** may be rapidly modified by amending the referred decree. In addition to drug prescription and medical care, the grand ducal decree on drug substitution treatment (30/01/2002) defines a series of psychosocial counselling services to be provided by licensed specialised centres. Licensed MDs may refer substitution patients to licensed treatment centres for more in-depth psychosocial counselling.

Diverted MEPHENON® (methadone in pill form prescribed by accredited MDs) is found on the national black market. Given that the centralised substitution treatment register did not yet reach full prescriber coverage, multiple prescriptions (a given patient visits more than one prescriber) may not be fully avoided. In that respect, the **central substitution register** is further developped jointly by the 'Surveillance Commission on Substitution Treatment'[43]', the national drug coordinator and involved specialised treatment centres. At the moment of writing, a test phase is running in order to find the best way to make the implementation of the substitution register and other surveillance mechanisms compatible with daily medical practice. The substitution treatment surveillance commission has been reformed by the Minister of Health and since August 2010 it is chaired by the National Drug Coordinator.

Outpatient: low threshold services and offers

Currently two agencies offer harm reduction services in the Centre, the South and the North of the country including offers such as day and night shelter and supervised injection facilities (currently only in the centre). A new integrated low threshold centre for drug addicts is planned to be implemented in the main city of the South of the country. In the North of the country a needs assessment on low threshold offers is currently carried out. The further development of harm reduction services in the North is part of the national drug action plan.

Inpatient: detoxification services and offers

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

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

Detoxification treatment is provided by psychiatric units within five general hospitals:
Centre Hospitalier du Nord – Ettelbrück (North)
Centre Hospitalier Emile Mayrisch – HVEA (South)
Centre Hospitalier de Luxembourg – CHL (Centre)
Hôpital Ste. Thérèse (Centre)
Centre Hospitalier du Kirchberg (Centre)

Inpatient: services and offers for adults

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

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

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

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

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

- Contribute to the physical and mental stabilization of the patient after clinical detoxification.
- Supervise the patient during the period going from the clinical detoxification to the admission in therapy or offer him a protected area to develop his project of social reintegration/rehabilitation.
- Free capacity of regional psychiatric services by admitting detoxificated patients for further care.
- As the national inpatient therapeutic facilities are limited and not covering the whole spectrum of drug related symptoms (e.g. double diagnosis) a series of patients are referred to specialised institutions abroad. If approved, related costs are covered by the national social security schemes.

The 2010 – 2014 national drugs action plan foresees the creation of a Stabilisation Unit (SU) within the CHNP. The SU should have a capacity of 12 beds and a limited duration of stay (e.g. 3 weeks). The objective is to take in charge drug users, detoxificated in hospital settings to further stabilise their health and mental state as well as to prepare their release and re-integration process. Preparatory works were undertaken by the time of writing and it is foreseen to open this new facility in the course of 2012.

Inpatient: services and offers for minors

A specialised residential centre for problematic youngsters has been opened in the beginning of 2007 in the North of the country under the management of CHNP. A new project defined as a residential referral and rehabilitation centre for minors in a rural setting is supposed to become operational in 2011/12. The referred case management programme will contribute to fill current gaps in the care system for minors.

CHARACTERISTICS OF TREATED CLIENTS AND TRENDS OF CLIENTS IN TREATMENT

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

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

SETTING	NUMBER OF ADMISSIONS (Specialised and hospital) NUMBER OF CONTACTS (Low threshold)							NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)						
	2000	2002	2004	2006	2008	2009	2010	2000	2002	2004	2006	2008	2009	2010
DEMAND REDUCTION: SPECIALISED DRUG TREATMENT														
OUTPATIENT														
- Drug Free								636	828	916	928	1,162	1,020	980
- Substitution								1,002	1,040	1,065	1,044	1,050	1212	1,248
INPATIENT														
- Drug free	43	57	53	44	129	156	130	158	153	182	183	124	119	128
- Hospital care[42]	/	/	617	637	600	/	527	316	429	476	484	397	400[50]	297
LOW THRESHOLD AGENCIES	13,083	29,536	39,526	55,808	78.415	110,674	140,093							
SUB TOTAL A: Number of drug treatment demanders (Multiple counts not excluded) (Multiple counts excluded)								**2,112 637**	**2,450 n.a**	**2,639 n.a.**	**2,639 n.a**	**2,733 n.a**	**2,675 n.a.**	**2,653 n.a.**
SUPPLY REDUCTION: LAW ENFORCEMENT INSTITUTIONS														
National prisons								161	101	92	243	332	224	232
Police - Judicial Police - Customs								1,758	2,217	1,808	1,573	1,487	1,963	2,530
SUB TOTAL B: Number of drug law offenders (Multiple counts not excluded)								**1,919**	**2,318**	**1,900**	**1,816**	**1,819**	**2,187**	**2,762**
TOTAL NUMBER OF PERSONS SHOWING DRUG-RELATED INSTITUTIONAL CONTACTS (Multiple counts not excluded)								**4,031**	**4,768**	**4,539**	**4,455**	**4,542**	**4,862**	**5,415**

Source: RELIS 2010 / CNS

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

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

Overall the number of persons showing drug related contacts with national DR or SR agencies has reached 5,415 in 2010. Until 2004 a sensible increase in drug treatment demands has been observed followed by an overall stabilisation confirmed by 2010 data, whereas contacts with law enforcement agencies have been increasing, from 2008 onwards. The number of substitution treatment demands begun to plateau around 2002 and showed a sensible increase in 2009 to stabilise anew in 2010. The number of adult out- and inpatient clients tends to decrease, while out-patient minor treatment demanders have been continually increasing. The most remarkable increases between 2008 and 2010 have been observed in substitution treatment demanders and in the number of contacts in low threshold facilities (2010:140,093). 4.7% (5.4%) of respondents are first treatment demanders, all treatment centres included. As far as first treatment demanders are concerned, 16.7 % are female against 83.3% of males.

Of clients in drug treatment, 78.3 (79%) are male against 21.7 (21%) females. The mean age of treatment demanders has significantly increased during the last ten years (1997: 28 years/ 2010: 32.1 years) and this mainly because of an observed increase in average male age (1997: 28Y2M/ 2010: 32Y7M). The mean age of the female clients is consistently lower (2010: 30Y6M). Respectively 58.3% of clients in treatment are natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French, Italian and German citizens.

Regarding the educational level of the clients in treatment, 73% have completed primary or complementary school, 26% have completed secondary school and 1% obtained a higher degree. 12.6% of respondents reported stable employment (important decrease - 1997: 65%) against 5.7% who are benefiting from unemployment allocations. Furthermore, 2.6% are students or engaged in a training contract. 27.8% of indexed treatment demanders had experienced one or more overdoses. As far as the exchange of syringes is concerned, 25.2% reported that they never shared syringes during their lifetime (39.1% during the last month). IDU combined to polydrug use (62.8%) is the most observed consume pattern in drug treatment demanders.

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

Outpatient: services and offers for adults

RELEVANT TREND: Ongoing decrease of total number of clients (980) compared with 2008 and 2009 data. Increase of male treatment demanders (73% male, 27% female). Stabilisation of the proportion of clients aged 30 and more (2010: 63% / 2008: 61%). A current trend is also to be seen in the increasing number of young mothers or couples with their child/children seeking out- and inpatient treatment.

After several years of stability, national outpatient drug counselling centres have been showing decreasing admission rates from 2008 onwards and decreasing first treatment rates intra and inter-agency wide. Gender distribution showed an overall increase of male clients over the last 10 years. Age distributions are varying according to the geographical situation of treatment centres. All in all, however, the proportion of treatment demanders aged 30 years and more has sensibly increased during recent years (2010: 63% / 2006: 57%). Underage clients tend to decrease until 2007 and stabilised since then, mainly because specialised agencies for minors have been implemented meanwhile. Treatment demands for problem i.v. opiate use associated to multiple-use is the main demand pattern (2010: 62% / 2009: 61% / 2008: 53% / 2007: 57% / 2006: 51% / 1997: 72%). Cannabis-related demands have shown a clear upward trend in 2009 and stabilised in 2010. The prevalence of cocaine use-related treatment demands is stable, however, bearing in mind that the exact prevalence is difficult to assess as in most PDU concomitant use of heroine is observed.

Outpatient: services and offers for minors

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

The rate of new treatment demanders has discontinuously increased since the implementation of the referred specialised agency. An increasing majority (71%) of clients are male. The proportion of clients aged below 14 years has been increasing slightly since 2008 (25% in 2008 and currently 30%). Cannabis use is the main reason of treatment demands (74%) witnessing a currently stable trend. However, the use/abuse of licit drugs and polydrug use is increasingly reported as reason of treatment. An increasing proportion of youngsters presenting psychiatric symptoms and/or socially deviant behaviour in addition to drug abuse are reported by specialised field agencies.

Outpatient: substitution treatment

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

The number of patients admitted to the national multidisciplinary substitution programme (JDH) has been sensibly decreasing from 2005 to 2009, 90 patients in 2010, which is supposedly due to the increasing access and admissions to lower threshold substitution treatment provided by independent yet specially licensed MDs. 35% (43%) of clients started substitution treatment in 2010. The proportion of female substitution treatment demanders (+/- 30% stable) is higher than the proportion of female PDU in the overall drug treatment population. 18% (20%) of the clients in substitution treatment are aged under 30, 48% (42%) are between 30 and 39, while 34% (38%) are over 40 years old. The **mean age** of clients has significantly increased over the last 10 years (36.5 years), which is due particularly to the steep increase of the number of treatment demanders over 35 (55% in 2008, 33% in 2000). The proportion of **native substitution treatment demanders has dropped (43%)**.The socio-economical situation of substituted patients is consistently more beneficial than the one observed in other treatment demanders. Polydrug use is the most observed consume pattern (72.5%) in substitution treatment demanders.

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

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

Table 5.2 Outpatient prescription of substitution drugs by the national network of licensed MDs / (1999-2010)

YEAR	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of indexed patients (double counting controlled)	745	844	849	820	913	/	970	939	979	961	1,128	1,246
Number of prescribing GPs (double counting controlled)	125	145	147	157	154	158	163	121	122	126	173	188

Source: CNS 2011

Table 5.3 Age distribution (%) of patients substituted by the national network of licensed MDs (2008-2010)

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

Source: CNS 2011 – data reformatted by NFP

The proportion of patients aged less than 25 years has been decreasing and the proportion of patients aged 45 and more has been increasing between 2008 and 2010.

Outpatient: low threshold services and offers

RELEVANT TREND: The number of contacts indexed by low threshold agencies has increased dramatically over the last 5 years (2010: 140,093 / 2005: 47,739), and so has the number of syringes distributed by the same agencies. The proportion of **new clients** within low threshold settings is on the decrease. Approximately 47% of clients are aged between 25 and 34 years, 31% of clients between 35 and 44, and 15% between 18 and 24.
The number of **female clients** has been showing a weak but constant decrease (currently 14% (20%)).

Inpatient: hospital care (detoxification treatment)

RELEVANT TREND: Drug detoxification units throughout the country have been showing a continuous increase regarding number of patients until 2006 (484) and a decrease to 297 in 2010. The number of treatment episodes, having remained fairly stable between 2004 (617) and 2009 (615), witnessed an obvious decrease to 527 episodes in 2010. Gender distribution has remained fairly unchanged between 2002 and 2010. Multiple drug use, including heroin, is the main reason for detoxification demands.

Inpatient: services and offers for adults

RELEVANT TRENDS: The number of inpatient treatment demanders (detoxification treatments excluded) appears to be slowly decreasing (183 in 2006, 2009: 119).The proportion of first treatment demands sets around 7%.

Heroin as preferential substance is reported by 76% (78%) (38% (49%) i.v./ 62% (29%) non-i.v.) of drug treatment demanders monitored by the national drug surveillance system RELIS whereas cocaine is only reported by 14% (9%) as first substance of use (18% (5%) i.v./ 45% (4%) non-i.v.) The average age at the first use of the preferred drug figures around 20.62 (18Y8M), whereas the mean age of the first i.v. consumption is 19.95 (21Y1M). 72% (73%) of the clients consume drugs more than once a day.

In 2009, a weak decrease in preference for intravenous heroin use (1997: 60%, 2009: 49%) was observed compared to 2008 (52%). This trend has been confirmed in 2010 (38%). The heroin inhalation mode (2010: 62%, 2009: 20%) has becoming more prevalent compared to 2008 (14%). Polydrug use is the most observed consume pattern (75%). The i.v. heroin sub-population shows the highest mean age (31.18) of all treatment groups. 5% (2%) of the latter are first treatment demanders compared to 8% (5%) of non-iv heroin users.

Cocaine use as main reason of treatment demand showed a significant increase from 2004 to 2006 and decreased again in 2007 (2010: 14%). Mean age of preferential cocaine using treatment demanders in 2010 was 31.82. With 20% (21%) of first treatment demanders, primary cocaine users show the highest lifetime first treatment rate. Cocaine prevalence as secondary drug has decreased from 43% in 2004 to 34% in 2009. In 2010 however, a slight increase is observed: 40% of inpatient clients reported cocaine as secondary drug. Crack has not been reported, neither as main problem drug nor as secondary or occasional drug.

The percentage of treatment demands related to cannabis use (5%) in 2010 has been decreasing following a peak in 2009 (11%). Treatment demands related to ecstasy use are rare (1-3%) and have shown a fair stability over the last years. The same comments apply to ATS use.

6. HEALTH CORRELATES AND CONSEQUENCES

INTRODUCTION

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

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

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

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

   Both sources are independent, meaning that for the SPJ register data collection occurs via police records and forensic evidence, while the GMR is updated according to information contained in death certificates. Discrepancies between the referred registers mainly originate from different encoding routines (e.g. death certificates often only mention primary cause of death) explaining the fact that the DRD v 0.3 systematically underestimates the SPJ based number of drug-related deaths as can be seen in figure 6.6.

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

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

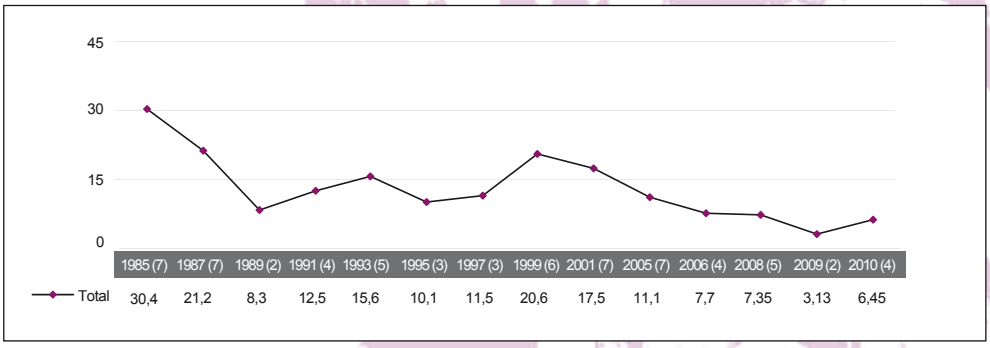
DRUG RELATED INFECTIOUS DISEASES

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

Data on drug-related infectious diseases are centralised at national level. No regional data sets exist. Official data from the national Retrovirology Laboratory of the CRP-Santé provide the number and proportion of IDU in HIV infected patients. Between 1984 and 2010, 1,011 HIV infected persons have been registered at the national level; 121 of the former were reported IDU, which leads to an average proportion of IDU in the national HIV population of 11.96% since the registration of the first HIV case in Luxembourg in 1984.

Currently, intravenous drug use appears to be the third most reported transmission mode of new HIV infection since 1989 (homo/bisexual and heterosexual transmission are currently in first and second position respectively). The proportion of intravenous drug use transmission has noticeably decreased between 1998 (23%) and 2010 (6.45%). The lowest proportion of IDU transmission mode ever recorded was observed in 2009.

Fig. 6.1 Proportion (%) of IDU in newly infected HIV patients (1985 - 2010)



Source : Laboratoire de Retrovirologie – CRP-Santé. 2010 (data formatted by NFP)

The Origer and Removille study (2007)[45] assessed the national HIV, HCV, HAV and HBV in the population of problematic users of illicitly acquired drugs prevalence via serological test results. Furthermore, the authors performed a cross sectional analysis of the relation between the studied infections and selected observable factors, to increase the national vaccination coverage and to refer infected persons towards appropriated medical treatment centres.

45 Downloadable at: http://www.relis.lu
Related peer reviewed paper published in 2010:
Origer A, Schmit J.-C. Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. *J. Epidemiol Community Health* doi: 10.1136/jech.2009.101378

Main results are the following:

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

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

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

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

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

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

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

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

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2010, (N=156) 83% of RELIS indexed PDU reported a HIV test during the last 12 months. The testing rates of female PDU were slightly higher than those of male PDU.

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

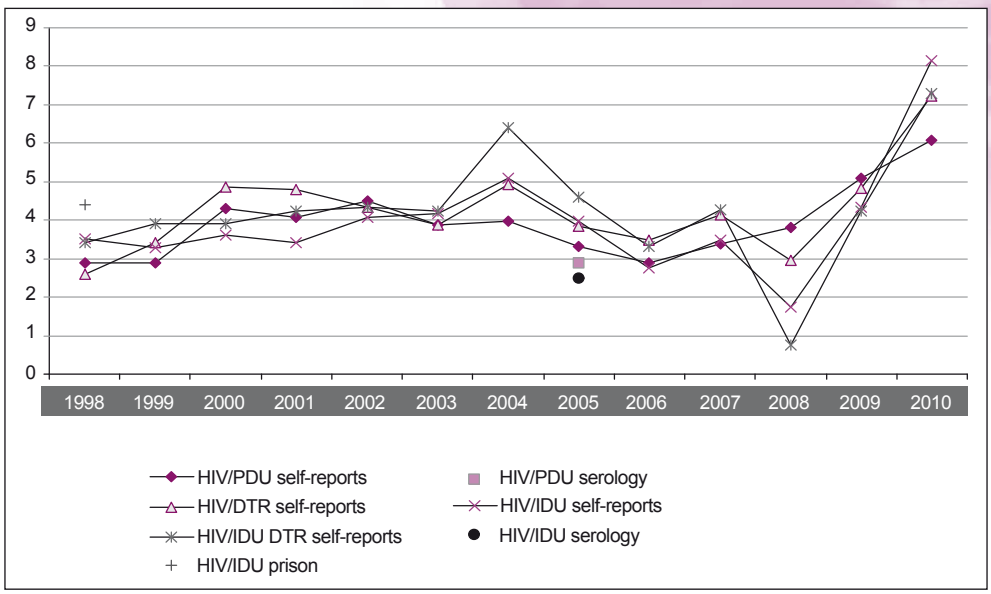


*Table 6.2 Synopsis of national data on **HIV** infection rate in drug using populations (valid %)*

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

Source: RELIS 2010

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

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

Source: RELIS 2010

HIV rates in current PDU have been varying over the last ten years although in quite narrow margins figuring 3 to 5%. In 2010, however, based on self-reported data from RELIS, the HIV rate increased for all categories figuring 6 to 8%. During the last five years, the HCV infection rate decreased for all PDU and for drug treatment demanders, but the same rate shows variations for IDU and even increased in 2010 for this category.

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

YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Self-reported HCV rate in drug users (RELIS)	25	32	46	50	49	59.92	64.55	64.94	64.95	64.06	63.39	50.55	49.61
HCV rate in PDU (Origer & Removille)								71.40					
Self-reported HCV rate in drug treatment demanders	29	41	53	54	54	60.49	66.16	66.22	63.23	63.08	61.11	53.79	50.47
HCV rate in IDUs prisoners (saliva tests)	37	/	/	/	/	/	/	/					
Self-reported HVC rate in IDUs (RELIS)	45	50	53	56	53	67.97	74.14	74.38	69.58	72.02	65.48	58.94	62.63
HBV rate in ever-injectors (Origer & Removille)								81					

Source: RELIS 2010 (Origer & Removille, 2007)

Summarily, HCV prevalence in PDU appears to have reached a plateau at a high level in 2006-07, showing, however a sensible decrease in 2009 and 2010. HIV infection rates show an increase especially referred to IDU.

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

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

OTHER DRUG–RELATED HEALTH CORRELATES AND CONSEQUENCES

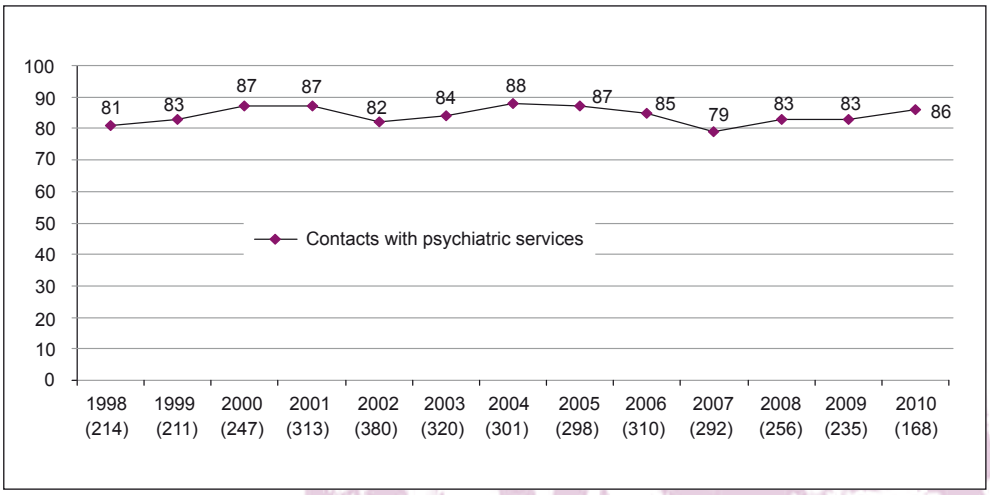
Psychiatric co-morbidity (Dual diagnosis)

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

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

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

Fig 6.3 Previous contacts of PDU with psychiatric services of RELIS indexed drug users. 1998 - 2010



SOURCE: RELIS 2010

Fig 6.4 Reasons for psychiatric care demands 1996-2010

SOURCE: RELIS 2010

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

Data from 1996 to 2010 reveal a fluctuating but a fairly stable long term proportion of PDU showing a psychiatric history.

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

DD patients are considered as drug treatment demanders with specific and highly diversified needs that are difficult to encounter in traditional drug care agencies. The concept of 'multiple vulnerabilities', that is, concomitant vulnerabilities to drug abuse and mental disorders, tends to be recognised by professionals. DD patients very often present a lack of behavioural structure or stability. Usually those patients are unable to function in a regulated environment. Moreover, the requirement of most therapeutic settings include that the patients submit to detoxification treatment prior to admission. This latter requirement is often impossible to meet with DD clients as drug intake often represent a kind of self-managed auto-medication, dangerous to change radically at the beginning of a therapeutic process. It is therefore most difficult to integrate DD patients in traditional drug care settings also in terms of consistency of rules to be respected by all drug treatment demanders. To date, no care facilities specialised in drug addiction co-morbidity exist at the national level. The Department of Medical Control of Social Security Administration, in collaboration with drug agencies, assesses whether a given patient should be referred to specialised institutions in foreign countries. Agreements between the latter administration and a series of specialised care agencies abroad have been made. If the referral demand is approved, related costs are reimbursed by Social Security.

As far as treatment of DD patients in prison is concerned, a collaboration convention between the national prison administration (CPL) and the national neuro-psychiatric hospital (CHNP) has been signed in 2002. The convention sets the framework for the creation of a psycho-medical department within prison and regulates prevention, care and referral of mentally disabled as well as alcohol and drug dependent inmates. Therapeutic care, substitution treatment and counselling is provided ad hoc. In case of severe mental disorders, imprisoned patients are referred to a high security department within the CHNP.
Compulsory treatment or confinement does only occur if there is a proved offence against the law by which the offender is declared irresponsible of his/her own behaviour. This only occurs following a legal psychiatric expertise.

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

Somatic co-morbidity

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDU. In 2010, 81 (83) per cent of problem drug users reported a self-perceived satisfying general health condition against 53% in 1997. 56% (60%) report no non-fatal overdose(s) during lifetime which is a small decrease compared to the previous year.

Drugs and driving

Figure 6.4 provides data on cannabis exposure of persons suspected to drive under influence of psychoactive substances from 1995 to 2010. Around 50% of referred persons were tested positive on cannabinoids.

Fig. 6.5 Detection of cannabinoids - Suspicion on driving under influence of psychoactive substances (1995 - 2010)

Pregnancies and children born to drug users

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

DRUG–RELATED DEATHS AND MORTALITY OF DRUG USERS

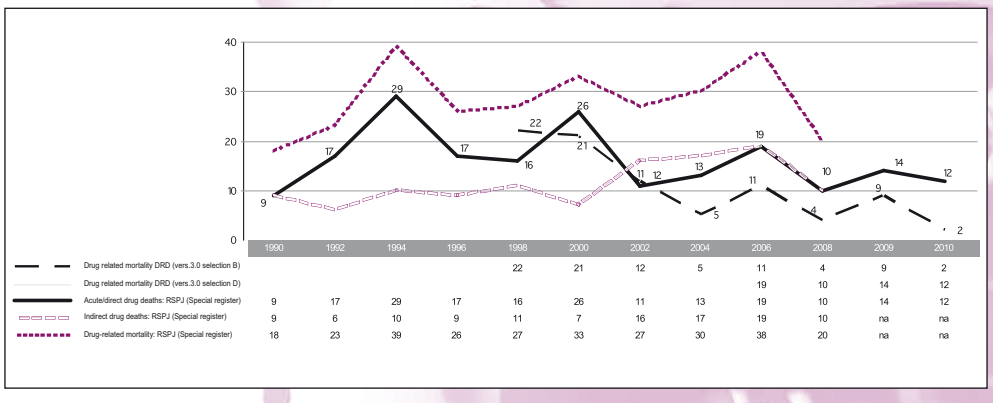
Direct overdoses and indirect drug related deaths (see ST5 and 6)

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

As can be seen in figure 6.6 the DRD v.3.0 standard (selection B) appears to be fairly weak proxy of direct, indirect and total drug deaths as indexed nationally by the RSPJ. Overall drug related mortality, however, should not be assessed by the same standard as far as Luxembourg is concerned. Cases not filtered by selection B mainly include combined X49 codes, followed by Y34 and T65.9 codes. A very high to perfect agreement is observed between the RSPJ register and selection D (DRD v.3.0).

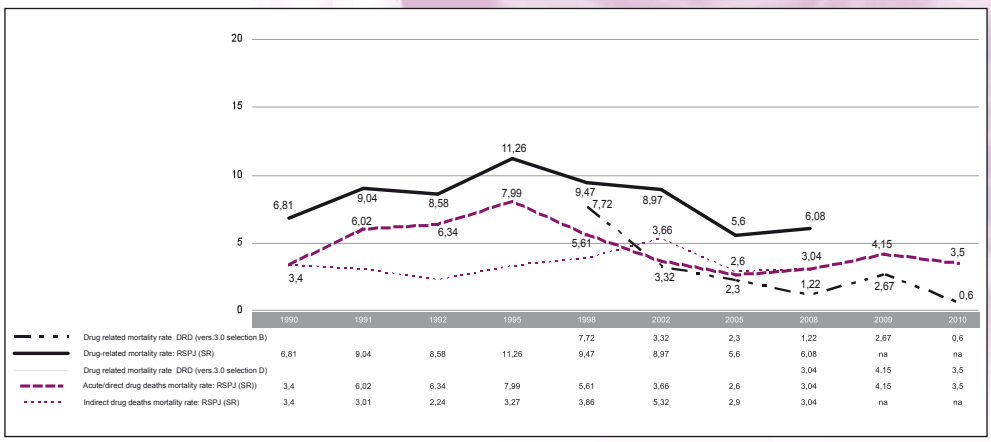
The number of **fatal acute overdoses** indexed at the national level has shown an overall discontinuous decrease since the beginning of the 21st century. In 2000, 26 acute drug deaths were registered whereas 12 cases were reported in 2010. Indirect drug-related deaths have known broad variations in number during the same period (2009 and 2010 data not available).

Fig. 6.6 Evolution of drug-related death cases (direct - indirect - total mortality) from 1990 to 2010 (Origer, 2011)



Confronted to most recent national prevalence figures on problem drug users referring to data of 2007 (N = 2.470), (Origer, 2009), **overdose rate in PDU** situates at 0.49 % cases / PDU (1.1 % in 2000). The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants[46] in 2000. In 2010 overdose rates of 2.39 and 3.5 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed. International comparison should be considered with caution since methodologies used to determining prevalence of DRD deaths are not necessary comparable throughout EU as shows for instance the structural underestimation of the number of acute drug death based on the EMCDDA DRD v.3 standard.

Fig. 6.7 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2010 (Origer 2011)



46 All age groups

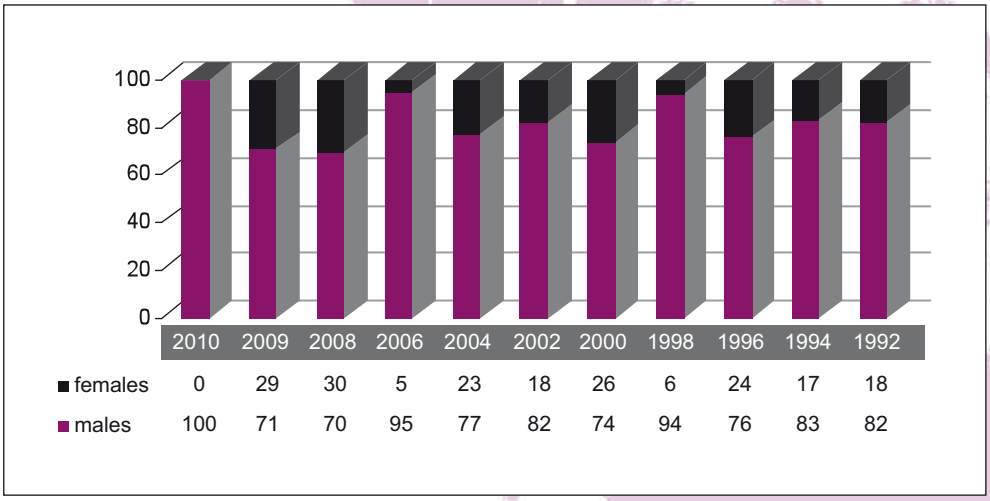
The overall discontinuous decrease of acute overdose cases from 1994 onwards has been associated to the regionalisation and extension of the methadone substitution programme as well as to the further development of low threshold facilities. The decreasing trend from 2000 to 2002 is thought to be a medium term consequence of the higher proportion of non-i.v. opiate users observed during that same period followed by a stabilisation around 4.5 percent. The positive evolution of direct drug deaths is to be associated to the implementation of a drug consumption room in 2005. Considering that since the opening in 2005 of the drugs injection room more than 800 overdose victims could be assisted and reanimated in this same facility, the life-saving effectiveness of such an offer is proven.

A retrospective study (1992-2006) on drug-related death cases performed in 2007 allowed a better understanding of risk and protective factors (Origer, 2008).
Forensic data by the department of National Toxicology Laboratory on Health [47] show that the most frequently involved substance in overdose cases is heroin, followed by methadone and cocaine. To stress that since 2000, methadone presence in blood samples of overdose victims has been increasing.

All the victims are male (100%) and their mean age at the moment of death shows an important increase over the past 15 years (in 1992: 28.4 years and in 2010: 31 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years remains relatively unchanged during the referred observation period.

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

Fig. 6.8 Gender distribution of direct drug-related death cases (1992 - 2010) (%)



SOURCE: RELIS 2010

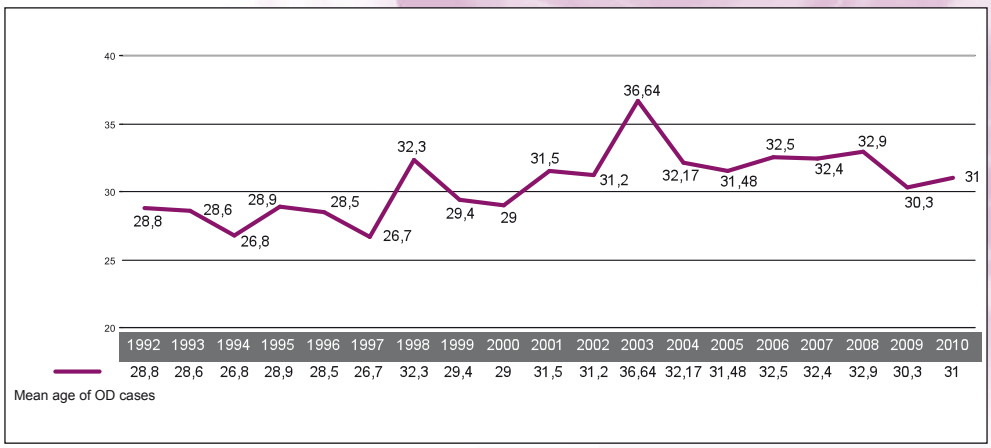
47 Département de Toxicologie du Laboratoire National de Santé

Table 6.5 Age distribution of direct drug death cases indexed from 1992 to 2010

	2010	2009	2008	2006	2004	2002	2000	1998	1996	1994	1992	Total
< 20	1	2		1			1		1	3		19
20-24	4	2	2	4	1	4	8	2	5	6	6	66
25-29	2	3	2	4	4	1	6	5	5	13	6	88
30-34	2	2	1	2	3	3	6	2	4	6	3	62
35-39		2	3	5	2	1	4	4	1	1		43
40-44	2	2	2	2	2		1	3			1	26
45-49	1	1			1	2	1				1	11
≥ 50				1					1			4
Mean Age	**31**	**30.3**	**33.16**	**32.5**	**32.17**	**31.18**	**29**	**32.3**	**28.5**	**26.8**	**28.4**	**319**
Male	31Y	32Y5M	32Y8M									
Female		25Y	33Y8M									

In 2010, the mean age of male overdose victims was sensibly lower than in 2009. In 2010, the youngest victim was aged 18 years and the oldest reached 48 years. No underage victims were reported in 2010. Considering the nationality of overdose victims, 92% were natives. During the entire observation period, Portuguese citizens have been the second most frequently observed victims. Recently, one could observe a rather stable number of victims from the frontier zone (BE, DE, F) and a decreasing number of victims of Portuguese origin.

Fig. 6.9 Mean age of acute drug overdose victims (1992-2010) (RELIS 2011)



Mortality and causes of deaths among drug users

The above mentioned study (Origer & Dellucci, 2002)[48], has revealed that, as far as the Grand-Duchy of Luxembourg is concerned, the mere application of the DRD standard does not allow for a valid computation of drug related death cases. Therefore, the authors did compute the total number of drug-related deaths by adding cases of the SR that were not indexed by the application of the DRD standard to the GMR. The figures resulting from corrected DRD v.3.0. data are referred to as **'national selection'** and provide the annual total number of controlled drug-related fatalities at the national level (12 direct/acute death cases in 2010).
In 2000, a first cohort study on the mortality in the national drug population has been performed by the NFP in the framework of a multi-methods prevalence study (Origer & Pauly, 2000). The cohort included 242 opiate drug addicts followed from 1991 to 1999. Mortality data have been collected from treatment agencies, the RELIS database, the GMR and the Special Overdose Register of the SPJ. In accordance to applied methodologies, results show **mortality rates varying between 2.36 and 2.51 per cent**.

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

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

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

INTRODUCTION

Responses to health correlates and consequences of drug use aim at minimising the resulting damage for the drug users and their environment, and at increasing individual/collective resources. The concept of risk and harm reduction is directly linked to health consequences of drug use, whereas nuisance reduction is seen as a correlate of the latter.

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

In September 2011 a new national HIV/AIDS action plan (Ministry of Health, 2011) covering the period 2011 to 2015 has been launched by the Ministry of Health. The action plan is based on 8 pillars including prevention of infectious diseases and harm reduction in drug using populations. It builds upon the external evaluation results of the 2006-2010 national HIV/AIDS plan and complements or enhances infectious diseases' reduction measures included in the national drugs action plan 2010-2014. The document can be downloaded under http://www.ms.etat.lu.

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

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

Research and recommendations

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

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

Drug injection room and low threshold shelters

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

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

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

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

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

Tab 7.1 Clients statistics of TOXIN centre services

Injection Room	**July 2005 - December 2010**	**2009**	**2010**
Number of user contracts signed	954	94	119
Number of users episodes	64,479	36,558	33,018
Number of injections	136,758	43,871	39,960
Number of non-fatal overdoses *With loss of consciousness* *Without loss of consciousness*	790 *149* *641*	198 *54* *144*	327 *42* *285*
Number of fatal overdoses	0	0	0
Medical emergency interventions	121	46	33
Day care	December 2003 – December 2010	2009	
Number of clients	283,720	77,333	65,307
Night shelter	December 2003 – December 2010		
Number of different residents	1,840		

Opening hours have been modified in course of 2010 due to an increasing number of clients and resulting temporary staff shortages. Currently the night shelter is open 7 days a week with a capacity of 42 beds. The TOXIN day centre, and injection room (7 injection tables) is temporarily closed on Saturday. TOXIN facilities are mostly used by men (86%); the most commonly used drugs were heroin (79%), cocaine (15%) or both of them (6%). Cocaine use has obviously increased in 2010. Age category 25-34 is mostly represented (47%).

No fatal overdose has occurred thus far but about 800 overdoses have occurred since the opening of the injection room and due to the immediate intervention of ad hoc staff all victims could be assisted, reanimated and their live saved. The drug scene of Luxemburg-City adheres to a great extend to the TOXIN concept with the positive effect that public nuisance has significantly decreased. The increasing number of users attracted by the TOXIN services poses however a problem of clients' management given the fact that the container structure was meant to be of provisional use and is currently reaching the limits of its service capacity. Therefore, a new centre will replace the previous one and should become operational in the beginning of 2012. Its implementation site is the immediate vicinity of the current centre. Architectural planning of the replacement structure has built upon past experience and also foresees the inclusion of a supervised drug inhalation facility, currently not available in the present centre. The concept of the drug injection room has been revised accordingly.

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

As far as the northern region of the country is concerned, it has been said that a needs assessment was commissioned by the Ministry of Health. The main objective of the latter was to determine the specificity of drug use patterns in this region and the gaps in existing harm reduction offers. During a 6 months prospection phase data have been collected via drug users, residents, shop owners, social actors and local municipal authorities. First results of the assessment (JDH, 2011) clearly emphasis the need of a tailor made low-threshold offer in the region. However, the type of offer needed appears to differ from those currently existing in bigger cities such as Luxembourg and Esch/Alzette. The drug user population living in the northern region is not locally concentrated and non-intravenous use is reported to be far more prevalent than IDU.

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

The law of 27 April 2001 introduced an important modification of the basic drug law with regard to overdose prevention. Art.10-1 of the referred law exempts drug users who call for assistance in case another user is in need of medical help, from prison sentences and from fines in certain circumstances. In general, witnesses meeting these conditions are not prosecuted. As an accompanying measure an information flyer has been elaborated jointly with field agencies and the Ministry of Health and broadly distributed. The flyer contains useful information on safer injection and advice in case of overdose events.

Heroin assisted treatment (HAT)

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

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

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

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

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

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

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

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

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

PREVENTION AND TREATMENT OF DRUG–RELATED INFECTIOUS DISEASES

Prevention

Interventions aiming at the prevention of drug-related infectious diseases as for instance needle exchange and substitution programmes have been initiated and developed prior to the set up of a specific legal framework. The drug law amendment of 2001 did not only allow maintaining and to further developing existing harm reduction offers but also set the foundation for the implementation of new services such as supervised drug injection rooms and medically assisted heroin distribution as foreseen by the national drugs action plan.

The objective of these interventions is straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Both IDU and non IDU are target groups of HR interventions. The planned inclusion of a drug inhalation facility in the new TOXIN centre is a sound example of the national approach.

The most relevant measure in the field of prevention of infectious diseases in drug users is the national needle exchange programme established in 1993 and co-ordinated by JDH. In addition to free of charge needle provision by specialised drug and AIDS agencies, automatic syringes dispensers/collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy.

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

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

As can be seen in table 7.2, the number of re-collected used syringes exceeded in recent years the number of distributed syringes via the national NEP, (vending machines excluded), which suggests that users also bring along syringes bought in pharmacies or originating from vending machines, which is considered to be a highly positive evolution.

Table 7.2 National needle exchange programme (NEP) 1996-2010 including specialised agencies, vending machines and the supervised injection room

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

Source: RELIS 2011

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

Table 7.3 Needle exchange programme (NEP) in prison (CPL) 2005-2010

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

Source: CPL 2011

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

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

Counselling and testing

AIDSBERODUNG (RED CROSS) is the main national counselling and prevention centre for HIV and AIDS. Prevention campaigns are conceptualised by the AIDSBERODUNG team in collaboration with the Ministry of Health and an important network of volunteers. Anonymous testing is provided by the CHL and the LNS and is free of charge. The 2011-2015 HIV/AIDS action plan foresees 2 new free testing sites in the North and the South of the country thus regionalising free testing opportunities.

Under the previous national HIV/AIDS action plan 2006-2010 a mobile intervention facility for sexual health (DIMPS) has been set up. DIMPS may be described as an outreach offer for specific target populations and vulnerable groups aiming to access difficult to reach sub-populations and provide prevention counselling and on site infectious disease testing. The project, started in May 2009, provides free rapid testing of HIV, hepatitis and outreach counselling targeting among others drug users' scenes, sex workers and asylum seekers. From the recent start of DIMPS to the end of 2010, 58 interventions have been reported, 184 persons counselled and 113 HIV/HCB/HBV rapid tests performed. Respectively 44% and 61% of persons tested declared that they have never been tested before for HIV and HCV respectively. More detailed information is retrievable at http://www.dimps.lu.

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

Infectious diseases treatment

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

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

Interventions related to psychiatric co-morbidity

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

RESPONSES TO OTHER HEALTH CORRELATES AMONG DRUG USERS

Somatic co-morbidity and general health related treatment

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

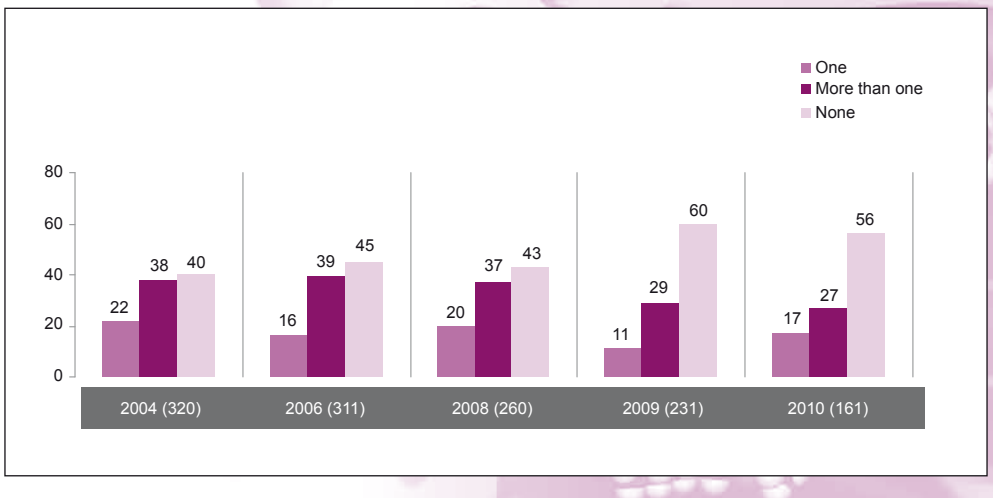
The vast majority of specialised out- and inpatient and low threshold drug care facilities include medical or paramedical care in their service provision. If needed, patients are referred to specialised treatment. Related costs are covered by health insurance schemes or by the Ministry of Health in case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

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

Non-fatal drug-related emergencies

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

Fig. 7.1 Non fatal, medically assisted drug overdoses in RELIS respondents (2004-2010) (valid %)



Source: RELIS 2010

Prevention and reduction of driving accidents related to drug use

The law of 18 September 2007 modifies the national traffic code and introduces testing of illicit drug use in vehicle drivers. The homologation of respective road side tests should be regulated by a grand-ducal decree in the course of 2011. For more details on the new legislation please refer to chapter 1 (laws).

Interventions concerning pregnancies and children born to drug users

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

Due to the improvement of, and the better access to drug-related treatment and especially the spread of substitution treatment, the birth rate in drug users has increased over recent years. According to data from the national drug surveillance system, the proportion of drug users having children has progressively increased over the last 10 years (RELIS 2010). This evolution has been leading to the first parental project launched by JDH in 2003 with the aim to provide psycho-social aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative abilities. This long term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

INTRODUCTION

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

SOCIAL EXCLUSION AND DRUG USE

Social exclusion among drug users

The question whether substance abuse leads to social degradation and exclusion or social factors (e.g. family situation, poverty, low education or job perspectives) lead individuals to substance use is an unsolvable one, although it tends to raise competence issues between ministries. Obviously a vast majority of homeless and socially excluded people also present to various extends licit and/or illicit substance abuse. Also, economic parameters tend to have a tangible impact on drug use prevalence and patterns as well as on the level of acceptance and perception of drug addicts by the general population.

A sound example of how social rejection and drug abuse are dynamically linked might be seen in the national results of the 4th wave of the European Values Study[49] . 55% of national respondents (N: 1,610) described drug addicts as most unwanted neighbours. In 1999 drug addicts still occupied the second position (43%).

Also, providing medical and psychological care to drug dependent persons is not enough as the social situation of these people needs to be improved before sustained outputs in drug treatment is expectable. This said, the national strategy of care for socially excluded people is based on the principle of progressive reintegration through capacity building and the improvement of the social abilities and environment. Associations as 'Stëmm vun der Strooss' (Street voice) and ARCUS asbl, financed by the Ministry of Health, try to involve the target population again in active life by providing a safe and common environment and respecting individual capacities and resources by applying case management methodologies further described below.

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

HOMELESSNESS

According to latest estimations around 700 persons are currently homeless in the Grand Duchy of Luxembourg [50]. The study reported a proportion of 54% males and 46% females and a relatively low age of the homeless population. Approximately 50% of homeless persons are aged 18 to 34 years and only 9% are aged more than 55 years.

More specifically, housing status of registered drug users has markedly improved during recent years and tended to balance over the last years, even though 2009 and 2010 data witnesses a first decrease. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Currently 62 percent (64%) of PDU report a stable housing situation (RELIS 2010). This positive evolution may be linked to an increased awareness of the housing problem and the set up of new housing networks for socially deprived people by the Ministry of Health and specialised agencies. Recent figures also tend to confirm that although specialised accommodation offers have been further developed, the current economic situation has created an even higher demand for this type of housing.

Fig. 8.1 Last known housing situation of problem drug users. 1995 - 2010

Source: RELIS 2010

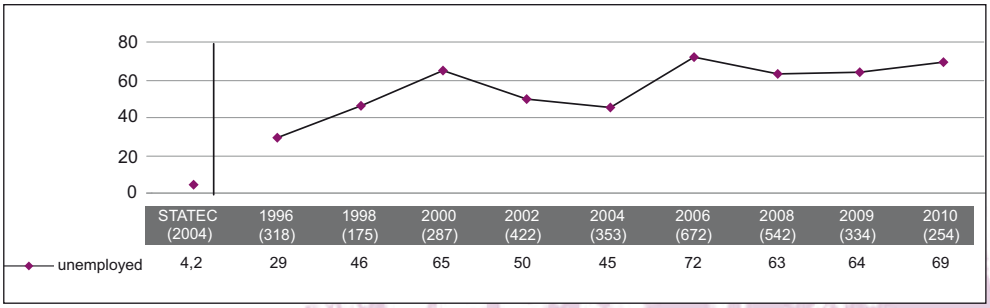
Youngsters aged less than 25 and living in the street are referred to as a quite new phenomenon. Societal changes as the increase of mono parental families, an increased number of divorces, increasing youth jobless rates and the necessity to work for economic reasons for the two partners of a parental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

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

UNEMPLOYMENT

The **unemployment rate** (69%) shows an increase for 2010. However, an in-depth analysis shows that the proportion of active respondents reporting a stable job situation (e.g. long term contract) (12%) has sensibly decreased over the 3 last years, which might be partly due to the ongoing economic crisis.

Fig. 8.2 Unemployment rate in problem drug users (1996 - 2010)



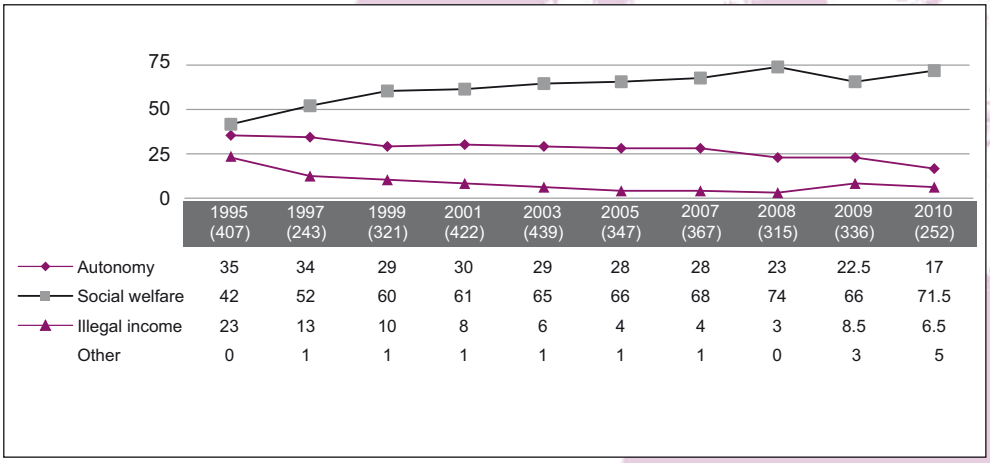
	STATEC (2004)	1996 (318)	1998 (175)	2000 (287)	2002 (422)	2004 (353)	2006 (672)	2008 (542)	2009 (334)	2010 (254)
unemployed	4,2	29	46	65	50	45	72	63	64	69

Source: RELIS 2010 **Remark:** STATEC: Statistical Department of State – Unemployment rate in active general population.

Data on revenues confirm observed trends in occupational status:

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

Fig. 8.3 Primary source of income of problem drug users (1995 - 2010)



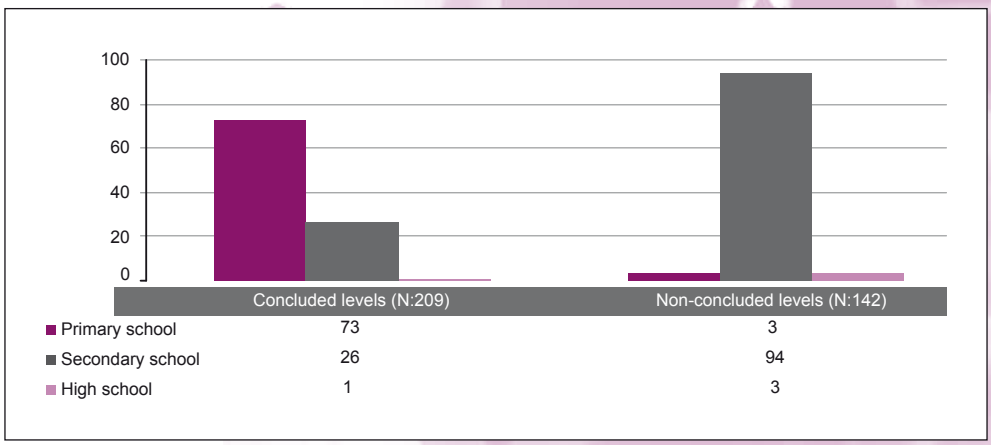
	1995 (407)	1997 (243)	1999 (321)	2001 (422)	2003 (439)	2005 (347)	2007 (367)	2008 (315)	2009 (336)	2010 (252)
Autonomy	35	34	29	30	29	28	28	23	22.5	17
Social welfare	42	52	60	61	65	66	68	74	66	71.5
Illegal income	23	13	10	8	6	4	4	3	8.5	6.5
Other	0	1	1	1	1	1	1	0	3	5

Source: RELIS 2010

SCHOOL DROP OUT

The study of 'School leave in Luxembourg'[51] (2006) surveyed a population of 37,347 secondary school students during 1st November 2004 and 30 April 2006. A total of 2.422 students left school without a professional certification (temporary stay offs from school have also been taken into consideration). The study refers to a proportion of 6.5% of 'school leavers'. This proportion figures 3.6% if one is considering the total number of students having been reached but did not reintegrated a school in Luxembourg. Concerning this category of school leavers, composed of students attending courses abroad, being employed, following professional insertion measures and those without occupation (N=1,357), the situation was as follows: 41.2% of students who dropped school have integrated the job market (work or professional insertion measure), 39.8% didn't work nor went to school and 19% attended school courses abroad. In general, boys, youngsters from abroad and aged more than 15 years (age of school obligation in 2006) are more vulnerable to the risk of early school leave.

Fig. 8.4 Educational level of RELIS respondents (2010)



Source: RELIS 2010

Regarding PDU, the **educational level** of the latter, low and mostly incomplete, has been showing a creeping deterioration since 1999 according to baseline data from RELIS. However, an increasing proportion of respondents start secondary school without bringing their studies to term. The average age at the end of studies shows a global decreasing tendency and currently situates at 17 years. Lower levels are particularly observed as regards acquired secondary and high school diploma.

FINANCIAL PROBLEMS

The RMG (Guaranteed Minimum Income) (31%) and the proper salary (16%) represent the main income sources of the PDU. Between 1997 and 2010, strong variations were observed in relation with these two revenues. RMG as a primary source of revenue has known a remarkable increase from 1997 onwards in contrast to the proper salary, which decreased during the last years (annual fluctuation in 2010 to be further observed). Money provided by parents as first source of income has also decreased (18% in 1997 to 4% in 2010).

Concerning secondary income sources, 38% referred to 'illegal activities'[52] and 18% were provided money by parents.

51 Ministère de l'Education nationale et de la Formation professionnelle (2006). Le décrochage scolaire au Luxembourg. Luxembourg.
52 Mainly selling of drugs.

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

SOCIAL REINTEGRATION

Housing

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

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

A project called 'Les Niches' functions as a social real estate agency for drug addicts. Approximately 35 flats and apartments are rented by a drug-counselling centre and provided to drug addicts in need by means of tailor made renting contracts. One of the medium term aims of the project is to allow demanding drug addicts to take over the renting contract on basis of their own financial means and thus dispose autonomously of a stable accommodation. The project is jointly financed by the Ministry of Health, National Fund against drug trafficking, and the City of Luxembourg (VDL). The vast majority of real estates are rented by the JDH from private proprietors; the remaining ones belong to the national housing Fund (Fonds de logement) or to municipalities.

A network of **supervised housing facilities** for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone are operational since September 2002 and are situated in the vicinity of the main centre in order to take advantage of training and social reintegration facilities offered by the CTM. The CTM also offers educational aid in several domains as well as professional training opportunities. 25 persons benefit from the referred offer that builds upon apartments and houses situated in 6 different municipalities.

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

Education, training

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

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

Employment

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

Additionally clients are offered task and job opportunities in the laundry service called *'Schweessdrëps' (Drop of sweat*) which covers the south of the country and is specialised in washing sports teams' uniforms. In 2010, 1 social worker, 2 educators and uniforms weekly. Besides these two main work-opportunities, the service also offers a therapeutic workshop called 'Dressed for success'. In 2010, the service has been managed by 2 clients (offering them a job opportunity and responsibility).

A new occupational project foreseen for 2013 and run by the 'Street voice' ('Stëmm vun der Strooss') association should further close the gap in occupational offers for drug addicts at the national level. The final concept of the residential centre offering temporary accommodation and day jobs will be described in the 2012 report.

Co-financed by the Ministry of Labour and Employment and the European Social Fund, the former Centre Emmanuel association launched the project **'START'** in 2007, targeting progressive re-integration of drug users into the first job market (G. Lambrette, 2009) [53]. The applied methodology combined case oriented follow-up and job coaching and aimed at helping beneficiaries to find a work or professional training place (e.g. establishing contact with companies, preparing job interviews, editing of resumes, etc.) and to assist them in their daily work routine (definition of tasks, conflict management, mediation between employee and employer, motivational follow-up, etc.). Intermediate feedback and final evaluation contributed to improve autonomy of clients and are ideally leading to a permanent work contract. As one of the main impediments regarding access to jobs by vulnerable groups, is the initially or even permanently reduced work performances. The main objective of a job coaching project is the mobilisation of individual resources and capacities of the beneficiary in tune with the need of the company he or she is given the opportunity to work for.

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

In 2011 Arcus asbl, formerly called Centre Emmanuel, candidated for the EU programme **"Job Alliance"** an initiative of the European Social Fund. Priorities of the referred project are:

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

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

The referent system

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

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

INTRODUCTION

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

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

- *'Interpellation' (Eng. Interpellation / peremptory questioning, to call on):*
  Intervention of law enforcement agents based on reasonable suspicion. The *'interpellated'* person is heard and a police record occurs. At this level, however, there is no notification to the Public Prosecutor and no mention in the judicial record.

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

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

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

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

DRUG–RELATED CRIME

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

Drug law offences

As can be seen in tables 9.1, the total number of arrests (229) has increased discontinuously during the last 10 years. Traditionally heroin was the most frequent substance involved in drug-related arrests. In 2004, cocaine has turned to be the main substance involved in those arrests (confirmed by 2005 data), followed by heroin and cannabis.

Table 9.1 Arrests broken down by type of reporting institution (1995-2010)

Year	ARRESTS											
	1995	**1997**	**1999**	**2001**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
S.P.J.	27	25	27	7	25	38	26	39	49	32	20	15
Gendarmerie	8	15	15	45	82	103	94	124	79	102	92	166
Police	32	32	32									
Customs	61	82	34	40	28	37	35	62	41	54	33	489
Total	**128**	**154**	**108**	**92**	**135**	**178**	**155**	**225**	**169**	**188**	**145**	**229**

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP), stable between 1996 and 1998, showed an important increase from 1998 to 2003 (825 to 1,660) and has been stabilising since then. In 2009 and 2010, however, the number of referred police records increased anew (2010: 2,546 records).

The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 1998 followed by a subsequent increase. From 2003 to 2008 (1,487), one observes a significant decrease in drug law offenders, but obviously a new increase in 2009 (1,963) and 2010 (2,530). The number of arrests on the same charge has decreased from 154 in 1997 to 135 in 2003 to increase and reach its peak in 2010 with 229 arrests.

Table 9.2 records the total number of law enforcement interventions and number of 'prévenus' at the national level ensured by respective law enforcement actors that are the Specialised Drug Department of the Judicial Police (SPJ), Police and Board of Customs from 1995 to 2010.

Table 9.2 Number of national law enforcement interventions (1995-2010)

Year	DRUG LAW ENFORCEMENT RECORDS									
	1995	**1997**	**1999**	**2001**	**2003**	**2006**	**2007**	**2008**	**2009**	**2010**
S.P.J.	123	137	343	216	239	190	177	110	121	134
Gendarmerie	198	255	782	1,126	1,326	824	998	881	1,465	1,969
Police[54]	199	177	189							
Customs[55]	244	236	173	113	95	186	197	228	328	443
Total	**764**	**805**	**1,187**	**1,455**	**1,660**	**1,200**	**1,372**	**1,219**	**1,976**	**2,546**

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

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

	OFFENDERS									
Year	**1995**	**1997**	**1999**	**2001**	**2003**	**2006**	**2007**	**2008**	**2009**	**2010**
S.P.J.	152	182	434	321	369	248	203	128	121	131
Gendarmerie	319	335	916	1,272	1,753	1,007	1,160	1,009	1,459	1,960
Police[56]	371	280	283							
Customs[57]	421	408	306	182	148	320	324	350	325	439
Total	**1,263**	**1,205**	**1,939**	**1,776**	**2,270**	**1,575**	**1,687**	**1,487**	**1,963**	**2,530**

Source: Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 85% **males**; a proportion that has been varying between 79% and 89% during the past decade. Since 1997, **non-natives** (53% in 2010) have been representing the majority of drug law offenders (52-68%). The spectacular increase in 2002-2003 of the proportion of **first drug law offenders** is confirmed and even exceeded by 2010 data reporting an increase from 808 in 2003 to 949 in 2010. Also the **percentage of minors** (< 18 years) among drug law offenders, having increased between 1994 (4.9%) and 2000 (8.7%), shows a clear decrease in 2004 (5.7%) and tended to stabilise from there on. However, in 2010, the percentage of minors among drug law offenders increases again (9.2%). Heroin and cocaine are the main drugs involved in first drug offences.

Table 9.3 Socio demographic data on 'offenders' (1986-2010)

AGE	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
0-14	9		7	6	1	3	7	27	21	11	15	41	24	9	8	11	8	7	26
15-19	121	212	179	320	169	270	249	415	413	399	647	602	334	436	279	318	282	323	484
20-24	264	569	383	527	403	447	321	519	497	566	650	557	510	617	415	480	436	594	677
25-29	119	220	278	371	309	304	220	448	354	299	388	375	278	345	323	321	274	421	551
30-34	49	67	124	159	186	191	187	269	208	194	219	254	250	230	188	216	205	257	318
35-39	17	29	27	52	65	80	76	131	113	139	177	162	190	174	136	162	134	157	233
≥ 40	17	19	43	46	21	42	78	84	108	113	82	174	126	153	181	165	129	189	209
unknown	27	21	30	50	20	31	32	46	44	55	40	106	95	70	43	14	19	15	32
TOTAL	623	1,137	1,071	1,531	1,174	1,368	1,170	1,939	1,758	1,776	2,218	2,271	1,808	2,034	1,575	1,687	1,487	1,963	2,530
Male	503	970	851	1,248	938	1,138	958	1,658	1,415	1,546	1,905	1,935	1,581	1,751	1,319	1,484	1,263	1,645	2,144
Female	120	166	220	256	209	173	193	248	241	215	292	288	181	237	218	190	206	283	367
gender unknown	0	1	0	27	27	57	19	33	44	15	21	48	49	46	38	13	18	35	19

Source: Specialised Drug Department of the Judicial Police 2010.

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

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

Table 9.4 Distribution of offenders ('prévenus) according to first offence and underage status (1992-2010)

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

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2010.

Table 9.5 Distribution of first offenders (use and use/traffic) according to substance involved ad minima (1992-2010)

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

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2010

Other drug-related crime

The routine data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results summarise the situation observed in 2010:

- 85% of drug users indexed[58] by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime.
- 59% of the total PDU population show multiple law enforcement contacts (increase).
- The proportion of 'interpellations' for other reasons than presumed offences against the drug law (e.g. **petty crime** such as criminality linked to drug supply or fights) has been decreasing since 1997 (38%) and has been fairly stable in recent years. In 2010 however, data on 'interpellations' for other reasons report an important increase (2006: 34%, 2009: 35% and 2010: 65%).
- 76% (58%) of indexed PDU have already served at least one **prison sentence** during lifetime. The proportion of PDU having served more than one prison sentence at the time of reporting (36% slight increase) has stabilised during the last years.

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

PREVENTION OF DRUG–RELATED CRIME

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

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

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

Table 9.6 Clients core statistics SOLIDARITE-JEUNES 1997 – 2010

		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of episodes		46	99	132	195	208	231	267	249	322	352	357	432	461
Referral from the criminal Justice system		26.1%	26.3%	41.4%	44.1%	44.2%	37.2%			46.2%	44.4%	43.4%	44.1%	50.8%
Gender distribution	**Female**	28%	26.3%	34.1%	32.3%	34.1%	31.6%	31.9%	31.3%	30.1%	24.4%	30.5%	24.3%	29.4%
	Male	72%	73.7%	65.9%	67.7%	65.9%	68.4%	68.1%	68.7%	69.9%	75.6%	69.5%	75.7%	70.6%
Age distribution	**< 14**						9.5%	4.9%	2.0%	4.7%	4.6%	5.9%	4.6%	4.6%
	14-15						38.1%	30.0%	22.9%	27.9%	25.6%	24.9%	25.8%	29.8%
	16-17						39.8%	46.4%	43.4%	46.9%	46.6%	50.4%	52.4%	47.5%
	> 17						12.6%	18.7%	20.5%	16.5%	18.5%	15.9%	17.2%	18.1%
	Unknown								11.2%	4.0%	4.7%	2.9%	0%	0%
Main substance involved	**Cannabis**						83.1%	72.3%	71.5%	73.3%	67.7%	69.4%	72.8%	74.2%
	Heroin						3.5%	4.5%	5.6%	3.7%	2.5 %	1.7%	1.6%	1.1%
	XTC/						1.3%	2.2%	0.4%	1.6%	1.1%	0.6%	0.9%	0.8%
	Cocaine													
	Legal drugs						2.6%	3.0%	2.4%	3.1%	5.1%	7.8%	6.2%	5.4%
	Polydrug						d.m.	1.9%	3.2%	3.7%	5.4%	4.5%	5.8%	5.1%
	Other						1.3%	3.3%	2.0%	2.5%	2.5%	2.5%	1.7%	1.1%
	None						8.2%	10.6%	10.4%	10.2%	9.6%	8.7%	6.1%	9.7%
	Unknown						0.0%	2.2%	3.7%	2.5%	6.1%	4.8%	4.9%	2.6%

Source: Solidarité Jeunes (Jongenheem). 2010

INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Alternatives to prison

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

The CPG, may be considered as an alternative to a strict penitentiary regime as it is defined as a semi-open prison established in a fairly rural setting. During daytime, inmates follow a professional activity or participate in one of the centre's workshops (agriculture, animal breeding, kitchen, horticulture, woodwork, locksmith's and duties). After work they return to their individual cells for the night. Every block has its own living room, kitchen, bathroom and laundry allowing inmates to live in more or less autonomy.
Part of inmates participates in the '*DEFI*' programme (see below under 'Reintegration of drug users after release from prison') working outside for a minimum loan (RMG - Guaranteed Minimum Income). Others live under a semi-liberty regime (they live at CPG but have an individual and external work contract).

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

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

In an experimental phase, this system was exclusively meant for prisoners:
- whose sentence was less than one year,
- who did not represent a danger,
- socially integrated and residing in Luxembourg,
- who were working or undergoing training.

DRUG USE AND PROBLEM DRUG USE IN PRISONS

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

MAIN RESULTS:

Drug use in prison

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

Risk behaviour

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

Miscellaneous

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

Source: Schlink, 1999

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

RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS

Table 9.7 provides the number of general admissions and the number of admissions according to drug-related convictions (DELIT 'STUP') in both national prisons from 1989 to 2010.

Table 9.7 General and DELIT 'STUP' admissions in both national prisons (1989 – 2010)

YEAR	1989	1990	1992	1994	1996	1997	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010
New entries (Total)					685	858	796	767	794	1.078	1.341	1.043	1.030	990	892	927
New "STUP" entries	163	244	157	288	292 42.6%	309 36%	167 21%	161 21%	101 12.7%	92 8.5%	247 18.8%	243 23.3%	212 20.6%	332 33.5%	224 25.1%	232 25%

Source: Greffe CPL, CPG. 2010

Drug treatment in prison

Following the law of 27 July 1997 concerning the modification of the penitentiary organisation[59], a pilot project named 'Global Drug Care Programme in Prison' (2000-2005 - TOX project) was set up by a group of experts assigned by the Ministry of Justice in 1999. The concept was designed to implement, among other objectives primary, prevention measures in regard to drug consumption and infectious diseases. The overall

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

aim of the project was to integrate drug dependant inmates into a medico-psycho-social drug care network in order to reduce recidivism, risks and criminality after release from prison. The implementation of the project had to be adapted to the two different prison settings. Joint financing by the Ministry of Justice, the National Fund against drug trafficking and the EU (regarding evaluation) was ensured.

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

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

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

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

Substitution treatment is also provided in prison but not by the services mentioned above. The nursery and MDs are in charge of methadone prescription within prison. More detailed figures on this type of treatment can be found in respective sections and STs. Three scenarios may occur:

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

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

Official figures show that 24,5% of the inmates (of full age) who entered CPL in 2010 received drug substitution treatment, representing a total of 219 persons.

Tab. 9.8 Number of prisoners receiving opioid substitution treatment (2010)

YEAR	2010
Methadone	192
Subutex ®	9 (SUBUTEX + METHAD) / 18 (SUBUTEX only)
Total (persons)	219

Source: Comité de Surveillance SIDA: Activity report 2010

The average dose of distributed methadone was 24 mg per day (minimal dose 1mg and maximal dose 80mg). The average period of treatment was 127 days.

Of clients in treatment units in prison, 93% (98%) are male against 7% (2%) of females. The mean age of treatment demanders is 27.93 (32 years and 8 months), whereas the average male age is 28.44 (32Y9M) and the mean age of the female clients is consistently lower (2010: 21Y, 2009: 29Y). Respectively 55% (46%) of clients in treatment are natives against 45% (54%) of non-natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French citizens.

Regarding educational level of the clients in treatment, 52% (83%) have completed primary school, 41% (15%) have completed secondary school. 21% (37%) of clients in treatment units in prison experienced one or more overdoses. As far as the sharing of used syringes is concerned, 39% (64%) reported that they never shared syringes during their lifetime (83% during the last month, 2009: 82%). IDU combined to polydrug use (27%, 2009: 34%) is the most observed consume pattern in drug treatment demanders.

Prevention and reduction of drug-related harm

In 2010, the activities of the previously referred to TOX-programme in prison were centred on three pillars:

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

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

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

As far as the CPL is concerned, in 2010, 157 demanders were provided with an individual psychosocial follow-up. 144 clients have benefited from 45 health prevention groups. A total of 18 clients participated in the "Programme Charly".

For 2010, the CPG reports a total of 37 groups (withdrawal prevention, tobacco prevention, HIV/AIDS prevention etc.) with a total of 410 participants. 61 clients were provided with an individual psychosocial follow-up and 635 individual counselling sessions were held.

In 2007, the external evaluation report [60] of the TOX project has been published and recommended the continuation of the action.

The programme is currently part of the RELIS routine data reporting network and first data on treatment demand became available in 2010. Thus, 93% (98%) of RELIS indexed clients are male against 7% (2%) of females. The mean age of treatment demanders is 27.93 (32 years and 8 months), whereas the average male age is 28.44 (32Y9M) and the mean age of the female clients is consistently lower (2010: 21, 2009: 29Y). Respectively 55% (46%) of clients in treatment are natives against 45% (54%) of non-natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French citizens.

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PREVENTION, TREATMENT AND CARE OF INFECTIOUS DISEASES

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

In 2010, approximately 800 HIV tests have been carried out. 11 tests were positive (9 men and 2 women), 3 co-infections (HIV/HCV) were diagnosed (all of those were known drug users). To prevent further contamination, vaccination against hepatitis B and A is recommended to those who present a negative serology.

A structured syringes distribution programme has officially been launched in 2005 in the framework of the global drug care programme in prison. In order to enrol, inmates have to send a written request to the prison's doctor. After counselling, the inmate is handed a kit containing 2 syringes which may be exchanged at the nursery. As the consumption and possession of drugs is illegal, those inmates in possession with a syringe in its kit, are exempted from sanctions for detention of injection paraphernalia. In 2010, 34 kits have been distributed and 328 syringes exchanged. The programme is under medical secrecy and is operational although a series of changes are currently being discussed to increase the coverage and impact of the programme.

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

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

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

Prevention of overdose-risk upon prison release

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

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

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

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

REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

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

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

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

10. DRUG MARKETS

INTRODUCTION

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

Overall, the national **drug market has become of a more aggressive nature** in terms of selling techniques (e.g. dealers approach potential clients and not vice-versa, the dealers insist on selling). New distribution networks have developed in recent years and operate in an obviously professional way and by doing so, have significantly increased drug availability and in particular the supply of **cocaine and cannabis**. Dealers increasingly tend to actively approach confirmed or potential clients. More recently ethnic groups join to improve their drug distribution strategies whereas previously none of these criminal groups actively searched contact with other groups. Moreover it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible to police as for instance private flats or bars.

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

Compared to the situation in 2004, purity of heroin remains fairly stable while the purity of cocaine has decreased (2004: 61.78% / 2010: 47.9%). Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (over 40%) in herbal cannabis samples seized in Luxembourg in 2009. However in 2010, the maximum concentration of THC (34.2%) as in 2009 has not been observed. **Prices** show broad ranges for heroin and cocaine. Cannabis and derivates, however, have known certain stability during the last 6 years as far as street prices are concerned.

In terms of **seized** quantities, important variations are observed for heroin since 2000. As far as cocaine and mainly cannabis are concerned, increasing quantities have been reported in 2010. The number of seizures also has been showing great variations during the same period, especially for cannabis.

AVAILABILITY AND SUPPLY

Perceived availability of drugs

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

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

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

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

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

Tab. 10.1 bis *Ease of acquisition of drugs in Luxembourg (2008)*

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

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

Even if heroin was the substance considered to be most difficult to get hold of, also cocaine was quoted by 67% of young people from Luxembourg as more difficult to obtain than did the EU average (61%).
Ecstasy was considered being more difficult to obtain in Luxembourg (65%) compared to the EU average (56%). Only 34% of youngsters from Luxembourg considered the access to ecstasy as easy (EU average: 38%).
Concerning cannabis, less youngsters from Luxembourg (28%) declared the access to cannabis difficult than the EU average (34%). Access to cannabis was perceived easier (71%) than the EU average (63%). Four out of ten youngsters (41%) found it very easy to obtain cannabis (EU average: 32%, three out of ten).

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

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

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

Tab. 10.1 ter *Ease of acquisition of drugs in Luxembourg (2011)*

2011	**Ease of access to heroin** (if desired)					
	impossible	**very difficult**	**fairly difficult**	**fairly easy**	**very easy**	**dk/na**
Luxembourg	30	35	24	8	2	1
EU27	24	36	22	8	5	5
	Ease of access to cocaine (if desired)					
LU	22	33	32	9	2	2
EU27	19	28	26	14	8	5
	Ease of access to ecstasy (if desired)					
LU	21	33	31	9	2	4
EU27	20	28	25	14	8	4
	Ease of access to cannabis (if desired)					
LU	17	11	30	41	1	1
EU27	19	15	31	32	4	4
	Ease of access to tobacco (if desired)					
LU		2	2	14	82	
EU27		2	2	14	81	1
	Ease of access to alcohol (if desired)					
LU		3	3	15	79	
EU27		1	2	14	82	1

Origins of drugs

The national production of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2010 no clandestine drug-manufacturing laboratory has been dismantled at the national level. Law enforcement sources[61] indicate that currently the majority of illicit drugs consumed in the G. D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). Till the beginning of the nineties, most of the persons involved in illicit drug distribution were consumers who supplied themselves in the Netherlands or acquired limited extra quantities of drugs in order to sell them within restricted local networks. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market.

Drug Trafficking patterns

The **expansion of more structured distribution networks** by organised criminal associations has been reported earlier. More recently different ethnic groups started to create synergies in drug distribution and traffic, whereas previously these groups have been operating separately. The proportion of non-natives involved in drug trafficking has been increasing until 2005 and has been decreasing quite sensibly since then, although non-native drug traffickers represent 63% (67% in 2009). Typically, involved dealers carry small quantities of drugs hidden in their mouth ready to be swallowed promptly in case of police controls. Initially drugs of high quality have been sold at low prices. Progressively however, the quality and diversity of sold drugs have been decreasing, which has induced major changes in consume patterns of national drug users.

SEIZURES

In terms of **seized** quantities, important variations are observed for heroin since 2000. As far as cocaine and mainly cannabis are concerned, increasing quantities have been reported in 2010. The number of seizures also has been showing great variations during the same period, especially for cannabis.

Quantities and numbers of drug seizures

Striking variations have been observed as to the quantity of illicit substances seized since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002[62]. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. However, this trend is not observed in 2009 and 2010 for heroin. Cocaine seizures (quantity) are highly variable since the beginning of the nineties. Compared to 2009 data, the quantity of seizures of nearly all listed substances went up in 2010 (except for MDMA and heroin, which is almost stable compared to 2009 data). This observation particularly applies to cocaine and cannabis.

61 Non published information from the Specialised Drug Unit of the Judicial Police.
62 Non–transit drugs destined to the national market.

Notwithstanding the quantities seized, increasing between 2009 and 2010, the **number of seizures** has grown discontinuously since 1990. This means that more seizures of bigger quantities have been reported. Since 2000 the number of cannabis seizures has clearly increased but likewise the number of heroin and cocaine seizures tends to stabilise. Markedly, the number of cannabis seizures has risen from 167 to 947 between 1994 and 2010. The total **number of persons** involved in traffic has followed a constant upward trend until 2000 and stabilised afterwards (2010: 2530, 2009: 1963 persons). In 2010, the data show an increasing trend concerning the total number of persons involved in traffic. A confirmed majority of offenders are non-natives. For detailed information, see standard table 13.

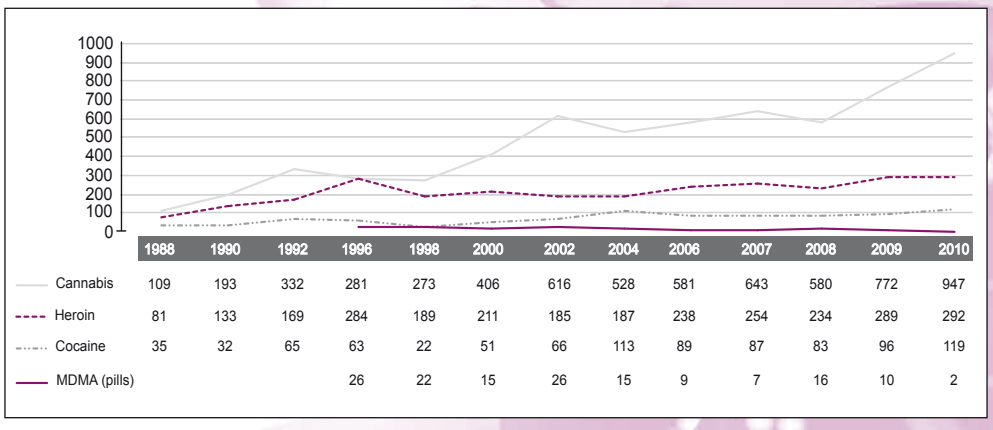
Crack (cocaine-base) seizures have not been reported to date by national authorities. It has, however, appeared on the national market according to field agencies. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. After years of rather modest XTC type pill seizures, 2009 data reveals consistently higher amounts of seizures. In 2010 however, the MDMA seizures show again an important decrease.

Fig. 10.1 Total quantites of national yearly seizures: heroin, cocaine, ecstasy type (1988 - 2010)

	1988	1990	1992	1996	1998	2000	2002	2004	2006	2007	2008	2009	2010
Cannabis (gr./10)	19003	3250	3448	3087	693	955	252	2369	6700	1379	2882	1597	6197
Héroine (gr.)	14888	527	6682	2934	3592	11358	2957	6255	9298	8510	7676	5343	5297
Cocaine (gr.)	4579	23260	12092	12891	5995	10757	2486	4481	3825	3450	5519	880	3257
MDMA (pills)	0	0	0	5545	145	318	1139	2232	555	145	107	9478	291

Specialised Drug Department of the Judicial Police 2010

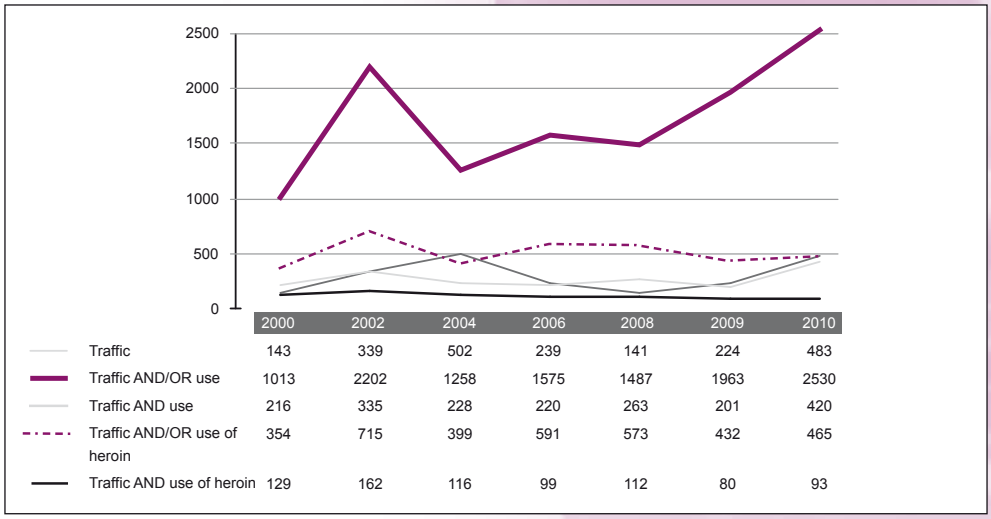
Fig. 10.2 Total number of national yearly seizures: Cannabis,Heroin, Cocaine, MDMA (1988 - 2010)



	1988	1990	1992	1996	1998	2000	2002	2004	2006	2007	2008	2009	2010
Cannabis	109	193	332	281	273	406	616	528	581	643	580	772	947
Heroin	81	133	169	284	189	211	185	187	238	254	234	289	292
Cocaine	35	32	65	63	22	51	66	113	89	87	83	96	119
MDMA (pills)				26	22	15	26	15	9	7	16	10	2

Source: Specialised Drug Department of the Judicial Police 2010

Fig. 10.3 Number of offenders involved in seizures according to type of offence (1988-2010)



	2000	2002	2004	2006	2008	2009	2010
Traffic	143	339	502	239	141	224	483
Traffic AND/OR use	1013	2202	1258	1575	1487	1963	2530
Traffic AND use	216	335	228	220	263	201	420
Traffic AND/OR use of heroin	354	715	399	591	573	432	465
Traffic AND use of heroin	129	162	116	99	112	80	93

Source: Specialised Drug Department of the Judicial Police 2010

Quantities and numbers of precursor chemicals

No information available.

Number of illicit laboratories and other production sites dismantled

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

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

PRICE/PURITY

Price of drugs at retail level

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen from 1998 to 2002/2003 but broader price ranges as well as higher maximum prices for cocaine and heroin have been observed since 2004, which is due to a high variability of purity. Cannabis and derivates however have known a fair stability during the last 8 years. Heroin is frequently sold as 'boule' containing 0.2-0.4 grams for 11-33. - EUR. Typical street retail cannabis is sold in pieces of 2.5 to 3 grams for 26 -30. – EUR.

Table 10.2 Price per unit evolution at the street level (1994-2010)

	1994	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010
Cannabis **Hashish** **Marijuana**	5-6	5-6 2.5-3	7.4 6.2	7	7.3 7.3	7.3 7.3	8	8 7.5	8-10 5-10	5-16	4-10 7-25
Cocaine	100-150	120-170	90	50	20-120	20-110	30-100	30-100	70-100	50-200	50-250
Heroin (brown)	65-150	90-150	74.4	50	82	80	50-90	50-90	60-80	33-100	20-250
STA		25-30	n.a.	25	n.a.	n.a.	5	5	20	n.a.	20
Ecstasy		9-13	7	7	10	10	5	5	5-15	n.a.	5-15
LSD	11-13	11-13	n.a.	n.a.	10	10	n.a.	n.a.	5-15	n.a.	12

Source: Specialised Drug Department of the Judicial Police (1994-2007), Tox-In (2008-2010)

Price: expressed in EURO at street level.
For cannabis, cocaine & heroin (since 2009) and amphetamines, price per gram is indicated.
For heroin and cocaine, minimum prices refer to traffic units (until 2008) Maximum and average prices refer to street retail quantities.
For ecstasy and LSD, price per pill or unit are indicated.

Purity/potency of illicit drugs

Compared to the situation in 2004, purity of heroin tends to stabilise while the purity of cocaine decreased (2004: 61.78% / 2010: 47.9%). However, a slight increase can be observed in 2010, compared to the data of 2009. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC (over 40%) in herbal cannabis samples seized in Luxembourg in 2009. In 2010, the maximum concentration of THC observed was 34.2%. Prices show broad ranges for heroin and cocaine. Cannabis and derivates however have known certain stability during the last 8 years as far as street prices are concerned.

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

Historically high maximum concentration of THC in cannabis samples seized in Luxembourg has been observed in 2009. Herbal cannabis showed highest maximum levels of THC concentrations (34.2% in 2010, 40.78% in 2009, 25% in 2008). In 2010 average THC concentration in herbal cannabis was higher than in resin cannabis. For more detailed information please refer to standard table 14.

Table 10.3 Purity of drugs at street level (1994-2010)

	1996	1998	2000	2002	2004	2006	2007	2008	2009	2010		
	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)		
	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	MIN.	MAX.	AVRG.
Cannabis *(THC)*			8.03	7.96	6.94	7.36	9.61	9.82	11.25	0.28	34.23	11.32
Marihuana							10.21	9.75	11.18	0.70	34.23	11.84
Hashish							8.52	10.3	12.39	0.28	21.27	7.30
Cocaine	60-90	60-90	60.25	62.99	62.37	58.80	51	52.00	43.20	11.58	91.90	47.90
Heroin (brown)	15-23	20-25	17.59	9.97	17.07	15.80	16.60	16.10	18.50	0.71	55.54	17.4
STA				15.09	9.44	7.1	13.81	18.2	15.38	3.47	19.36	10.43
Ecstasy[61]												
(MDMA)			35.5	71.11	29.77	26.44	20.52	23.52	17.32	95	113	**104**
(MDEA)			6.8		6.25		1.25	23.57		nd	nd	**nd**
(MDA)									13.94	nd	nd	**nd**
Psylocine				0.15	0.41	/	/	/	/	0.016	0.065	**0.05**

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2010

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

63 **Ecstasy :** dose in mg/pill

In 2011, Schneider and F. Meys[64] published a paper on analysis results of illicit cocaine and heroin samples seized in Luxembourg from 2005 to 2010. **Abstract:** This article discusses drug purity, frequency of appearance and concentration ranges of adulterants of 471 illicit cocaine and 962 illicit heroin samples seized in Luxembourg from January 2005 to December 2010. For cocaine samples the mean concentration was lowest in 2009 (43.2%) and highest in 2005 (54.7%) but no clear trend could be observed during the last 6 years. 14 different adulterants have been detected in cocaine samples, from which phenacetin has been the most abundant in terms of frequency of appearance and concentration until 2009. In 2010 the veterinary antihelminthic drug levamisole has become the most abundant adulterant detected in cocaine samples, its concentrations however remained low (1.5-4.1%). The mean heroin concentration was 26.6% in 2005, a decline has been observed in 2006 and the concentrations have been relatively stable since then (15.8-17.4%). Paracetamol and caffeine were by far the most abundant adulterants detected in heroin samples.

Composition of illicit drug tablets

Information for this section was provided by the National Laboratory of Health (LNS) and formatted by the NFP. 49 pills were analysed during year 2010. 11.7% of analysed pills contained MDMA as main active substance and 58.8% contained other substances, as caffeine, paracetamol or ibuprofene.

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

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

PART B:

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ALPHABETIC LIST OF RELEVANT INTERNET ADDRESSES

http://www.ceps.lu/
http://www.cept.lu/
http://www.crp-sante.lu/
http://www.ecbap.net/
http://eddra.eu.int/
http://eldd.emcdda.eu.int/
http://www.emcdda.eu.int/
http://www.etat.lu/
http://www.etat.lu/MS/
http://www.gouvernement.lu/
http://www.ilres.com/
http://www.jdh.lu/
http://www.legilux.public.lu/
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http://www.unodc.org/
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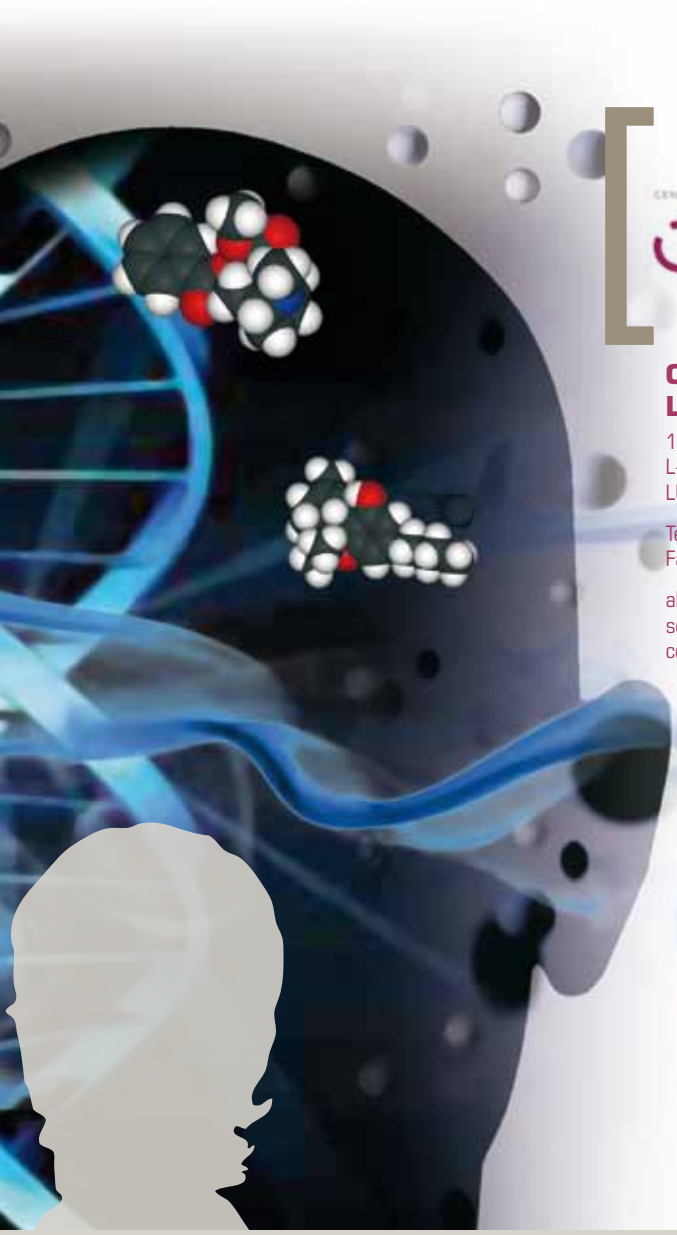

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