

2017

National Drug Report

Grand Duchy of Luxembourg

New developments, trends and in-depth
information on selected issues

L'ETAT DU PHENOMENE DES DROGUES ET DES TOXICOMANIES AU GRAND-DUCHE DE LUXEMBOURG

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

EDITION 2017

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RESEAU NATIONAL D'INFORMATION SUR LES DROGUES ET LES TOXICOMANIES (R.E.L.I.S)

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ABBREVIATIONS

AST	Service d'Action Socio-Thérapeutique
CATF	Chemical Action Task Force
CePT	Centre de Prévention des Toxicomanies
CAS	Commission d'admission et de surveillance (CHDP)
CFSP	Common Foreign and Security Policy
CHNP	Centre Hospitalier Neuro-Psychiatrique
CICAD	Inter-American Drug Abuse Control Commission
CMO	Comprehensive Multidisciplinary Outline (UN)
CND	Commission on Narcotic Drugs
CNDS	Comité National de Défense Sociale
CNER	Comité National d'Éthique de Recherche
CNPD	Commission Nationale de Protection des Données
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
CPOS	Centre de Psychologie et d'Orientation Scolaire
CRP-HT	Centre de Recherche Public - Henri Tudor
CRP-Santé	Centre de Recherche Public – Santé
CTM	Centre Thérapeutique de Manternach
DEA	Drug Enforcement Administration (United States)
EWS	Early Warning System on New Synthetic Drugs
GID	Groupe Interservices Drogue (de la Commission européenne)
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMA	European Medicines Agency
EUROPOL	European Police Office
FBI	Federal Bureau of Investigation (United States)
FED	Fonds Européen de Développement
FATF	Financial Action Task Force on Money Laundering
FEDER	Fonds 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 Drogenh�llef
LIH	Luxembourg Institute of Health
LNS	Laboratoire National de Sant�
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 Coop�ration et de D�veloppement Economiques
OGD	Observatoire G�opolitique 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	R�seau Luxembourgeois d'Information sur les Stup�fiants
REITOX	European Information Network on Drugs and Drug Addiction
SADC	Southern African Development Community
SCRIPT	Service de Coordination de la Recherche et de l'Innovation p�dagogiques et technologiques
SEPT	Semaine Europ�enne de Pr�vention des Toxicomanies
SID	Syst�me d'Information Douanier
SIS	Syst�me d'Information Schengen
SNJ	Service National de la Jeunesse
SPG	Syst�me de Pr�f�rences G�n�ralis�es
SPJ	Service des Stup�fiants de la Police Judiciaire
TRANSRELIS	R�seau transfrontalier d'Information sur les Stup�fiants
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 f�r Empirische P�dagogische Forschung – Universit�t Landau



AVANT-PROPOS

Le rapport 2017 sur l'état du phénomène des drogues et des toxicomanies 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 et institutions suivants ont été consultés: Dr Arno Bache (Direction de la Santé), Catherine Trierweiler (Ministère de la Justice), Fabienne Gandini (Administration des Douanes), Claude Frieden (CNS), Sophie Hoffmann, Raymond Herbrink, Alain Hensgen (Police Grand-Ducale), Guy Theisen, Guy Reinart et Simone Schram (Direction de la Santé), Dr Serge Schneider et Dr Michel Yegles (Laboratoire National de Santé) ainsi que l'ensemble des ONG nationales spécialisées en matière de prévention et de prise en charge.

FOREWORD

The 2017 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 and institutions consulted in the framework of the 2017 edition of the report: Dr Arno Bache (Directorate of Health), Catherine Trierweiler (Ministry of Justice), Fabienne Gandini (Customs Administration), Claude Frieden (CNS), Guy Theisen, Guy Reinart and Simone Schram (Ministry of Health), Sophie Hoffmann, Raymond Herbrink, Alain Hensgen (Police), Dr Serge Schneider and Dr Michel Yegles (National Laboratory of Health LNS) as well as all national specialised NGOs.

RESUME

RAPPORT NATIONAL SUR L'ETAT DU PHÉNOMÈNE DES DROGUES ET DES TOXICOMANIES AU GRAND-DUCHÉ DE LUXEMBOURG (RELIS - Edition 2017)

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 Drogues et les Toxicomanies (RELIS).

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

Les efforts déployés depuis plus de 20 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, notamment lors de la mise en place de plans d'action et de stratégies d'intervention en matière de lutte contre les addictions.

ORIENTATIONS POLITIQUES ET BUDGÉTAIRES

Le gouvernement a confié la coordination des actions de réduction de la demande et des risques associés aux drogues 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'appuyaient 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 2010-2014 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**. Le **plan d'action gouvernemental 2015-2019** a par ailleurs été élaboré sur base d'une **évaluation externe** du plan d'action 2010-2014. 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 de réponse aux drogues et aux toxicomanies 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 2.066.000.- EUR en 2000 à 12.987.138.- EUR en 2017 ce qui équivaut à un taux de progression de 529%. En 2000, le nombre de postes 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 121,5 ETP en 2017.

INDICATEURS ÉPIDÉMIOLOGIQUES

A l'échelle mondiale (UNODC 2017), le nombre global de personnes âgées de 15 à 64 ans ayant consommé au moins une drogue d'origine illicite au cours de l'année 2015 a été estimé à 250 millions, ce qui équivaut à 1 personne sur 20 au niveau de la population mondiale dans cette classe d'âge. L'usage à caractère problématique de drogues illicites concerne quelque 29 millions de personnes, dont 12 millions sont des injecteurs. L'UNODC estime que 1,6 millions d'usagers par injection sont VIH+. Le cannabis reste de loin la drogue la plus consommée¹ au monde (183 millions de personnes équivalent à 3,8% de la population mondiale telle que définie). Le nombre d'usagers des stimulants de type amphétamine (STA) s'élèverait à 37 millions de personnes (0,77%). La prévalence de « l'ecstasy » (21,6 millions de personnes ou 0,45% de la population) a diminué par rapport aux données de 2009. Le nombre de consommateurs d'opiacés se situe approximativement à 17,7 millions de personnes (0,37%).

Au sein de l'UE, selon les dernières données de l'OEDT issues du *Rapport européen sur les drogues 2017 (Observatoire Européen des Drogues et des Toxicomanies 2017)*, 93 millions de personnes ont déjà consommé une drogue illicite. Des évolutions positives sont à voir dans la baisse des nouveaux usagers d'héroïne, une diminution du recours à l'injection, et une stabilisation de l'usage de cannabis et de cocaïne dans certains pays. Aussi, des niveaux records du nombre de personnes en traitement ont été observés (1,4 millions d'Européens en 2015). Les amphétamines et l'ecstasy demeurent les stimulants de synthèse les plus fréquemment consommés en Europe. Des données récentes suggèrent toutefois que l'usage d'amphétamines est stable ou en baisse chez les jeunes adultes.

En ce qui concerne le cannabis, environ 1% d'Européens adultes (de 15 à 64 ans) consomment du cannabis quotidiennement ou presque quotidiennement. 13,9% de jeunes Européens âgés entre 15-34 années ont consommé du cannabis au cours de l'année écoulée. Aussi, le nombre, le type et la disponibilité de nouveaux produits psychoactifs en Europe ont continué à croître. La mondialisation, les avancées technologiques et l'internet ont contribué au développement d'un marché ouvert à ces mêmes produits.

A l'échelle micro-géographique, les tendances au Grand-Duché de Luxembourg reflètent dans les grandes lignes celles observées au sein de l'UE, avec toutefois une tendance à la baisse du taux de prévalence générale de l'usage problématique de drogues d'origine illicite.

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

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

L'étude European Health Interview Survey – EHIS a été menée entre 2013 et 2015 dans l'ensemble des états membres de l'UE. Au-delà des items communs, le Grand-Duché de Luxembourg a inclus le volet de l'usage de drogues illicites au protocole de l'enquête. Il s'agit ainsi de la première enquête représentative de la population générale au niveau national en matière d'usage de substances illicites. L'échantillon représentatif était constitué de résidents âgés de 15 ans et plus.

Les substances les plus consommées au Luxembourg, après le cannabis, sont la cocaïne et les substances de type ecstasy et leurs prévalences d'usage se situent en règle générale en dessous des moyennes observées au sein de l'UE. Seule la prévalence usage-vie nationale de cannabis (23,3%) est supérieure à la moyenne de l'UE au cours des dernières années (EMCDDA, 2016). Comparés aux répondants féminins, les consommateurs masculins témoignent de taux de prévalence de consommation de cannabis supérieurs, toutes classes d'âge confondues. La première consommation de substances illicites survient majoritairement dans le groupe d'âge de 15 à 19 ans à l'exception des premiers usages d'héroïne et de cocaïne qui s'observent le plus souvent entre 20 à 24 ans.

En matière d'études ciblées sur les populations jeunes, des données comparables issues d'enquêtes scolaires menées entre 1999 et 2010 témoignaient d'un taux de prévalence « vie » (consommation au moins une fois au cours de la vie) généralement décroissante en ce qui concerne la consommation de drogues illicites, toutes catégories confondues. Une analyse plus approfondie révèle une baisse tangible de la prévalence-vie de l'usage de drogues illicites entre 1999 et 2006 suivie d'une stabilisation subséquente. Tous types de drogues illicites ont suivi cette même tendance à l'exception de la cocaïne qui a connu une popularité croissante surtout en matière d'expérimentation parmi les jeunes âgés entre 15 et 16 ans. L'usage d'opiacés par les jeunes (16 à 20 ans) continue toutefois de témoigner d'une prévalence basse.

Bien que le cannabis demeure la drogue illicite la plus consommée parmi les jeunes de 12 à 18 ans, une baisse au niveau de l'usage-vie à partir du début du 21^{ème} siècle a pu être observée au niveau national. Les taux de prévalence de l'usage récent ou actuel de cannabis parmi ces mêmes jeunes ont affiché une tendance à la baisse sensible entre 1999 et 2006 pour se stabiliser ensuite. Actuellement il est estimé que 18% des jeunes âgés de 15 ans vivant au Luxembourg ont déjà consommé au moins une fois au cours de leur vie du cannabis (HBSC, 2014).

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'usagers problématiques indexés par les institutions nationales en 2016 équivalait à 5.846 personnes (comptages multiples inclus³) (2002: 4.701).

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).



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 2016, ces mêmes instances ont recensé respectivement 2.974 et 2.872 personnes. Sommairement, le nombre de personnes entrées en contact avec des instances sanitaires et répressives a baissé entre 2011 et 2013 pour afficher une nouvelle hausse entre 2014 et 2016. A noter enfin une hausse continue au niveau du nombre de contacts enregistrés par les services de bas seuil et de réduction des risques entre 2014 et 2016.

Caractéristiques socio-démographiques de la population nationale d'UPD recensés

Le sex-ratio (M/F) de la population des UPD recensés par RELIS est actuellement de 85/100. Sur les dix dernières années, on constate que la proportion de ressortissants étrangers parmi les UPD recensés a témoigné d'importantes fluctuations affichant cependant des hausses marquées en 2015 (58%) et en 2016 (63%) face à un taux de non-luxembourgeois de 47,7% en population générale à l'échelle nationale (1er janvier 2017). La population des non-luxembourgeois(es) est principalement composée de citoyens d'origine portugaise dont la proportion (28% de l'ensemble des UPD non-luxembourgeois) est actuellement inférieure à celle observée au sein de la population générale (34,6%).

L'âge moyen des usagers recensés est passé de 28 ans et 4 mois en 1995 à 34 ans et 2 mois en 2016. 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. Le pourcentage des UPD de la classe d'âge 40 ans et plus a augmenté continuellement au cours des dernières années, tandis que le pourcentage d'UPD âgés de moins de 30 ans affiche une tendance générale à la baisse. 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** au cours de la dernière décennie.

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

Les données nationales en matière de prévalence UPD sont issues d'études sérielles menées en 1997, 1999, 2000, 2007, 2009 et 2017 (Origer, 2012⁴, 2017). En référence à l'étude sérielle de prévalence la plus récente (Origer, 2017), portant sur les données de 2015, la prévalence et le taux de prévalence actuels d'**Usagers Problématiques de Drogues** (UPD) sont estimés respectivement à 2.250 personnes représentant et 5.79 par mille personnes issues de la population nationale âgée entre 15 et 64 années. Une tendance à la baisse du taux de prévalence UPD au sein de la population nationale est observée depuis 2003. Une évolution similaire est également constatée pour ce qui est de **l'usage par injection (UID)** à partir de 2009. La prévalence de **l'usage d'opiacés (OU)** a été estimée la première fois en 2017 sur base de données de 2015 et se situe autour de 4.46 usagers par 1,000 habitants âgés entre 15 et 64 années ce qui équivaut à environ 1.700 personnes.

L'usage par injection d'opiacés et de cocaïne associé à une **polyconsommation généralisée** constitue le comportement le plus observé au sein des UPD répertoriés par le réseau institutionnel. Le ratio entre usagers-injecteurs et non-injecteurs se situait à 3/4 en 2016. La cocaïne en tant que drogue préférentielle demeure à un niveau élevé (17%) comparable aux années précédentes (2014 : 19,9%) et (2015 : 19%).

Le nombre de personnes en contact avec le réseau institutionnel spécialisé pour usage (préférentiel) de **cannabis** affiche une tendance à la hausse représentant actuellement 32,8% (2015 : 23,1%). Les substances de **type amphétamines et ecstasy** sont faiblement représentées, ce qui toutefois ne

4 Origer A. Prevalence of Problem Drug Use and Injecting Drug Use in Luxembourg: A Longitudinal and Methodological Perspective. *Eur Addict Res.* 2012;18:288-296.

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** (47% en 2013) a diminué entre 2011 et 2013 et a augmenté de nouveau en 2014 (54%) et 2015 (61%) pour se stabiliser en 2016 (54%).

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 en traitement hospitalier est en hausse, tandis que le nombre de patients en traitement résidentiel spécialisé affiche une légère tendance à la baisse. Depuis 2010, le nombre de demandeurs de traitement de substitution s'est stabilisé et le nombre de contacts avec l'ensemble des structures d'accueil à bas-seuil est en hausse depuis 2013 (2016 : 150,937, 2015 : 142 054, 2014 : 131 375 ; 2013 : 124 048; 2012 : 127 080 2010 : 140 093 contacts). Tous centres et services de traitement confondus, 15,5% des clients ont formulé leur première demande d'aide en 2016. Une tendance qui se confirme est la baisse de la proportion de 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

La prévalence des cas **VIH/sida** au sein de la population d'UPD était globalement stable avant 2014, mais à l'instar d'un certain nombre d'autres pays de l'UE la proportion d'usagers de drogues parmi les cas de nouvelles infections VIH (taux d'incidence) a suivi **une tendance à la hausse à partir de 2014**, alors que les offres nationales en matière de réduction des risques et dommages sont fort développées et diversifiées et que le nombre de seringues stériles distribuées dans le cadre du programme national d'échange de seringues est en hausse et a atteint un niveau record en 2016. Les données encore incomplètes de 2017 laissent prudemment espérer une première inversion de cette tendance depuis 2014 tout en soulignant que l'incidence VIH demeure à un niveau élevé. **L'infection à l'hépatite C** parmi les usagers de drogues semble s'être stabilisée à un niveau élevée.

La proportion moyenne d'usagers intraveineux de drogues parmi les personnes nouvellement infectées par le VIH se situait autour de 8% entre 2012 et 2013 alors qu'elle se situe autour de 20% pour la période 2014-2015. Si cette hausse, qui s'observe également dans certains autres pays de l'UE peut s'expliquer en partie par une couverture de dépistage accrue au sein de la population d'usagers de drogues au niveau national, des facteurs tels que la consommation accrue de stimulants, et en particulier de cocaïne par injection par des usagers polyconsommateurs fortement marginalisés, semblent être en jeu. Le taux d'infection VIH parmi les usagers intraveineux se situe actuellement autour de 10% (hausse par rapport aux données 2015).

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 (5 cas en 2016). 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 2016, 0,9 surdoses aiguës pour 100.000 habitants ont été enregistrées (2009 : 4,15), représentant une tendance décroissante. Les données médico-légales de 1992 à 2016 confirment que la quasi-totalité des décès impliquent la consommation d'héroïne et de substances prescrites dans un contexte de polyconsommation.



Pour les victimes, il s'agissait uniquement d'hommes en 2016 et l'âge moyen au moment du décès a connu une hausse discontinue mais sensible sur les dernières vingt années (1992 : 28,4 années et 2016 : 41,1 années). Bien que la moyenne d'âge ait augmenté, le nombre de victimes âgées de moins de 20 ans est resté relativement stable. La victime la plus jeune en 2016 était âgée de 25 ans au moment du décès, tandis que la plus âgée avait 51 ans.

Une majorité confirmée de 60% (67% en 2015) de victimes était de nationalité luxembourgeoise. Une analyse détaillée des cas de victimes de surdoses fatales depuis 1994 a été effectuée dans le cadre d'études à grande échelle dont les résultats ont été publiés entre 2013 et 2015 (Origer *et al.*, 2013, 2014, 2015)⁵.

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.

Le niveau d'enseignement des usagers recensés est pour la plupart faible et incomplet. Leur situation résidentielle affiche toutefois une amélioration longitudinale. Si en 1995, 31% des usagers disposaient d'un logement stable, cette proportion se situe actuellement autour de 67%, ce qui pourrait en partie être 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 plus difficile des dernières années.

Le taux d'inactivité professionnelle (55%) parmi la population cible tend à stagner. Cependant, la proportion d'UPD professionnellement actifs présentant une situation d'emploi stable est restée assez inchangée les dernières années.

- 5 **Origer A, Lopes da Costa S, Baumann M.** Opiate and cocaine related fatal overdoses in Luxembourg from 1985 to 2011: A study on gender differences. *Eur Addict Res.* 2014;20(2):87-93. DOI: 10.1159/000355170
- Origer A, Baumann M.** Opiate and cocaine related Fatal Overdoses in Luxembourg from 1985 to 2011: a time-stratified study. 21th IUHPE World Conference on Health Promotion. 25-29th August 2013, Pattaya, Thailand, Volume: Health Issues and Populations in Health Promotion.
- Origer A, Baumann M.** Suicide attempts prior to fatal drug overdose in Luxembourg from 1994 to 2011. 21st World Congress Social Psychiatry, 29 June- 3 July 2013, Lisbon, Portugal, Volume: The bio-psycho-social model: The future of psychiatry.
- Origer A, Bucki B, Baumann M.** Socioeconomic inequalities in fatal opiate and cocaine related overdoses: transgenerational baggage versus individual attainments. 28th Conference of the EHPS "Beyond prevention and intervention: increasing well-being", 26th - 30th August, 2014, Innsbruck, Austria.
- Origer A, Le Bihan E, Baumann M.** Social and economic inequalities in fatal opiate and cocaine related overdoses in Luxembourg: A case-control study. *Int J Drug Pol.* 2014. 25:911-915. DOI: 10.1016/j.drugpo.2014.05.015
- Origer A, Le Bihan E, Baumann M.** (2015) A Social Gradient in Fatal Opioids and Cocaine Related Overdoses? *PLoS ONE* 10(5): e0125568. doi:10.1371/journal.pone.0125568

MESURES DE RÉDUCTION DES RISQUES

Le **nombre de contacts enregistrés par les structures d'accueil bas-seuil et de réduction de risques** a connu un accroissement remarquable jusqu'à 2010 et a diminué pour la première fois en 2011 (2005 : 47.739 / 2011 : 123.465). En 2016, le nombre de contacts s'élevait à 150,937 (hausse par rapport à 2015). Environ 20% des clients appartiennent à la classe d'âge 24-34 ans et 80% ont 35 ans ou plus. Approximativement 20% des clients sont des femmes. On constate une augmentation des contacts de femmes par rapport à l'année passée (14% en 2015).

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 2006. Entre 2006 et 2013 on assistait à une tendance à la baisse alors qu'entre 2014 et 2016 une nouvelle hausse remarquable s'observait (1996 : 76.259 ; 2013 : 190.257 ; 2014 : 250.552, 2015 : 359.340, 2016 : 423.060). Le taux global de retour de seringues usées a augmenté pendant la période de référence et se situe actuellement à 94%. Un nombre croissant d'injecteurs se procurent leurs seringues auprès de structures spécialisées suivies des pharmacies.

INDICATEURS DE RÉDUCTION DE L'OFFRE⁶

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 fait apparaître une tendance générale à la baisse⁷ des **quantités saisies** d'héroïne, de cocaïne et de cannabis entre 2006 et 2013, affichant toutefois une nouvelle hausse pour le cannabis et la cocaïne à partir de 2014.

Nonobstant les quantités de cannabis et de cocaïne saisies, **le nombre de saisies** a augmenté de façon discontinue depuis 1990 en ce qui concerne le cannabis et depuis 2010 pour la cocaïne, alors que le nombre de saisies d'héroïne a eu tendance à diminuer depuis 2010 avec une légère reprise à partir de 2014. Le **nombre total de personnes impliquées dans des infractions de détention de drogues** a suivi par ailleurs une tendance discontinue à la hausse jusqu'en 2015 pour accuser une première baisse en 2016. (2000 : 1.758 ; 2013 : 2.066 ; 2014 : 2.779 ; 2015 : 3.345 ; 2016 : 2.566).

Aucune saisie de crack n'a été rapportée à ce jour par les instances répressives bien que les associations de terrain rapportent la pratique du **free-basing** / *cocaine cooking* par certains usagers.

Les premières saisies de substances de type XTC ont été enregistrées en 1994 et les quantités saisies au niveau national affichent une nette tendance à la hausse depuis 2014.

Mesures judiciaires et pénales

Le nombre de **procès-verbaux** pour motifs d'infraction à la loi modifiée de 1973 est passé de 2.546 en 2010 à 3.385 en 2015 (2.624 en 2016). En ce qui concerne le nombre respectif de **prévenus**, on note une évolution similaire à celle du nombre de procès-verbaux. En 2016 furent enregistrées 234 **arrestations** (2015 : 217) pour motifs d'infraction à la loi modifiée de 1973.

6 Sauf indication contraire, les données présentées se rapportent à l'année 2016. A défaut d'autres indications, les données entre parenthèses se rapportent à l'année 2015.

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



La population des prévenus se compose de 88% d'hommes, proportion qui variait entre 79% et 90% durant les dix dernières années. 808 prévenus nouveaux ont été enregistrés en 2003 et 938 en 2016. Le **pourcentage de prévenus mineurs** (< 18 ans) parmi les premiers auteurs a connu une tendance à la hausse entre 2010 (18,7%) et 2014 (22,2%). En 2016, le taux de prévenus mineurs parmi les premiers auteurs était de (19%). Le cannabis est la principale substance impliquée dans les premières infractions.

Depuis 1998, les personnes originaires de pays autres que le Luxembourg (59% en 2016) ont représenté la majorité des prévenus (50-68%). 37% (32% en 2015) des cas enregistrés sont des premiers auteurs.

Les données statistiques fournies par l'administration pénitentiaire pour l'année 2016 font état de 962 nouvelles entrées au CPL (950 en 2012 ; 818 en 2013, 904 en 2014, 951 en 2015) dont 306 (31,81%) pour infraction(s) à la loi modifiée 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 de qualité. En 2016, 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 (transit et production d'ecstasy et d'amphétamines) et du Maroc (production de cannabis). L'importation de cocaïne depuis l'Amérique latine s'effectue 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 continue à emprunter la route du Balkan (Roumanie et Bulgarie) ou des dérivés de celle-ci (Pologne, Turquie, Bélarusse). Le pays producteur principal reste l'Afghanistan.

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 et produits associés (Legal highs) sont également à surveiller de façon rapprochée. Les stratégies et techniques de vente de drogues impliquent plusieurs acteurs avec des tâches bien définies afin de réduire les risques liés au trafic. Par ailleurs, les réseaux de vente œuvrent à délocaliser leurs points de vente vers des endroits moins visibles aux forces de l'ordre, tels qu'appartements privés ou cafés.

Au vu de la position géographique du Luxembourg et de son statut de pays de transit, 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.

Comparée à la situation de 2006, **la pureté** de la cocaïne a baissé et une tendance générale mais discontinue à la baisse au niveau de la pureté moyenne de l'héroïne est observable pendant la même période. La concentration moyenne de THC détectée dans des produits du cannabis affiche une tendance à la hausse depuis plusieurs années.

Il s'agira de continuer à suivre attentivement les variations importantes au niveau des puretés minimales et maximales et plus particulièrement les concentrations de THC dans différentes variétés de cannabis saisies au Luxembourg.

Les prix de rue de l'héroïne, de la cocaïne et du cannabis connaissent des marges croissantes, ce qui est dû partiellement aux différences de plus en plus marquées de la qualité de l'ensemble des drogues de rue.

TENDANCES ESSENTIELLES

Tous indicateurs de tendances confondus, les données les plus récentes confirment **une stabilisation de la prévalence d'usagers problématiques de drogues et d'usagers intraveineux au Grand-Duché de Luxembourg**. Au cours de la dernière décennie un nombre croissant d'UPD a commencé un traitement ou profite des offres bas-seuil et un nombre décroissant d'UPD entre en contact avec les forces de l'ordre.

L'usage intraveineux d'héroïne et de cocaïne associé à une polyconsommation demeure le mode de consommation préférentiel des usagers répertoriés par le réseau institutionnel. Toutefois la pratique de l'inhalation (*chasing*) gagne progressivement du terrain sur l'usage intraveineux.

La qualité des drogues vendues sur les marchés illicites au niveau national a connu une dégradation importante, ce qui a eu comme conséquence une augmentation généralisée de la polyconsommation. Le nombre de victimes de surdosages mortels affiche une tendance générale à la baisse depuis 2007 (27 cas) pour atteindre 5 cas en 2016.

Bien que la prévalence UPD récente témoigne d'une tendance à la baisse, de nouveaux phénomènes sont apparus dont le « cocaine freebasing » et l'usage de nouvelles drogues de synthèse (NPS) et de produits contenant ces dernières. Ces nouveaux phénomènes doivent être observés de près aussi en raison de l'impact important qu'ils peuvent avoir sur l'incidence UPD à l'avenir.

Les maladies infectieuses dont souffrent beaucoup d'usagers de drogues et particulièrement les UDVI demeurent un phénomène préoccupant. La proportion des UPD infectés par le VIH, restée stable de 2000 à 2008, a montré une tendance à la hausse entre 2009 et 2010, pour se stabiliser à nouveau autour de 3 à 5% entre 2011 et 2014. En 2015 et 2016 par contre, une nouvelle hausse du taux d'UPD infectés par le VIH s'affiche (8% et 9%). On observe également une hausse de la proportion des injecteurs de drogues dans les cas VIH nouvellement diagnostiqués à partir de 2014 alors que les offres nationales en matière de réduction des risques et dommages comptent parmi les plus développées et diversifiées au sein de l'UE. Les données encore incomplètes de 2017 laissent prudemment espérer une première inversion de cette tendance depuis 2014 tout en soulignant que l'incidence VIH demeure à un niveau élevé. Par ailleurs, le nombre de seringues stériles distribuées dans le cadre du programme national d'échange de seringues est en hausse et a atteint un niveau record en 2016.

Le marché illicite de drogues au niveau national se caractérise par des techniques de vente et de stratégies de distribution plus agressives ce qui est notamment dû à une collaboration plus perfectionnée entre des groupes criminels d'origines ethniques différentes qui auparavant ont opéré de façon indépendante. Dans ce contexte on a observé que les points de vente sont devenus moins visibles pour les forces de l'ordre, p.ex. des appartements privés ou des bars. Une attention particulière doit aussi être portée sur les différences accrues observées dans les puretés minimales et maximales des drogues de rue ainsi qu'à la concentration maximale de THC au niveau des saisies de cannabis les dernières années. Les différences de qualité des drogues de rue ont tendance à augmenter ce qui suggère des mécanismes plus diversifiés de distribution et qui pourrait expliquer les variations de prix importantes observées au cours des dernières années. L'ensemble des



indicateurs disponibles suggère par ailleurs que les consommateurs de drogues illicites s'approvisionnent de plus en plus sur le marché national.

Les développements en termes de **réponses** apportées aux problèmes associés à l'usage problématique de drogues sont à mettre en lien direct avec la mise en exécution de la stratégie nationale « drogues et addictions » et des plans d'action y associés. Au cours des dernières années, les services de consultation et de traitement spécialisés ont été largement adaptés aux réalités observées et aux défis nouveaux.

Des mécanismes de coordination ont été renforcés entre les ONG et les autorités nationales et des mécanismes d'évaluation sont en place. Il a été procédé à une deuxième évaluation externe du plan d'action drogues et addictions (2010-2014). Les résultats ont été intégrés, ensemble avec les recommandations issues d'une série de groupes de travail d'experts nationaux et de résultats d'enquêtes auprès des usagers/clients, dans l'élaboration de la nouvelle stratégie drogues et addictions et plan d'action 2015-2019 qui a son tour sera soumis à une évaluation externe.

SUMMARY

ANNUAL NATIONAL REPORT ON THE STATE OF THE DRUGS PROBLEM (Edition 2017)

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** relied upon the priorities of the Ministry of Health and a sustained collaboration with field actors and civil society. In order to optimize its impact, the new action plan has taken into account relevant issues from EU and EC treaties, **the EU anti-drugs strategy 2005-2012** and the **EU drugs action plans 2009-2012**. The elaboration of the new **national drugs action 2015-2019** has built upon the outcome of an **external evaluation** of the previous action plan. 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 and 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 has increased from 2,066,000.- EUR in 2000 to 12,987,138.- EUR in 2017, thus witnessing a progression rate of 529%.

EPIDEMIOLOGICAL INDICATORS

Globally, UNODC (UNODC 2017) estimates that, 250 million people aged 15 to 64 years used at least one illicit substance during the past year, meaning 1 person out of 20 from this age group. Problematic drug use affects some 29 million people; of which 12 million are intravenous drug users. L'UNODC estimates that 1.6 million of intravenous drug users are HIV+.

Cannabis remains the most widely consumed drug worldwide (183 million people or 3.8% of the population aged 15 to 64 years) which represents a slight increase compared to the estimations of 2009. The use of amphetamine-type stimulants reached 37 million people (0.77%). The prevalence of "ecstasy" (21.6 million people or 0.45% of the population aged 15 to 64 years) has decreased compared to 2009 data. The number of opiate users has stabilised and situates around 17.7 million people (0.37%).

According to the European Drug Report 2016, published by the EMCDDA, 93 million people have used an illicit drug in Europe. Positive evolutions are to be seen in the decline of new heroin users, the decrease of the number of people who inject drugs and the stabilisation of the use of cannabis and cocaine in several countries. In addition, record levels of the number of people in treatment have been observed (1.4



million of Europeans in 2015) as well as a continuing decrease of the HIV infection associated to drug use. Amphetamines and ecstasy remain the synthetic stimulants mostly used in Europe. Recent data suggest, however, a stable and declining use of amphetamines by young adults.

Concerning cannabis, around 1% of European adults are estimated to use cannabis daily or nearly on a daily basis. 13.9% of young Europeans aged 15 to 34 years have consumed cannabis during the past year.

Also the number, type and availability of new substances in Europe continue to increase. Globalisation mechanisms, technical progress and the use of the internet have contributed to a market open for new drugs mostly of synthetic origin.

At the micro-geographical level, tendencies observed in the Grand-Duchy of Luxembourg reflect those observed in the EU with however local prevalence variations and a general reduction of the prevalence of problematic drug use.

National drug prevalence in the general population

Drug prevalence in school population and in the general population

The European Health Survey- EHIS has been conducted in EU Member States between 2013 and 2015. In addition to the common items, questions on illicit drug use have been included in the national survey protocol. It is thus the first representative general population survey on illicit drug use at national level. The representative sample was composed of residents of the Grand-Duchy of Luxembourg aged 15 years and more.

Controlled substances most often used in Luxembourg after cannabis were cocaine and XTC type substances and national use prevalences situate below the EU average. Only life time use of cannabis (23,3%) showed a higher national prevalence than the EU average in recent years (EMCDDA, 2016). Male users showed higher rates of cannabis prevalence use than female users. The first use of illicit substances occurs most often in age group 15 to 19 years with the exception of heroin and cocaine which occurs most often in age group 20 to 24 years.

In terms of surveys targeting younger populations, serial school survey data (HBSC 1999 – 2010) reveal a decrease in the prevalence of any illicit drug use from the end of the 20th century to 2010. In-depth analysis shows an overall decline in prevalence between 1999 and 2006 and a fair stabilization afterwards. All common illicit drugs follow declining prevalence trends with the notable exception of cocaine witnessing an increase, particularly in the age group 15 to 16 years. Opiates' use in school-aged children has been consistently low over the last decade.

Even though cannabis is still the most used illicit drug by youngsters aged 12 to 18 years, an obvious decline has been observed from the beginning of the 21st century as far as lifetime prevalence is concerned. Recent and current cannabis use prevalence rates have been declining remarkably between 1999 and 2006 and seem to have stabilised since then. Currently it is estimated that 18% of national youngster aged 15 have already used cannabis at least once during lifetime (HBSC, 2014).

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 use before having reached 15 years, whereas this same proportion figured 12.03% in 2006.

Data on institutional contacts and drug treatment demands

The annual **number of PDU person-contacts** indexed by national institutions figured 5,846 in 2016 (multiple counts included⁸) (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 2016, the same agencies have indexed 2,974 and 2,872 persons respectively. Overall the number of persons showing drug-related contacts with DR or SR agencies has discontinuously increased until 2010 and witnessed a first decrease in 2011 to increase again 2015 onwards. In 2016 an important decrease of contacts registered by supply reduction agencies is noted. Worth mentioning is also the decrease between 2011 and 2013 of national low threshold agencies' contacts. Successive increases, however, have been noted 2014 onwards.

Socio-demographic profile of PDU

In 2016, the **male/female ratio** of the PDU population set at 85/100. Over the last decade the proportion of indexed non-native PDU has been showing strong variations but marked increases in 2015 (58%) and in 2016 (63%) compared to a rate of non-native citizens in the national population of 47.7% (1st of January 2017). The population of non-native drug users largely consists of Portuguese nationals (28% of total number of non-native PDU), representing, however, currently a proportion that is lower than the one observed in the general population (34.6%).

The **mean age** of indexed PDU has been evolving from 28 years and 4 months in 1995 to 34 years and 2 months (SD=9.91) in 2016. The mean age of male PDU has been increasing faster than for females. The proportion of PDUs aged 40 and more has been increasing over recent years while the proportion of PDUs aged 30 years and less has been witnessing a general decreasing tendency. 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 over the last decade.

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, 2007, 2009 and 2017 (Origer, 2012⁹, 2017). According to the latest serial drug use prevalence study (Origer, 2017) performed on 2015 data, the national prevalence of **Problem Drug Users** (PDU) situates around 2,250 persons. A decreasing trend in the PDU prevalence rate in the national population aged 15 to 64 years has been observed from 2003 onwards. A similar evolution occurred also for **Injecting Drug Use** (IDU) prevalence since 2009. The prevalence rate of **Opioid Use** (OU) was estimated for the first time on 2015 data at 4.46 per 1,000 inhabitants aged 15-64 years which equals to approximately 1,700 opioid users.

Injecting heroin and cocaine use associated to **poly-drug use** have been reported being the most common consume pattern in PDU. The ratio between non-injectors and injectors figured 3/4 in 2016. In 2016, cocaine as primary drug reached a high level (17%) similar to the ones observed in 2014 and 2015 (19.9%, 19%).

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

9 **Origer A.** Prevalence of Problem Drug Use and Injecting Drug Use in Luxembourg: A Longitudinal and Methodological Perspective. *Eur Addict Res.* 2012;18:288-296.



The number of persons in contact with the national specialised network for (preferential) **cannabis** use currently represents 32.8% (23.1% in 2015). **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** has been decreasing 2011 onwards with increasing trends in 2014 (54%) and 2015 (61%) followed by a stabilisation in 2016 (54%)

DRUG-RELATED TREATMENT

The number of adult outpatient clients and hospital based treatments tends to increase, while the number of adult inpatient treatment demanders have been decreasing slightly at national level. Since 2010 the number of substitution treatment demanders has been stabilising and the number of contacts in low threshold facilities has been decreasing from 2010 to 2013 (2010: 140 093; 2012: 127,080; 2013: 124,048; 2014: 131,375; 2015: 142,054 contacts). In 2016, the number of contacts in low threshold facilities increased to 150,937 contacts. In 2016, approximately 15.5% of respondents have been 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 30 years and the increase of the proportion of patients aged 40 years and more.

HEALTH CORRELATES AND RESPONSES TO CONSEQUENCES

The **HIV/AIDS prevalence**¹⁰ in PDU has been fairly stable until 2014 according to RELIS data. In 2016, however, an important increase concerning HIV prevalence is observed. The **infection of HCV (hepatitis C)** in drug users seems to have stabilised at high level. Data from the National Laboratory of Retrovirology suggest a long term and discontinuous decreasing tendency of the average proportion of IDU in newly diagnosed HIV cases. From 2004 to 2008 this proportion has been varying between 7 and 14 %, followed, however, by an increasing trend from 2014 onwards (2016: 21%) although national harm reduction offers are highly developed and diversified. Other EU member states also reported recent HIV outbreaks in IDU populations (EMCDDA, 2016). Still uncomplete 2017 data may suggest a first trend inversion as regards new HIV infections in IDU since 2014, although the current incidence remains high.

The implementation of the 2005-2009 and 2010-2014 action plans has been accompanied by a discontinuous but significant overall decrease of fatal **overdose cases** in the Grand Duchy of Luxembourg (2016: 5 cases).

In terms of number of overdose cases in the general population of the Grand Duchy of Luxembourg, this proportion figured 5.9 overdose deaths per 100,000 inhabitants aged 15 to 64 years in 2000 (2007: 5.67 cases per 100,000 inhabitants). In 2016, 0.9 acute OD cases per 100,000 inhabitants have been registered (2009: 4.15), showing a decreasing tendency. Forensic data from 1992 to 2016 show that the most frequently involved substances in drug-related deaths are heroin and prescription drugs and/or heroin consumed in a polyuse context. All victims were male in 2016 and the mean age of victims has been showing a discontinued increase over the past 20 years (in 1992: 28.4 years and in 2015: 41.1 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. The youngest victim was 25 years old and the oldest was 51 at the moment of death.

¹⁰ 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

As regards the nationality of overdose victims, 60% (67% in 2015) were natives. A detailed description of fatal overdose victims since 1994 as well as the gender impact in overdose victims have been analysed by extensive studies which results have been published between 2013 and 2015 (**Origer et al.**, 2013, 2014, 2015)¹¹.

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 at 67%. This improvement may be partly due to various accommodation and housing offers for addicted people set up in the framework of the national 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** (55%) tends to plateau. However, the proportion of active respondents reporting a stable job situation (e.g. long term contract) has been stable over the last 3 years.

HARM REDUCTION ACTIVITIES

The **number of contacts** indexed by national low-threshold agencies has been increasing markedly since 2013 (124,048). In 2016, 150,937 contacts have been registered. Approximately 20% of clients are aged between 24 and 34 years, and 80% of clients aged 35 and more is observed. Around 20% of clients are females. An increase of female contacts is observed (14% in 2016).

The number of **syringes** distributed in the framework of the national needle exchange programme peaked in 2006 and has been decreasing discontinuously until 2013. In 2016, however, a marked increase and new peak are observed (2016: 423,060 / 1996: 76,259). Return rates of used syringes have been increasing during the referred period and reached 94% in 2016. An increasing majority of injectors procure their syringes in specialised agencies followed by pharmacies.

LAW ENFORCEMENT INDICATORS¹²

Seizures of illicit substances at the national level

Great variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency in heroin, cocaine and cannabis (herbal and resin) seizures¹³ between 2006 and 2013, followed by a new increase of cocaine and cannabis seizures 2014 onwards.

Notwithstanding the quantities of cannabis and cocaine seized; the **number of seizures** of cannabis has grown discontinuously since 1990 and since 2010 for cocaine, whereas the number of heroin seizures has been discontinuously decreasing since 2010 showing signs of increase 2014 onwards. The total **number of**

¹¹ **Origer A, Lopes da Costa S, Baumann M.** Opiate and cocaine related fatal overdoses in Luxembourg from 1985 to 2011: A study on gender differences. *Eur Addict Res.* 2014;20(2):87-93. DOI: 10.1159/000355170

¹² If not specified, data refer to 2016. Figures in brackets refer to 2015 if not otherwise specified.

¹³ Non-transit drugs destined to the national market



persons involved in drug possession offences has followed a global upward trend until 2015 to witness a first decrease in 2016 (2000: 1,758; 2012: 1,782, 2013: 2,066; 2014: 2,779; 2015: 3,345; 2016: 2,566).

Crack (cocaine-base) seizures have not been reported to date by national authorities, although freebasing is reported by field agencies. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994 and seized quantities remarkably increased 2014 onwards.

Drug law offenders and prison sentences

The **number of police records** for presumed offences against the modified drug law of 1973 went from 2,546 in 2010 to 3,385 in 2015 (2,624 in 2016). A similar evolution has been observed with regard to the **number of drug law offenders**. In 2016, 234 **arrests** (217 in 2015) for presumed drug offences have been reported.

The population of drug law offenders is composed of 88% **males**; a proportion that has been varying between 79% and 90% during the past decade. 808 **first drug law offenders** were reported in 2003 and 938 in 2016. Also the **percentage of minors** (< 18 years) among first drug law offenders has been increasing until 2014: 1994 (4.9%); 2000 (8.7%); 2014 (22%) and figured 19% in 2016. Cannabis is the main drug involved in registered first drug offences.

Since 1998, **non-natives** (59% in 2016, 56% in 2015, 50% in 2014; 48% in 2013) have been representing the majority of drug law offenders (50-68%). 37% (32% in 2015) of the registered cases were **first drug law offenders**. National **prison data** of 2016 refer to 962 (951 in 2015) new admissions of which 306 (31.81%) were related to drug law offences; a proportion that represented 42.6% in 1996.

PROFILE OF THE NATIONAL DRUG MARKET

The national production and culture of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2016 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 (transit and 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).

In recent years more organised distribution networks have been developing nationally. The expansion of these distribution networks by criminal associations thus contributed to a significant increase in drug availability, and particularly in the supply of cocaine and cannabis. Dealing and selling techniques involve several actors and drugs to minimise traffic-related risk. 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 gross quantities.

Over the last 10 years, purity of cocaine has been generally decreasing and average heroin purity has also been following a discontinuous downward trend. Attention has to be paid to the striking differences in maximum and minimum purities as well as to a high maximum concentration of THC in cannabis products seized in Luxembourg in recent years. **Prices** move within increasingly broader ranges for heroin, cocaine and cannabis, which is partly due to increasing differences in quality levels of street drugs.

MOST RELEVANT TRENDS

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

Injecting opiate and cocaine use, combined with polyuse, is the predominant PDU pattern. However, recent data suggest that the inhalation mode (chasing) is becoming increasingly popular. The overall quality of street drugs decreased, which resulted in an overall increase of polydrug use. The number of acute drug deaths went down to 5 cases in 2016 (27 cases in 2007).

Although current PDU prevalence shows a decreasing trend, new phenomena such as early drunkenness, binge drinking in youngsters, cocaine freebasing, stimulants' injection 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 concern about infectious diseases in drug users and particularly in IDU. HIV rates in PDUs have been low and stable from 2000 to 2008, but showed an increasing tendency in 2009 and 2010, to stabilise again around 3 to 5% between 2011 and 2014. In 2015 and 2016, however, a new increase (8% and 9%) is observed concerning the proportion of PDUs infected by HIV, although the number of clean syringes provided to IDU via the national needle exchange programme has reached a record level in 2016. Also, the proportion of IDU in newly detected HIV cases has been increasing since 2014. Still uncomplete 2017 data may suggest a first trend inversion, knowing, however, that the HIV incidence in IDU is currently still high. The prevalence of hepatitis C has been increasing continuously from 2000 to 2008, slightly decreasing in 2009 and 2010, as well as in 2012 to increase again in 2014. In 2016, the proportion of PDUs infected by hepatitis C has been stabilised at high level. Former 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 and distribution strategies as well as improved strategies of trafficking involving 'multiplayers' with specific tasks. 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 in cannabis samples seized over the last years. Quality ranges of street drugs tend to increase which suggest more diversified distribution mechanisms and may explain the important price variations observed during recent years. Available indicators suggest that users increasingly acquire illicit drugs on the national market.

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 been improvements in early intervention measures. Major efforts have also been made in the diversification of care offers and finally harm reduction measures have been significantly developed. Housing offers and reintegration programmes have obviously contributed to improve socio-professional situations as documented by latest RELIS data. Substitution treatment and low-threshold offers have been diversified and decentralised and continue to be so.



Coordination mechanisms have been reinforced between NGOs and national authorities and evaluation mechanisms are in place. A second 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 users/clients surveys in the elaboration of the new drugs strategy and action plan 2015-2019.

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 2015-2019 on addictions (and not exclusively on illicit substances' related problems).

The governmental programme 2013¹⁴, foresees to further develop the national drugs action plan and specifically refers to the decentralisation of care and harm reduction structures, to the creation of a heroin assisted treatment programme and to the extension of post-therapeutic offers. The 2010-2014 national drug action plan was externally evaluated in 2014 (Trimbos Instituut – NL).

The 2015-2019 national action plan on drugs and addictions builds upon the outcome of the referred external evaluation of the national drug strategy and action plan 2010-2014.

GENERAL LEGAL FRAMEWORK¹⁵

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'¹⁶ 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 2001¹⁷. 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).

In 2014, new laws were voted and adopted, mainly relating to the grand-ducal decrees from 1973 and 1974.

14 Gov. Declaration of 2013, <https://www.gouvernement.lu/3322796/Programme-gouvernemental.pdf>

15 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>

16 Official gazette A 1973, p.319

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



Since June 10th 2014¹⁸, custom officers were attributed new competences and are held to attend a professional training on the search and verification of drug law offences and controlled psychoactive substances. Moreover, a new drug law offence was added to the law from 1973, namely any attempt to falsify blood samples and medical protocols in the framework of drug-tests.

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 **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 **13 February 2007** on the surveillance and commerce of drug precursors¹⁹

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://www.emcdda.europa.eu/eldd>

CHANGES IN 2012:

The grand ducal decree of July 21, 2012²⁰ puts the following substances and plants under national control:

- *MDPV (3,4 méthylène-dioxy-pyrovalerone)*
- *Salvia Divinorium (Salvinorine A)*
- *Mytragyna Speciosa, Kratom (Mytragynine, 7-Hydroxymytragynine)*

Furthermore, it regulates the modalities for the incorporation of certain cannabinoids in recognized medicaments as well as the cultivation of certain cannabis varieties for agricultural, non-psychoactive purposes.

18 Official gazette A-97 du 10 juin 2014, Loi du 30 mai 2014 portant modification de la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie, p. 1488 (Adoption: 30. 05.2014. Entry into force: 10.06.2014.)

19 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.

20 Règlement grand-ducal du 21 juillet 2012 modifiant :
- le règlement grand-ducal modifié du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie ;
- l'annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques ;
- l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;
- l'annexe du règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants
Official gazette A 157, p.1888 (Adoption : 21.07.2012, Entry in force : 30.07.2012)

CHANGES IN 2013:

The grand ducal decree of January 29, 2013²¹ puts the following substances under national control:

- MDMC (Methylone)
- 4-MA (Methylamphetamine)

CHANGES IN 2014:

The grand ducal decree of January 24, 2014²² puts the following substances under national control:

- 5-(2-aminopropyl)-indole (5-IT)

CHANGES IN 2015:

The grand ducal decree of June 19, 2015²³ puts the following substances under national control:

- 4-iodo-2,5-diméthoxy-N-(2-méthoxybenzyl)phénéthylamine (25I-NBOMe);
- 3,4-dichloro-N-[[1-diméthylamino)cyclohexyl]méthyl]benzamide (AH-7921);
- 2-(3-méthoxyphényl)-2-(éthylamino)cyclohexanone (Méthoxétamine).

CHANGES IN 2016:

The grand-ducal decree of June 9th 2016²⁴ put the following substances under national control :

- 2-(4-bromo-2,5-diméthoxyphényl)-N-[(2-méthoxyphényl)méthyl]éthanamine (25B-NBOMe),
- 2-(4-chloro-2,5-diméthoxyphényl)-N-[(2-méthoxyphényl)méthyl]éthanamine (25C-NBOMe),
- 1-phényl-2-(1-pyrrolidinyl)-1-pentanone (alpha-PVP),
- 4-méthyl-5-(4-méthylphényl)-4,5-dihydrooxazol-2-amine (4,4'-DMAR),
- 1-cyclohexyl-4-(1,2-diphényléthyl)piperazine (MT- 45).

CHANGES IN 2017:

The grand-ducal decree of October 12th 2017²⁵ put the following substances under national control :

4-MEC (4-méthylethcathinone)	2-(éthylamino)-1-(4-méthylphényl)propan-1-one
Ethylone	1-(2H-1,3-benzodioxol-5-yl)-2-(éthylamino)propan-1-one
Pentédrone	2-(méthylamino)-1-phénylpentan-1-one
Ethylphénidate	éthyl phényl(pipéridin-2-yl)acétate
MPA (méthiopropamine)	N-méthyl-1-(thiophen-2-yl)propan-2-amine
Butyrfentanyl	N-phényl-N-[1-(2-phényléthyl)-4-pipéridinyl]butanamide
U-47700	3,4-dichloro-N-(2-diméthylamino-cyclohexyl)-N-méthylbenzamide

21 Règlement grand-ducal du 29 janvier 2013 modifiant :

- le règlement grand-ducal modifié du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie ;
- l'annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques ;
- l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;
- l'annexe du règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants

(Adoption : 29.01.2013. Entry in force : 01.02.2013)

22 Règlement grand-ducal du 24 janvier 2014 modifiant :

l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;

(Adoption : 24.01.2014. Entry in force : 30.01.2014)

23 Règlement grand-ducal du 19 juin 2015 modifiant :

l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;

(Adoption : 19.06.2015. Entry in force : 17.07.2015)

24 Règlement grand-ducal du 9 juin 2016 modifiant l'annexe du règlement grand-ducal modifié

du 20 mars 1974 concernant certaines substances psychotropes. (Adoption: 09.06.2016. Entry in force : 22.06.2016)

25 Règlement grand-ducal du 12 octobre 2017 modifiant

1. l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;
2. l'annexe du règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants. (Adoption: 12.10.2017. Entry in force : 19.10.2017)



Laws implementation

Legally speaking, police has no discretionary 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.

Drug-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.

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.

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 2001²⁶ modifying the basic drug law of 19 February 1973 by decriminalising cannabis use (without aggravating circumstances), 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 2002²⁷ 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

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

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

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 in 2005 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 a drug addicted person remains a simple user, any damage caused to himself/herself and the legal response remains minimal as long as public order is not greatly disturbed. However, if the drug user causes harm to others, the response will become firmer according to the seriousness of the offence.

In practice the median expected sentence varies by drug type and quantity. Indeed, cannabis substances are less harshly punished with median expected penalties of 1 year and 6 months for 1kg and 3 years for 10kg. For amphetamines the expected sentences range from 1 year and 9 months for 100g and 3 years for 1kg. More severely punished, cocaine and heroin trafficking median expected sentences are 2 years for 100g and 3 years for 1kg.²⁸

In 2016, 32% of all confirmed prison sentences were related to offences against the national drug legislation. Men are overrepresented in drug-related sentencing statistics with 88% men and 12% females. It should be noted, however, that from 2014 to 2015, the proportion of drug-related offences in female offenders increased from 7% to 20%. This proportion, however, slightly decreased again in 2016.

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 since 2006 by the National Drug Coordinator, appointed by the Minister of Health. The ICD is composed of official delegates from involved governmental departments, the Ministry of Health and invited experts, and constitutes the top advisory level with respect to coordination and orientation of actions. Both, the ICD and the Ministry of Health are responsible for the implementation of national drugs strategies and action plans, supervising field activities and guaranteeing an effective consultation process with other ministries. While the National Drug Coordinator is responsible for coordination in the areas of demand and harm reduction, research, information and coordination, the Ministry of Justice and the Ministry of Foreign Affairs are, respectively, responsible for supply reduction and international cooperation in close collaboration with the National Drug Coordinator. The ICD, has an advisory role and addresses issues ranging from illicit drug use and "legal highs" to alcohol use and prescription drugs under the general heading of addictive behaviour and its consequences.

28 Technical Report: Drug trafficking penalties across the European Union, A Survey of expert opinion. EMCDDA. EMCDDA, 2017



The National Drug Coordinator is also the head of the national delegation within the Horizontal Working Party on Drugs (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 HIV/AIDS surveillance commission as well as of the steering committee of the *Fund against the fight of certain forms of criminality* and the consultative committee of the *Œuvre Nationale de Secours Grande-Duchesse Charlotte*.

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.

The new 2015-2019 national strategy and action plan on drugs and addictions build upon the outcome of the referred external evaluation of the national drug strategy and action plan 2010-2014 and will be further addressed in the upcoming edition of this report.

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 2015-2019 national action plan²⁹ 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 2015-2019 governmental drugs strategy has builded upon a more holistic approach than the previous ones. It addressed addictive behaviour as a whole and not only illicit drugs and drug addiction. Thus alcohol, tobacco and psychotropic pharmaceuticals dependence as well as addictive behaviour not associated with substance use are now an integral part of a 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.

29 Ministère de la Santé (2015). Stratégie et plan d'action gouvernementaux 2015-2019 en matière de lutte contre les drogues d'acquisition illicite et les addictions associées. Ministère de la Santé. Luxembourg. Available at : <http://www.ms.public.lu/fr/activites/medecine-sociale-toxicomanie/index.html>

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.

The national plan lists **61 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-benefit/quality factors, quality assurance mechanisms and measurability of results or impact.

The overall objective of the national action plan is to:

- prevent the initiation of addictive behavior,
- provide diversified care offers to drug dependent persons,
- reduce significantly the prevalence of drug consumption in the general population
- reduce adverse social and health outcomes caused by the consumption and sale of illicit drugs.

The main priorities of the national action plan are as follows:

- prevention in the broadest sense,
- youngsters, recreative drug use,
- drug dependent parents,
- further decentralisation of care and harm reduction offers,
- further development of substitution treatment,
- elderly drug users,
- fight against infectious diseases in drug users,
- reduction of drug-related morbidity and mortality,
- new psychoactive substances and
- emerging use patterns.

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 2014, in order to best meet current needs in the elaboration of the 2015-2019 action plan, the National Drug Coordinator has launched a fourth 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 are involved from 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 564% of the budget invested by the Ministry of Health in drug demand reduction occurred between 2000 and 2017.

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) in 2009.

In 2014, the drugs strategy and action plan 2010-2014 were also evaluated by the Trimbos Instituut (Trautmann & Braam, 2014). The contractual scope of the evaluation was a critical analysis of the implementation of the National Drug Action Plan 2010-2014. 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 external evaluation of was based upon an assessment of the achievements of the National Drug Action plan 2010-2014 and a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis.

Over the 61 actions listed in the plan, 45 out of them (74%) were fully implemented and most of the outcomes were judged as “positive”.

The full outcome of the evaluation have been published and is publically available³⁰.

The evaluation report also lists a set of recommendations regarding the new **National Drug Action Plan 2015-2019**, the coordination structure and the policy-making process. Evaluation results and recommendations of the working groups, and the final output of the external evaluation exercise have been serving the National Drug Coordinator and the Interministerial Commission on Drugs to elaborate the new national drugs action plan 2015-2019.

30 Trimbos Instituut (2014). Evaluation of the national drug action plan (2010-2005) of Luxembourg, Utrecht



Main recommendations of the evaluation report:

- Continuation of the drug policy developed in the past years,
- Further implement the national strategy with action plans addressing all types of addiction,
- Increase prevention effectiveness by integrating a broader health education approach,
- Set up an inventory of research priorities for effective interventions,
- Further develop cooperation and exchange between all relevant services and organisations,
- Further develop drug prevention programmes in schools, based on life skills development,
- Develop comprehensive prevention programmes for young regular users of cannabis and alcohol,
- Strengthen parent involvement in drug prevention,
- Promote specialised training for professionals based on research evidence and best practices,
- Set responsibility division between services, health professionals, police and justice,
- Continue to develop harm reduction services with increased involvement of municipalities,
- Implement heroin assisted treatment as foreseen in the national drugs action plan,
- Further develop specialised care and treatment programmes for drug using parents, their children and pregnant users,
- Adapt services for ageing and elderly drug users.

Other drug policy developments: Initiatives in Parliament and civil society

No projects or propositions of law in relation with drugs or drug addiction were introduced in 2016 and no specific Parliamentary debates or initiatives in the field of illicit drugs are to be reported.

Special topics addressed by the Interministerial Group on Drugs (IGD) in 2016 were:

- Use of certain cannabinoids for pharmaceutical purposes
- Products based on or enriched with cannabidiol
- Psychoactive drugs in e-cigarette liquids
- The spread of fentanyl
- Substitution treatment and diacetylmorphine assisted treatment
- Supervised drug injection rooms in Luxembourg-City and in Esch/Alzette
- The phenomenon of research chemicals, designer drugs, NPS and their diversion. Creation of new legal instruments to fight the phenomenon of NPS. Regulation of selling and confiscation of psychoactive substances not yet controlled
- NPS testing facilities
- The spread of shisha smoking

Also, increased attention is currently paid to the following topics:

New HIV infections in PWID, partly due to the increase of cocaine injections and new responses – outreach further developed in 2017;

Recreative drug use and drug testing facilities in festive settings;

Regulation on New Psychoactive Substances in the light of amendments at EU level (i.a. EU directive and amendment of EMCDDA regulation);

Alcohol and cannabis use in the general population with special focus on youngsters.

ECONOMIC ANALYSIS³¹

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)³²,
- In terms of follow-up: budget lines may be restructured, integrated or divided over time,
- In the field of public health, expenditures may result from direct state financing or social security reimbursement,
- Lack of clarity due to national mixed (Multi-ministries) financing (e.g. Public research Centres – multi projects' financing) or National & EU & International shared financing,
- Eligibility of cooperation projects vs. variability of yearly contributions,
- Assessment of impact of general education and educational interventions (e.g.) on DDR impossible.

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

In order to tailor and fine tune a methodology that fits the national context and which is 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.

31 See related chapter in Part B

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



METHODOLOGY

In the 2014 edition of the present report an overall estimation of direct public expenditures based on studies performed respectively in 1999 and 2009 are reported (Origer 2002b, 2010). Main results of these former comparative studies are summarised in tables 1.4 and 1.5. To date they represent the only overall drug-related public expenditures studies at the national level. As a matter of fact, exhaustive public expenditure studies are highly time and cost-consuming exercises and can therefore not be performed routinely. This said, trends surveillance of dedicated public budgets may rely transitionally on partial indicators such as 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 himself.

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:

Origer, A. (2017). A methodological inventory for the assessment of selected, unlabelled direct public expenditure in the field of drug demand reduction. Drug treatment expenditure: a methodological overview. EMCDDA Insights: 63-72.

Ministère des Finances (2016). Projet de loi concernant le budget des recettes et des dépenses de l'Etat. Ministère des Finances, Luxembourg.

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Ministère de la Santé (2015). Stratégie et plan d'action national en matière de lutte contre les drogues et les addictions 2015 – 2019. 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.

Ministère de la Santé, Direction de la Santé & Cellule De Coordination « Drogues ». (2015). Stratégie et plan d'action gouvernementaux 2015–2019 en matière de lutte contre les drogues d'acquisition illicite et les addictions associées. Luxembourg : Ministère de la Santé

National estimates of labelled and non-labelled public drug demand reduction expenditures (2012)

Table 1.1 provides an synopsis 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.



Table 1.1: National estimates of labelled and non-labelled public drug demand reduction expenditures (Data : 2012)

7. Ministry of Justice	S7.2/12.370 0.30 TOX PROGRAMME: Care and treatment programme for drug addicts in prison	826,800.-	Extracted from the national state budget 2012
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 2012
14 /44 Ministry of Health	S 14.1/33.013 05.23 – 33.015 05.23 Staff and operational costs of specialised drug agencies and the NFP EMCDDA conventionned by state (40% non specialised)	7,584,373.-	Extracted from the national state budget 2012
	S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	750,000.-	Idem
	S 14.2 12.301 05.20/12.301 05.20 Toxicological surveillance of drug addicts	200,000.-	Idem
	I52.000 05.22 Construction, and maintenance of drug treatment facilities.	100,000.-	Idem
	I52.002 05.22 Participation in equipment costs of drug treatment facilities.	50,000.-	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	210,326.-	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
22/55 Ministry of Public Works	Maintenance work and equipment on/in buildings occupied by specialised NGOs (not covered by other budgets)	40,000.-	Extracted from the national state budget 2012
TOTAL LABELLED DRUG DEMAND REDUCTION EXPENDITURES: 9,483,499.-			

* Ministry of Social Security (Health expenditures)

* 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 EXPENDITURES

Health/Social Insurance

A. OST (Opioid substitution treatment)		
Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (net patients' contribution excluded)	515,343.-	Detailed breakdown by the National Health Insurance Funds
Reimbursement of pharmacies fees generated by substitution medication preparation /delivery	35,080.-	Detailed breakdown by the National Health Insurance Funds
Reimbursement of medical counselling costs related to substitution prescriptions	215,800.-	Number of substitution prescriptions X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)
B. Inpatient hospital drug treatment		
Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification)	2,358,510.-	ICD-10, F11, F12, F14, F16,F18, and F19 hospital episodes X average cost per episode (see study report 1999) (adjusted CNS data)
Medical counselling costs associated to hospital treatment episodes	205,000.-	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	1,479,000.-	Year-adjusted breakdown provided by CNS
D. Inpatient therapeutic treatment extra-hospital		
	829,933.-	Institution specific budget of 2001 adjusted for salary costs and inflation
E. Drug treatment costs subsidised by Min. Health		
	239,444.-	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		
	510.000.-	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		
	240,000.-	Yearly sum of differences between paid rent and market value rent.

TOTAL NON LABELLED DRUG DEMAND REDUCTION EXPENDITURES: 6,388,110.-EUR

TOTAL DEMAND REDUCTION EXPENDITURES 2012: 16,231,609.- EUR



Table 1.2: Comparative analysis of drug demand reduction costs in Luxembourg 1999 vs. 2009/2012(EUR)

Year	1999	2009	2012
Total expenditure	6,903,203.-	15,458,853.-	16,231,609.-
Expenditure per inhabitant per year	16.-	31.-	30,1.-
Expenditure per PDU	2,937.-	7,468.-	7,841.-
Percentage of GNP	0.03	0.04	0.04
Percentage of state budget	0.15	0.17	0.15

Source: Origer 2002, PF OEDT, REITOX report 2009/2012

National estimates of overall public drug-related expenditures (2009) (Origer 2010)

Table 1.3: National estimates of non-labelled drug-related expenditures (attributable proportions) (2009) (Origer 2010)

Ministry / Department	Budget /Title	Budget / Expense (EUR)	Attributable proportion	COFOG 1	COFOG 2	SECTOR
01 Ministry of Foreign Affairs and Immigration	S. 01.7 Staff, operational and mission cost related to drug-related issues	21,400.-	Estimation by MFA based on analysis of work and mission reports and career of involved agents	Gf01	Gf0101	S1312
07 Ministry of Justice	S. 07.0 Staff, operational and mission cost of MJ related to drug-related issues	25,000.-	Estimation by MJ based on analysis of work / mission / career	Gf03	Gf0306	S1312
		1,250,000.-		Gf03	Gf0303	S1312
	S. 07.1. 0 Staff, operational and mission cost of judiciary services (courts, etc.) related to drug-related issues	10,802,430.-	Total cost of judicial services x proportion of drug offences affairs (based on ad hoc register)	Gf03	Gf0304	S1312

07 Ministry of Justice	S. 07.2 Prison drug-related expenditures	1,200,000.-	Total prison budget x proportion of drug law offenders in total prison population	Gf03	Gf0301	S1312
	S.07.4 Police drug-related expenditures	3,780,000.-	Dedicated staff, operational and mission costs (Special drug units 100%) + Assessment by Police Directorate based on analysis of job descriptions and related operational costs	Gf03	Gf0301	S1312
12/13 Ministry of Family, Social Solidarity and Youth	S. 13.1 / 12,140 06. 32 Information campaigns on drugs	15,000.-	Internal budget breakdown	Gf10	Gf010	S1312
	S. 13.1 / 11.000 11.00 Staff, operational and mission costs of MF related to drug-related issues	22,700.-	Estimation by MF based on analysis of work / mission / career	Gf10	Gf1004	S1312
14 Ministry of Health	S 14.0 Staff, operational and mission cost of MH related to drug-related issues	25,000.-	Estimation by MH based on analysis of work / mission / career	Gf07	Gf0704	S1312
<i>14.1 Directorate of Health</i>	S 14.1 / 33.014 05.23 Staff and operational cost of National Aids counselling Centre	191,341.-	25% of total budget : average proportion of PLWHIV/AIDS infected via IDU in clients	Gf07	Gf0702	S1312
<i>14.2 Public Health Laboratory</i>	S 14.1 / 11.000 05.00 / 12.010 05.00 Staff and mission costs of Directorate of Health allocated to drug-related issues	250,000.-	Dedicated staff to drug issues + Estimation by MH based on analysis of work / mission / career	Gf07	Gf0704	S1312
	S 14.2 / 11.000 05.20 Staff, operational and mission costs of Laboratory related to drug-related issues	25,000.-	Estimation by Laboratory based on analysis of work / mission / career	Gf07	Gf0704	S1312
17 Ministry of Social Security	S 17.2 Staff, operational and mission costs for agents in charge of drug treatment referral abroad	75,000.-	Estimation by MSS based on analysis of work / mission / career	Gf07	Gf0704	S1312
<i>Health / Social insurance</i>	A. Substitution treatment - Reimbursement of prescription substitution drugs (methadone, buprenorphin, etc.) (Net, patient's contribution excluded)	647,604.-	Detailed breakdown by National Health Fund (CNS) Detailed breakdown by the National Health Insurance Funds (N Detailed breakdown by Union of Sickness Fund (CNS)	Gf07	Gf0701	S1312



- Reimbursement of pharmacies fees generated by substitution medication delivery	32,913.-	Number of substitution prescriptions (- free prescription JDH) X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)	Gf07	Gf0701	S1312
			Gf07	Gf0702	S1314
- Reimbursement of medical counselling costs related to substitution prescriptions	404,790.-	Detailed breakdown by National Health Fund (CNS) (extrapol.)	Gf07	Gf0703	S1314
<u>B. Inpatient hospital drug treatment</u>					
- Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification) (2007)	2,876,498.-	ICD-10: F11, F12, F14, F15, F16, F18 and F19 hospital episodes (CNS) (extrapol.)	Gf07	Gf0706	S1314
<u>C. Drug treatment abroad</u>					
- Reimbursement of drug treatment costs abroad (e.g. residential therapy or specialized therapeutic offers not available in Luxembourg)	1,220,000.-	Extraction from the generic state budgetary section 14.0.34.011	Gf07	Gf0703	
<u>D. Drug treatment costs subsidised by Min. Health</u>					
	75,000.-		Gf07	Gf0702	
<u>E. Cost of HIV/AIDS treatment provided to patients infected via IDU</u>					
	1,927,000.-	Number of HIV/AIDS patients infected via IDU in treatment x yearly average cost of HIV/AIDS treatment (+/- 20,000.- EUR) x reimbursable proportion		Gf0703	
TOTAL A	Non-Labelled Public drug-related expenditures	24,866,676.-			
TOTAL B	Labelled Public drug-related expenditures (not detailed)	13,571,807.-			
TOTAL A+B	Non-Labelled + Labelled public drug-related expenditures	38,438,483.-			

Table 1.4: Overall expenditure in fiscal year 2009 by 1st level COFOG functions

COFOG 1 st level function	Labelled expenditures	Non-labelled expenditures	TOTAL
1 General public services	122,000.-	59,100.-	181,100.- (0.4%)
3 Public Order and Safety	4,838,543.-	17,057,430.-	21,895,973.- (57%)
6 Housing and community amenities	627,430.-	0.-	627,430.- (1.52%)
7 Health	7,968,789.-	7,750,146.-	15,718,935.- (41%)
8 Recreation, culture and religion	0.-	2,000.-	2,000.- (0.01%)
9 Education	0.-	13,045.-	13,045.- (0.07%)
TOTAL			38,438,483.-

Table 1.5: Comparative analysis of drug-related public expenditures treatment in Luxembourg 1999-2009 according to various indicators (EUR)

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

Source: Origer 2002/2009

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. Table 1.6 shows the budgetary progression since the implementation of the first drugs action plan in 2000 and table 1.7 summarises the annual progression of budget of the Ministry of Health and human resources allocated to NGOs specialised in drug demand reduction.



Table 1.6: Annual budget of the Ministry of Health allocated to drug demand reduction activities 2000 – 2017

Year	2000	2005	2011	2012	2014	2015	2016	2017
Budget (EUR)	2,066,000.-	6,196,000.-	8,321,620.-	8,590,033.-	10,949,211.-	12,349,000.-	12,519,993.-	12,987,138.-
Cumulative progression rate	Reference year	200%	303%	316%	430%	498%	506%	529%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour les exercices 2000-2017. Volume 1. (Ministère des Finances 1999-2017)

Table 1.7: Annual progression of the budget of the Ministry of Health and human resources allocated to specialised drug-related demand reduction NGOs 2004 – 2017

Budget Year	2004	2006	2009	2011	2013	2014	2015	2016	2017
Budget (EUR)	5,771,000.-	6,584,000.-	7,991,583.-	8,321,620.-	9,531,000.-	10,949,211.-	12,349,000.-	12,519,993.-	12,987,138.-
Annual progression rate	Reference year	6.27%	9.65%	4.13%	10.9%	14.8%	12.8%	1.4%	3.73%
Annual cumulative progression rate	Reference year	14.09%	38.48%	44.20%	65.15%	89.73%	114%	117%	125%
Dedicated human resources Full Time Equivalent (FTE)	59.5	69.25	83.75	88.75	110.75	111.75	114.75	118.75	121.50
Annual progression rate	Reference year	16.39%	20.94%	5.97%	9.93%	0.90%	2.68%	3.49%	3.16%
Annual cumulative progression rate	Reference year	16.39%	40.76%	49.16%	86.13%	87.82%	92.86%	99.58%	104.20%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour les exercices 2006-2017. Volume 1. (Ministère des Finances 2004-2017)

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 coordinating 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 'coordination platform'.

The funding of the 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 Certain Forms of Criminality, Oeuvre de Secours Grande-Duchesse Charlotte, Foundations, private funds, etc.) or international bodies (EU, EMCDDA, etc.).

Economic 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.

A chapter dedicated to methodological aspects of drug-related expenditures estimations in Luxembourg has been published in an EMCDDA publication in 2017 (EMCDDA, Drug treatment expenditure: a methodological overview, 2017)

In 2006 and 2014, the STATEC (Central service of statistics and economical studies) published **studies estimating the economic impact of the illegal drugs related activities in Luxembourg** (Statec, 2006, 2014). These studies were 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. Results of the 2014 study may be retrieved from:

<http://www.statistiques.public.lu/catalogue-publications/regards/2014/PDF-13-2014.pdf>



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

INTRODUCTION

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

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

Prevalence estimations on drug use in the general population are based on data collected in more (e.g. schools) or less (general population: age group 15-64 years) targeted and representative samples of the national overall population. According to the most recent surveys, cannabis and derivatives are by far the most common illicitly used psychoactive substances in the national population followed by cocaine and Amphetamine Type Stimulants (ATS). Cannabis use in youngsters has been decreasing since the beginning of the 21st century, according to latest school surveys, but still shows the highest prevalence regardless age categories, whereas the prevalence of other psychoactive drugs varies according to age and data collection setting factors. Most recent school survey data presented in the present report stem from the HBSC studies from 2010 and 2014. New prevalence data provided by the recent general population survey on health behaviour (European Health Interview Survey – EHIS) is reported in the present edition.

DRUG USE IN THE GENERAL POPULATION

General population survey on health behaviour (European Health Interview Survey – EHIS)

Prior to 2015, no large-scale (representative) general population survey on illicit drug use has been conducted in Luxembourg. Several community or targeted population surveys, however, provide selective prevalence data. In 2014, the NFP agreed with the national epidemiological working group on health behaviour to include illicit drug use in the national version of EHIS (European Health Interview Survey - Eurostat).

The European Health Interview Survey (EHIS) includes information from all European Union (EU) Member States and is conducted every five years according to the Regulation 1338/2008 on Community statistics on public health and health and safety at work. EHIS wave 2 has been conducted in EU Member States between 2013 and 2015 according to the Regulation 141/2013 as regards statistics based on the European Health Interview Survey (EHIS).

EHIS covers the following topics:

- Health status (self-perceived health, chronic diseases, limitation in activities, mental health, pain, accidents, etc.)
- Health determinants (smoking and alcohol consumption, body weight, physical activity, dietary habits, etc.)
- Health care (use of different types of health care services including hospitalisations, consultations, prevention, use of medicines but also unmet needs for health care).

EHIS is a pluriennial survey implemented in 3 phases. In 2013 started the preparation phase at national level, followed by a data collection phase in 2014 and a final phase of data base cleaning, analysis and drafting of the methodological report in 2015. From March to November 2014 sixteen waves of recruitment, each including 1,000 participants, were programmed. After these recruitment waves followed waves of relaunching. The last wave has been launched in December 3, 2014.

The target of 4,000 participants was reached by the end of 2014. On December 31, 2014 the number of participants reached 4,138.

EHIS is an observational transversal survey, based upon a health data questionnaire of the resident population of the Grand-Duchy of Luxembourg. The methodology of EHIS was developed by 28 member states of the European Union (see methodological manual EUROSTAT).

By random drawing the General Inspection of Social Security (IGSS) extracted files of 16,000 affiliated persons to the National Health Fund, all residents of the Luxembourg population aged 15 years and more, who were invited to participate in the survey by paper-based posted questionnaires or by completing an online questionnaire. The sample is representative at the national level with regard to gender, age and district of residence.

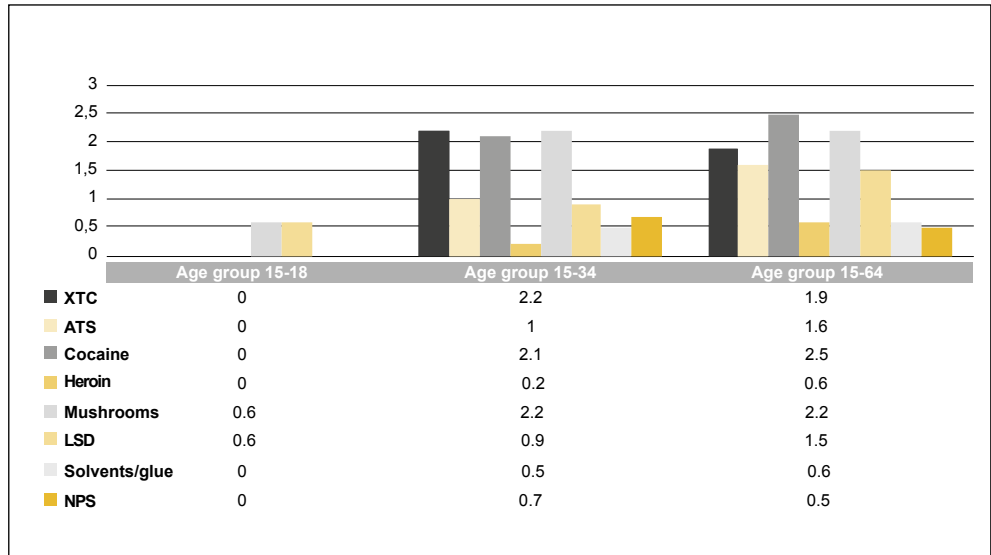
Illicit drugs' and NPS' use are not mandatory items of the basic EHIS questionnaire. A drug-related data protocol based on EMCDDA requirements and the EMQ (European Model Questionnaire) has been elaborated and tested jointly by the NFP and the LIH. The target for illicit and new psychoactive substances' use was the general population aged 15-64 years. 3,421 valid questionnaires from different respondents of this age category could be retained. Special attention was also paid to new psychoactive substances (NPS) and related questions were included in the EHIS questionnaire. NPS were qualified as follows in the national EHIS questionnaire: Substances/products commercialised/sold as being legal and imitating the effect of illicit drugs (e.g. powders, pills, tablets, liquids, herbs). Commonly used names/denominations are: legal highs, designer drugs, smart drugs, research chemicals, new psychoactive substances).



SUMMARY OF MAIN RESULTS:

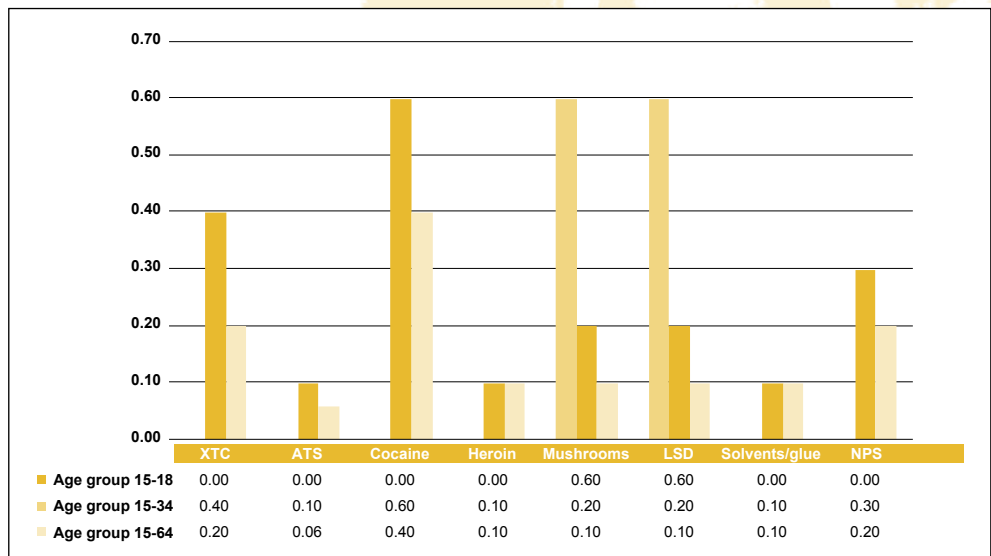
1. Prevalence of psychoactive substances' use in the general population (EHIS, 2015)

Fig. 2.1 Life-time prevalence of psychoactive substances' use according to different age groups (valid %)



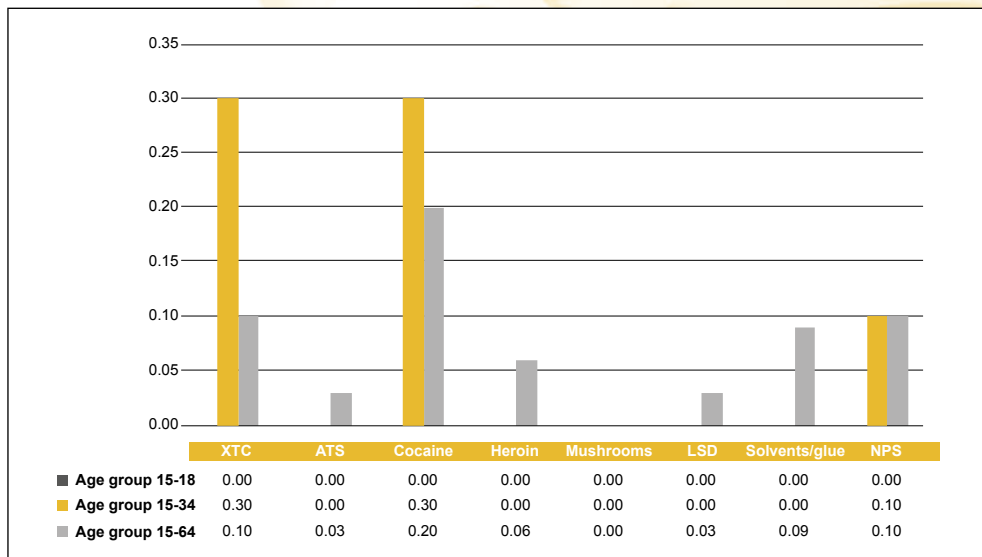
Source: EHIS, 2015

Fig. 2.2 Last 12 months prevalence of psychoactive substances' use according to age groups (valid %)



Source: EHIS, 2015

Fig. 2.3 Last 30 days prevalence of psychoactive substances' use according to age groups (valid %)

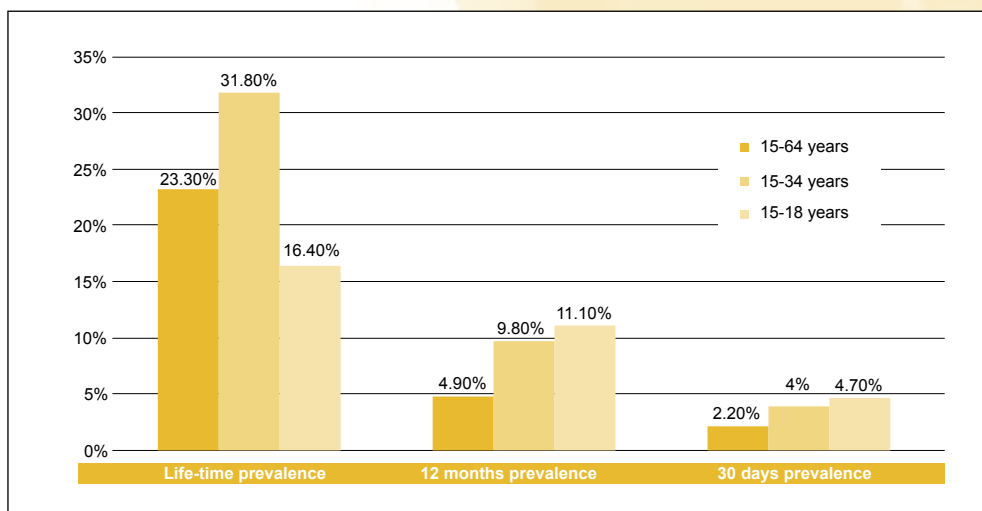


Source: EHIS, 2015

Summarily, national prevalence rates of illicit psychoactive substances, all levels and all age ranges included, appear to be fairly low with regard to EHIS data. A comparative analysis shows that national prevalence rates tend to situate around and often bellow currently observed EU mean averages. As far as current and recent use is concerned, this can be observed for all substances.

2. Prevalence of cannabis use in the general population (EHIS, 2015)

Fig. 2.4 National life-time, last 12 months and last 30 days prevalence of cannabis use according to different age groups (valid %)



Source: EHIS, 2015



The national life-time prevalence for cannabis is the only rate (23.3%) that is higher than the EU average based on most recent and available results from surveys within the EU conducted between 2008 and 2014 (EMCDDA, 2016). Substances most often consumed in Luxembourg after cannabis are cocaine and XTC type substances, even though prevalence rates of recent use of the latter situate below the EU average.

Table 2.1: Gender distribution in cannabis use prevalence according to different age groups

	LIFE-TIME	LAST 12 MONTHS	LAST 30 DAYS
15-64 years			
Male	30%	6.6%	3.2%
Missing v. /N	32/1,501	35/1,501	38/1,501
Female	18.1%	3.5%	1.3%
Missing v. /N	40/1,903	35/1,903	38/1,903
15-34 years			
Male	42.4%	14.3%	6.7%
Missing v. /N	11/490	13/490	9/490
Female	24.4%	6.6%	2.1%
Missing v. /N	7/686	5/686	6/686
15-18 years			
Male	22.2%	16.4%	9.7%
Missing v. /N	2/74	1/74	2/74
Female	12.4%	7.1%	1%
Missing v. /N	3/100	2/100	3/100

Source: EHIS, 2015

National prevalence data on cannabis show higher rates for male users compared to female users at all levels. Gender differences in cannabis use are important, and more pronounced though in younger sub-populations and with regard to recent use.

Table 2.2: Do you personally know people who use the following drugs (%) (EHIS, 2015)

	15-64 Y			15-34 Y			15-18 Y		
	T	M	F	T	M	F	T	M	F
Cannabis (105 ³³ /3,421 ³⁴)	35.8	38.5	33.7	54.7	58.9	51.8	53.0	54.9	52.7
XTC (163/3,421)	4.7	6.5	3.4	8.1	11.3	5.9	7.3	7.1	7.5
ATS (173/3,421)	3.5	4.8	2.5	4.9	6.9	3.5	1.8	1.4	2.2
Cocaine (161/3,421)	7.6	9.5	6.0	11.1	13.6	9.3	6.1	2.9	8.6
Heroin (177/3,421)	2.7	3.5	2.2	2.7	3.7	2.0	3.7	1.4	5.4
Mushrooms (168/3,421)	4.4	5.8	3.3	7.5	10.7	5.3	3.6	5.7	2.2
LSD (174/3,421)	3.0	4.2	2.0	4.8	6.9	3.3	4.9	4.3	5.4
Solvents/glue (176/3,421)	1.0	1.3	0.9	1.1	1.7	0.8	0.6	0.0	1.1
NPS (177/3421)	1.4	1.8	1.0	2.1	2.8	1.7	4.9	5.7	4.3

Source: EHIS, 2015

33 Missing value

34 N

In age groups 15-34 years and 15-64 years, male respondents do more often know other people using drugs, compared to their female pairs. In age group 15-18 years, female respondents show higher rates for XTC, ATS, cocaine, heroin and LSD. Cannabis use in persons known by the respondents is most prevalent followed by cocaine.

Table 2.3: Mean and median age of first use

Substance	Total Mean	Total Median	Female Mean	Female Median	Male Mean	Male Median
Cannabis	18.89 y	18 y	18.64 y	18 y	19 y	17.5 y
XTC	21.13 y	20 y	19.16 y	20 y	22.54 y	22 y
ATS	20.83 y	20 y	20.35 y	19.5 y	21.31 y	20 y
Cocaine	24.55 y	22 y	24.81 y	22 y	24.12 y	22 y
Heroin	22.89 y	21 y	25.43 y	22 y	21.42 y	20.5 y
Mushrooms	21.01 y	20 y	21.18 y	19 y	20.96 y	20 y
LSD	18.69 y	18 y	17.93 y	18 y	19.07 y	18 y
Solvents/glue	17 y	16 y	16 y	15 y	18 y	16 y
NPS	22.45 y	19 y	20 y	18 y	23.38 y	20.5 y

Source : EHIS, 2015

Solvents and glue appear to be the first of listed psychoactive substances ever used by respondents, followed by LSD and cannabis. On average, female respondents report earlier first use of most substances, compared to their male counterparts, except for heroin, cocaine and magic mushrooms.

Table 2.4: Age distribution of first substance use

	Cannabis	XTC	ATS	Cocaine	Heroin	Mushr.	LSD	Solvents	NPS
Age <18	47.4%	23.3%	19.2%	7.7%	5.3%	13.2%	31.1%	66.7%	18.2%
Min. age	12 y	12 y	13 y	13 y	13 y	13 y	10 y	14 y	11 y
Max. age	55 y	42 y	45 y	45 y	48 y	45 y	27 y	27 y	40 y
12-14	6.1%	5%	3.8%	1.3%	5.3%	2.9%	4.4%	11.1%	9.1%
15-19	62.4%	38.3%	42.4%	25.6%	31.5%	44.2%	64.5%	72.2%	45.4%
20-24	22.3%	38.4%	34.6%	35.9%	36.9%	36.7%	24.4%	16.6%	9.1%
25-29	5.1%	10%	15.4%	14.1%	10.5%	10.3%	6.7%	5.6%	18.2%
30-34	1.5%	5%	1.9%	7.7%	10.5%	1.5%	0%	0%	9.1%
35-39	1.1%	1.6%	0%	7.7%	0%	2.9%	0%	0%	0%
40-44	0.5%	1.7%	0%	5.1%	0%	0%	0%	0%	9.1%
45-49	0.5%	0%	1.9%	2.6%	5.3%	1.5%	0%	0%	0%
50-54	0.4%	0%	0%	0%	0%	0%	0%	0%	0%
55-59	0%	0%	0%	0%	0%	0%	0%	0%	0%

Source: EHIS, 2015



Table 2.4 shows that first substance use most frequently occurs in age group 15-19 years, with the exceptions of heroin and cocaine, for which first use typically occurs between 20 and 24 years. Cocaine and heroin appear to be the only substances for which first use still frequently occurs between 30 and 49 years.

Other targeted population surveys

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.

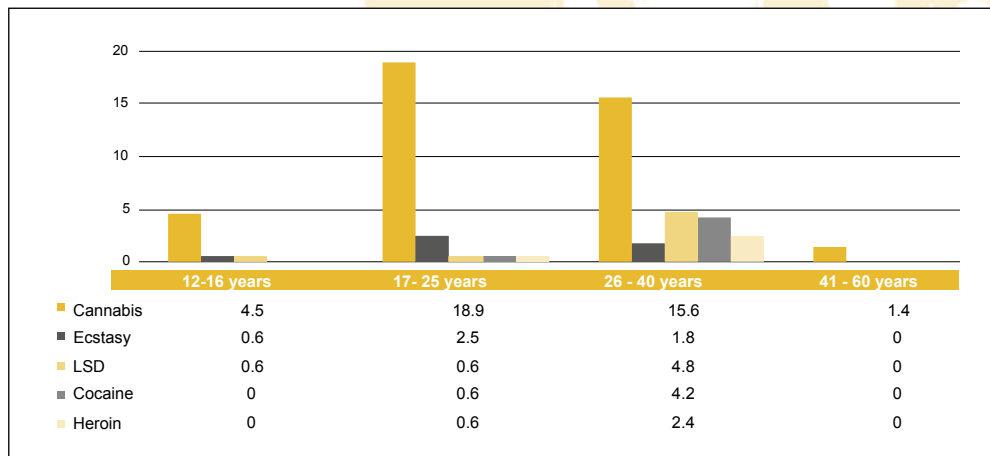
REFERENCE 1

Fischer U. CH. & Krieger W. (1999). Suchtprävention an der Gemeng – Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg. **EN:** Drug prevention at the communal level

Year of data collection	1998
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	7 council districts of the Grand-Duchy of Luxembourg
Age range	12-60 years
Data coll. procedure	Anonymous self-administrated questionnaires
Sample size	667 valid cases

Source: Fischer 1999

Fig. 2.5 Lifetime prevalence according to age (valid %) (Fischer 1999)



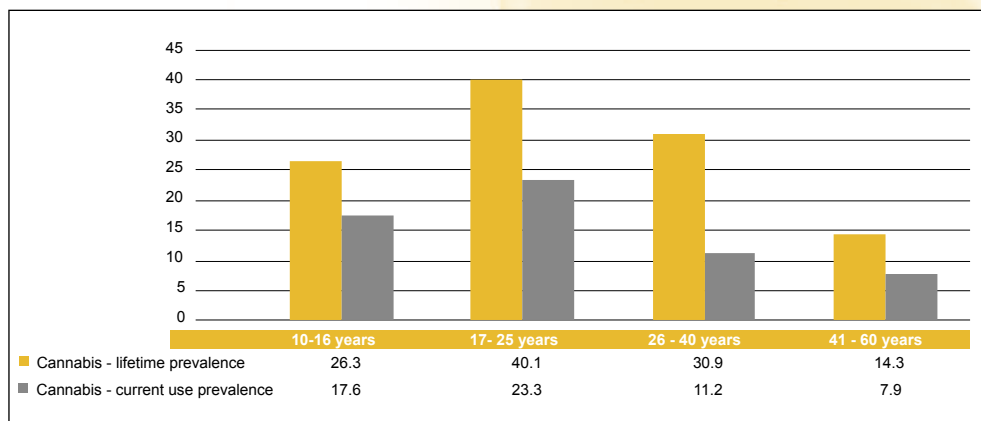
A second survey conducted by the CePT was published in 2000 ("Fischer 2000 study"). Even though cannabis consumption was the main subject of the study, several other substances have been taken into account. The samples have been drawn on the one hand from a cinema visitor's population in Luxembourg City (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. 2.6 Current and lifetime prevalence of cannabis use according to age: Cinema sample (valid %) (Fischer 2000)

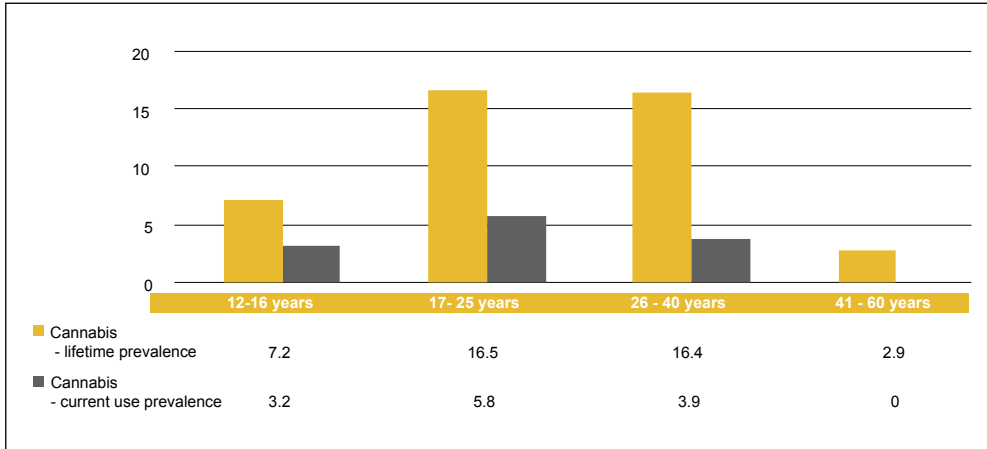
**REFERENCE 2.2**

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



As can be seen in figures 2.6 and 2.7, cannabis prevalence rates show relevant differences according to type of recruitment settings.

DRUG USE IN THE SCHOOL AND YOUTH POPULATION

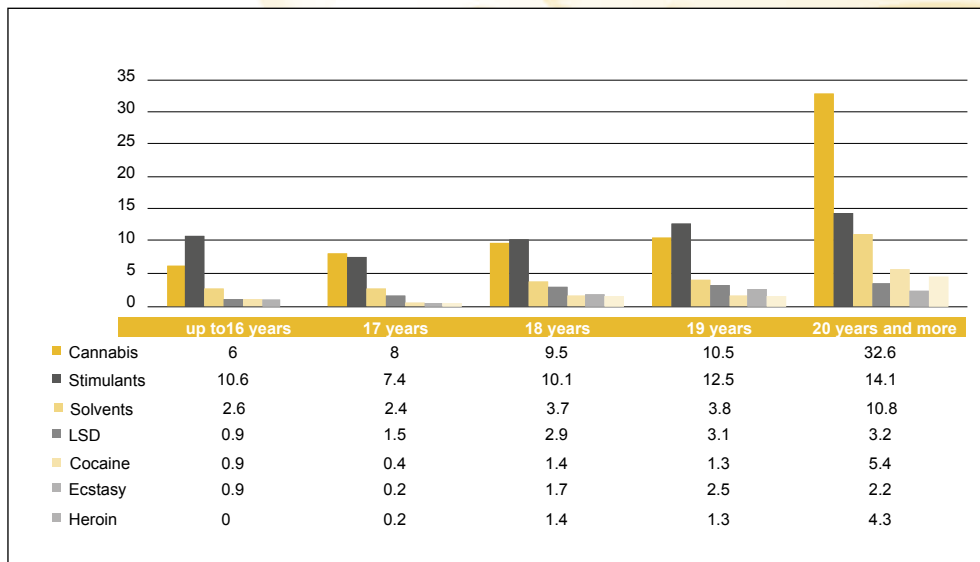
LIFETIME PREVALENCE: SCHOOL POPULATION

REFERENCE 1

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

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

Fig. 2.8 Lifetime prevalence of drug use according to age (valid %) (Matheis, Prussen 1995)



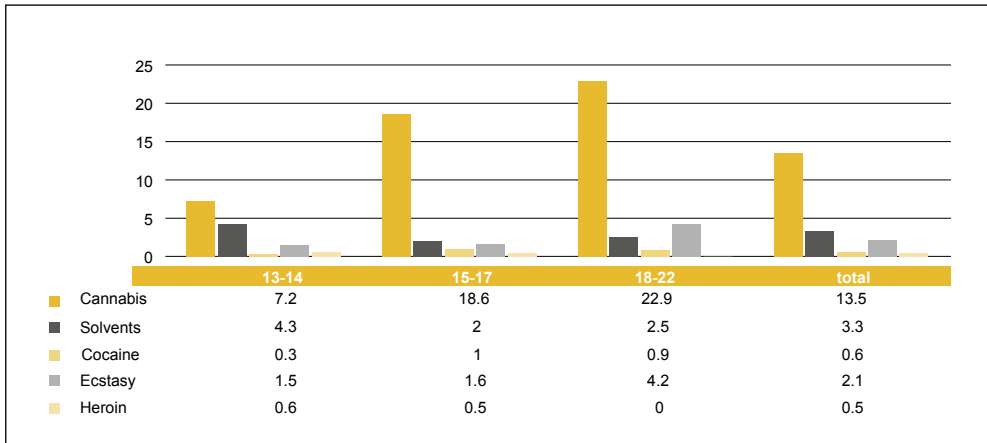
REFERENCE 2

Meisch, P. (1998), Les drogues de type ecstasy au Grand-Duché de Luxembourg, CePT, Luxembourg. **EN:** Ecstasy type drugs in the G. D. of Luxembourg

Year of data collection	1997
Single/repeated study	Single
Context	Public Health – primary drug prevention
Area covered	Nation wide
Type of school	2 nd and 6 th years of classical (N: 311) and technical (N: 355) secondary schools
Age range	13-22 years (13-14: N347; 15-17: N193; 18-22: N118)
Data coll. procedure	Self-administrated questionnaires
Sample size	666
Sampling frame	Schools participating in the "European 'Health-Schools' network"
Response rate (M, F, T)	100%



Fig. 2.9 Lifetime prevalence of drug use according to age groups (valid %) (Meisch 1998)

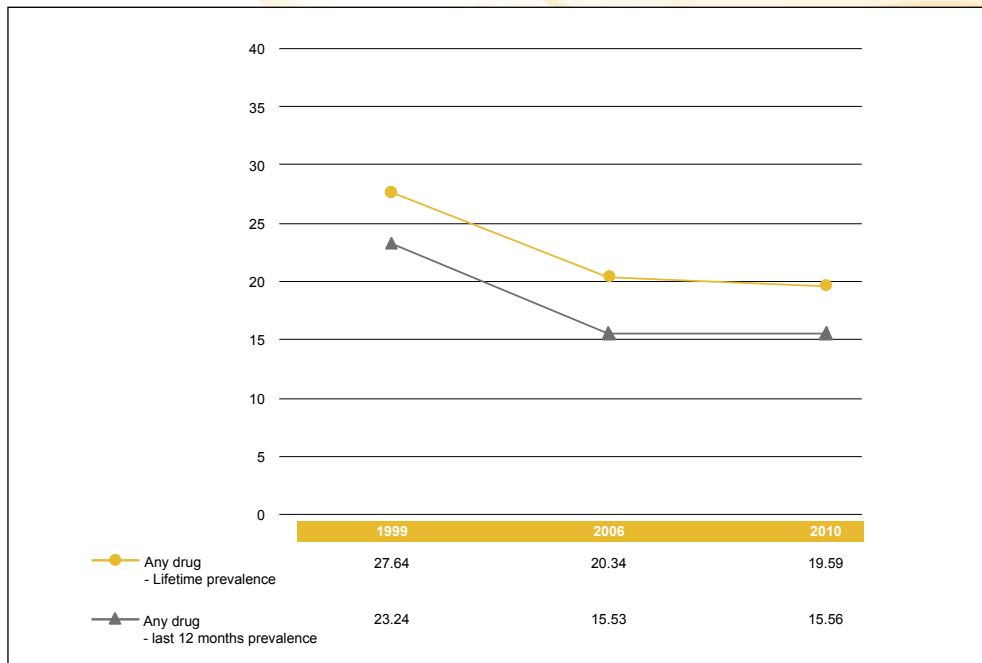


REFERENCE 3

Das Wohlbefinden der Jugend – HBSC Studie (1999 / 2006 / 2010),
Ministère de l'Éducation 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 / 2006 / 2010
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	12-18 years
Data coll. procedure	Anonymous self-administrated questionnaires in school classes
Sample size	7,000 – 8,000
Response rate (M,FT)	Over 95 %

Fig. 2.10 Lifetime and last 12 months prevalence of any drug. Age 12-18 years (valid %) (HBSC 1999 - 2010)



Lifetime and last 12 months' prevalence rates of illicit drug use in youngsters, aged 12 to 18 years, have been showing a harshly decreasing trend between 1999 and 2006 and a fair stabilisation towards 2010.

Fig. 2.11 Lifetime prevalence of illicit drug use according to type of drugs. Total school population aged 12-18 years (valid %) (HBSC 1999 - 2010)

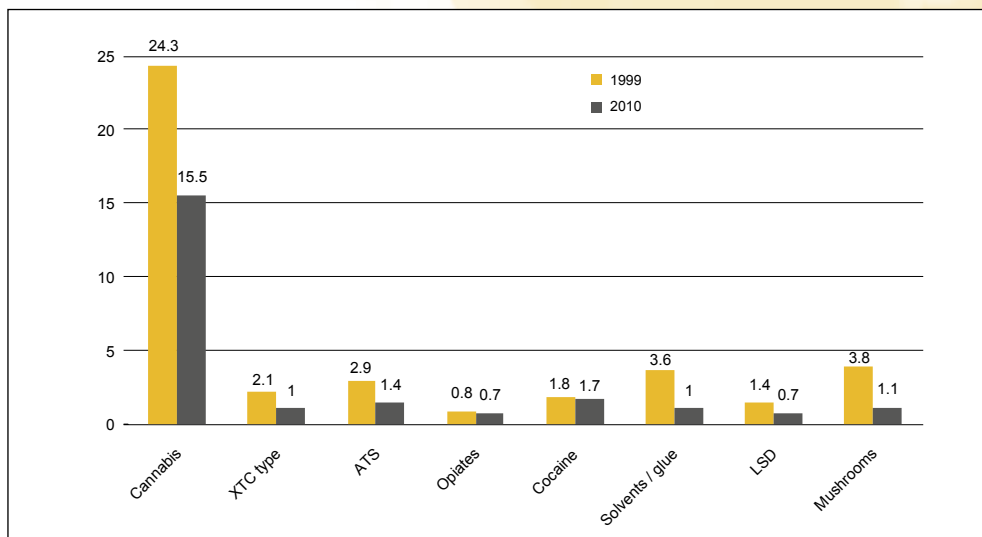




Fig 2.12 Lifetime prevalence according to age and type of drugs (valid %) (HBSC 2010)

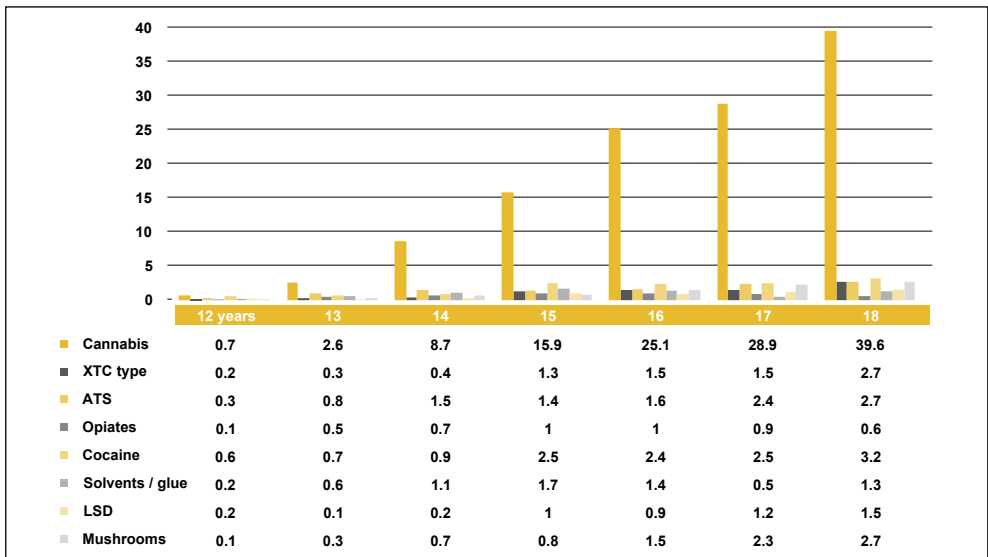
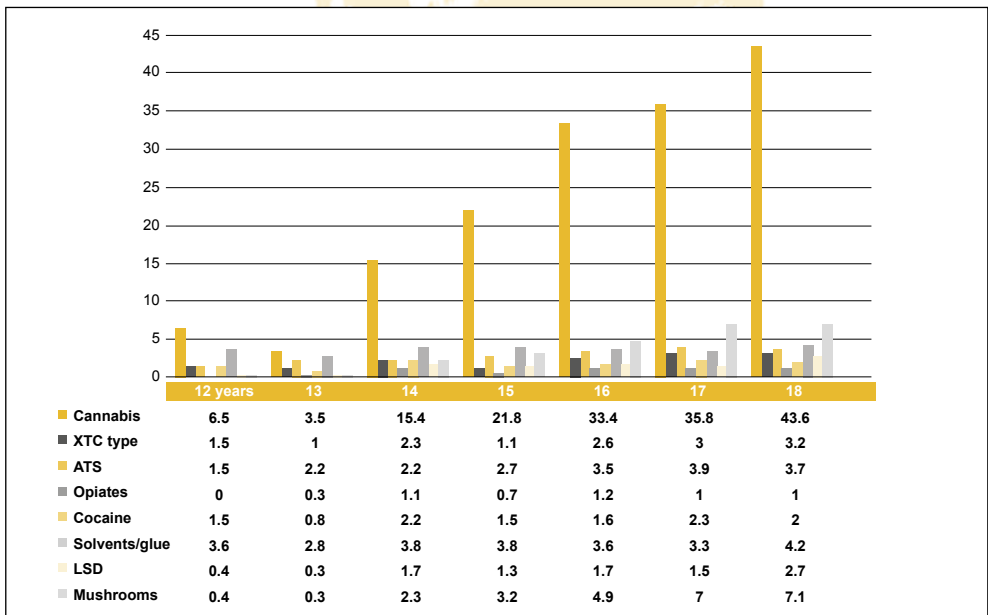


Fig 2.13 Lifetime prevalence according to age and type of drugs (valid %) (HBSC 1999)



A comparison of serial HBSC data from 1999 and 2010 reveals highest prevalence rates of cannabis use, irrespectively of age and year of survey. Lifetime cocaine use is the only to show a consistently higher prevalence in 15 to 18 years aged schoolchildren in 2010 compared to 1999. Opiates' use in youngsters has been remaining consistently low over the same period.

Fig 2.14 Longitudinal lifetime prevalence data according to type of drugs in age group 15-16 years. (valid %)

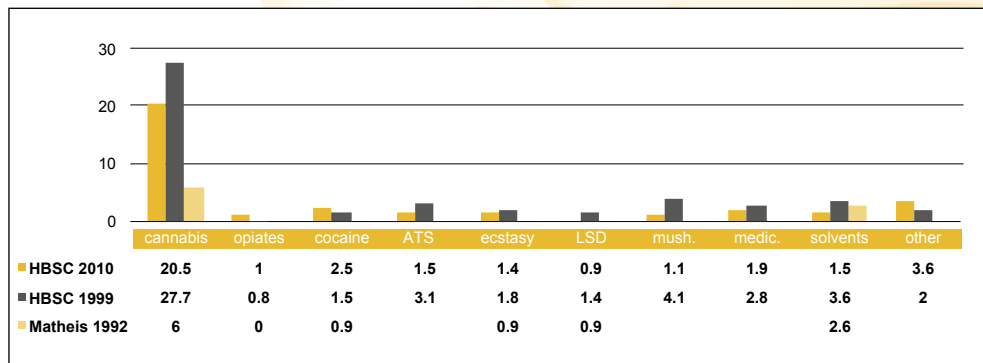
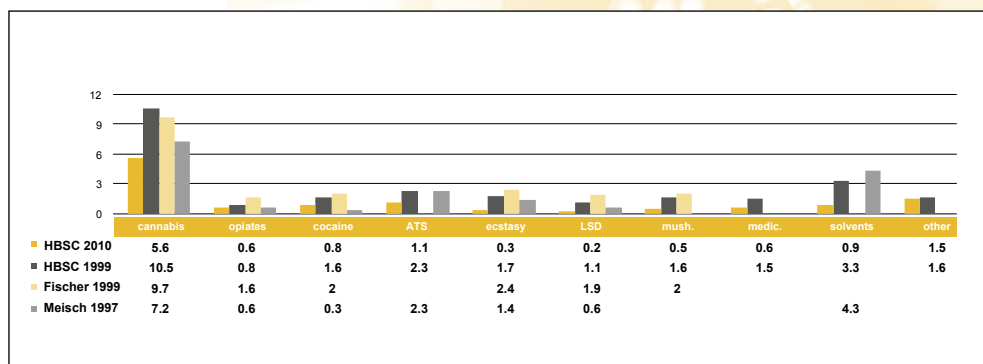


Fig 2.15 Longitudinal lifetime prevalence data according to type of drugs in age group 13-14 years. (valid %)



The HBSC surveys (1999 / 2006 / 2010), the Fischer study (1999) and the serial surveys by Matheis (1985/95) provide trends in lifetime prevalence between 1992/1997 and 2010 applied to age groups **13-16**. Compared to the end of the 20th century, most recent data from HBSC surveys indicate decreasing lifetime prevalence rates for all substances with the notable exception of cocaine use in 15 to 16 years old students witnessing a tangible increase.



LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

Fig 2.16 Last 12 months prevalence of illicit drug use according to type of drugs. Total school population aged 12-18 years (valid %) (HBSC 1999 - 2010)

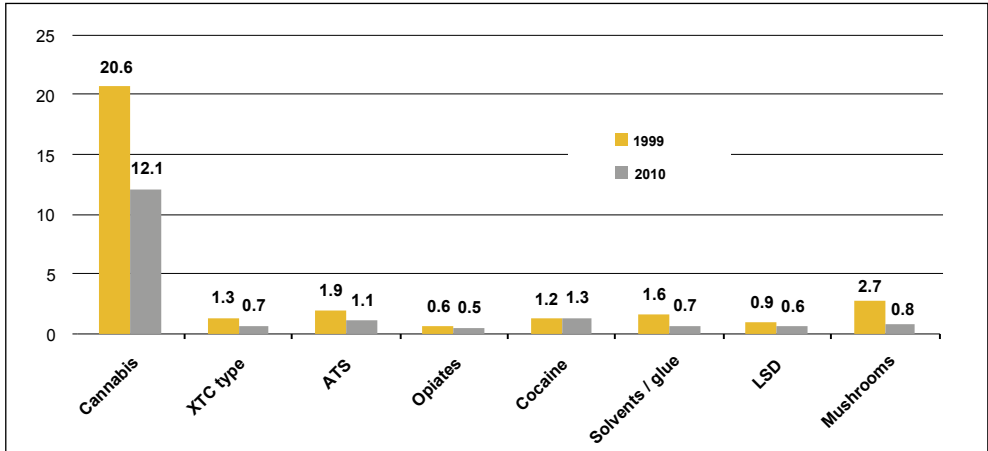
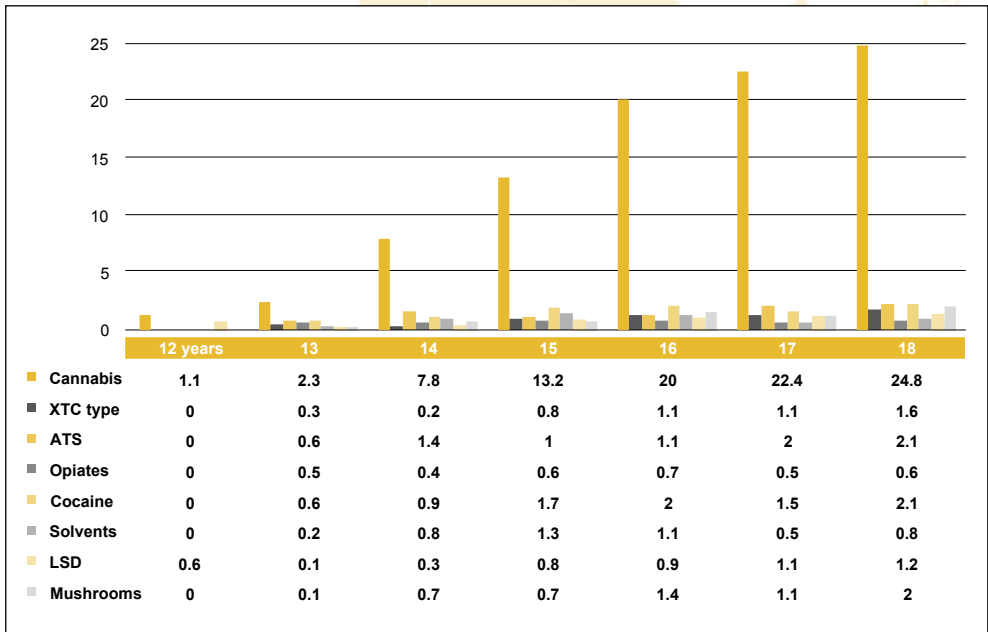


Fig 2.17 Last 12 months prevalence according to age and type of drugs (valid %) (HBSC 2010)



Latest 12 months' prevalence data (HBSC 2010) confirm highest rates for cannabis use followed by stimulant type amphetamines and cocaine in schoolchildren aged 12 to 18 years.

Table 2.5: HBSC 2002 / 2006 / 2010 : Trend analysis according to age and type of drug (last 12 months prevalence)

HBSC /Year	13			14			15			16			17		
	2002	2006	2010	2002	2006	2010	2002	2006	2010	2002	2006	2010	2002	2006	2010
Cannabis	3,5	<u>3,0</u>	<u>2,3</u>	15,4	<u>7,9</u>	8,0	21,8	<u>18,3</u>	<u>13,2</u>	33,4	<u>18,8</u>	20,3	35,8	<u>23,9</u>	<u>22,5</u>
XTC	1	<u>0,6</u>	<u>0,3</u>	2,3	<u>0,8</u>	<u>0,2</u>	1,1	1,5	<u>0,8</u>	2,6	<u>1,1</u>	<u>1,1</u>	3	<u>1,4</u>	<u>1,1</u>
ATS	2,2	<u>0,8</u>	<u>0,6</u>	2,2	<u>1,3</u>	1,4	2,7	<u>1,8</u>	<u>1,0</u>	3,5	<u>1,5</u>	<u>1,1</u>	3,9	<u>1,0</u>	2,0
Opiates	0,3	<u>0,3</u>	0,5	1,1	<u>0,9</u>	<u>0,4</u>	0,7	1,3	<u>0,6</u>	1,2	<u>0,8</u>	<u>0,7</u>	1,0	<u>0,5</u>	<u>0,5</u>
Medicaments	0,6	<u>0,8</u>	<u>0,2</u>	2,2	<u>1,3</u>	<u>0,6</u>	2,1	2,4	<u>1,3</u>	3,6	<u>1,6</u>	<u>1,2</u>	2,9	<u>1,9</u>	<u>1,4</u>
Cocaine	0,8	<u>0,8</u>	<u>0,6</u>	2,2	<u>1,4</u>	<u>0,9</u>	1,5	3,2	<u>1,7</u>	1,6	<u>1,4</u>	2,0	2,0	<u>1,6</u>	<u>1,5</u>
Glue/solvents	2,8	<u>0,9</u>	<u>0,2</u>	3,8	<u>1,5</u>	<u>0,8</u>	3,8	<u>2</u>	<u>1,3</u>	3,6	<u>1,5</u>	<u>1,1</u>	4,2	<u>1,3</u>	<u>0,5</u>
LSD	0,3	<u>0,1</u>	<u>0,1</u>	1,7	<u>0,4</u>	<u>0,3</u>	1,3	<u>0,8</u>	<u>0,8</u>	1,7	<u>0,6</u>	0,9	2,7	<u>0,7</u>	1,1
Mushrooms	0,3	0,5	<u>0,1</u>	2,3	<u>0,8</u>	<u>0,7</u>	3,2	<u>2,1</u>	<u>0,7</u>	4,9	<u>1,8</u>	<u>1,4</u>	7,1	<u>2,1</u>	<u>1,1</u>

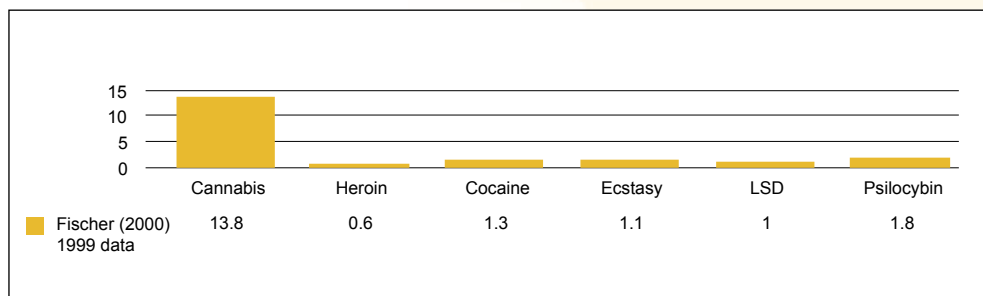
- downward trend 2002 - 2010 - upward trend 2002 - 2010

Serial HBSC surveys (2002, 2006, 2010) provide last 12 months national prevalence figures in 12 to 18 (respectively 13 to 17) years aged schoolchildren. Results mirror respective proportions of lifetime prevalence rates with particular emphasis on high cannabis prevalence in all age groups followed by XTC type products and cocaine.

Table 2.5 shows prevalence trends between 2002 and 2010. A vast majority of substances show declining last 12 months prevalence rates in all age groups. Cocaine use in 15 to 16 years aged youngsters, however, has been showing a notable increase during the referred observation period.

LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

Fig 2.18 Last 30 days prevalence according to type of drugs: school population - 13-20 years (Fischer 2000)





REFERENCE 4

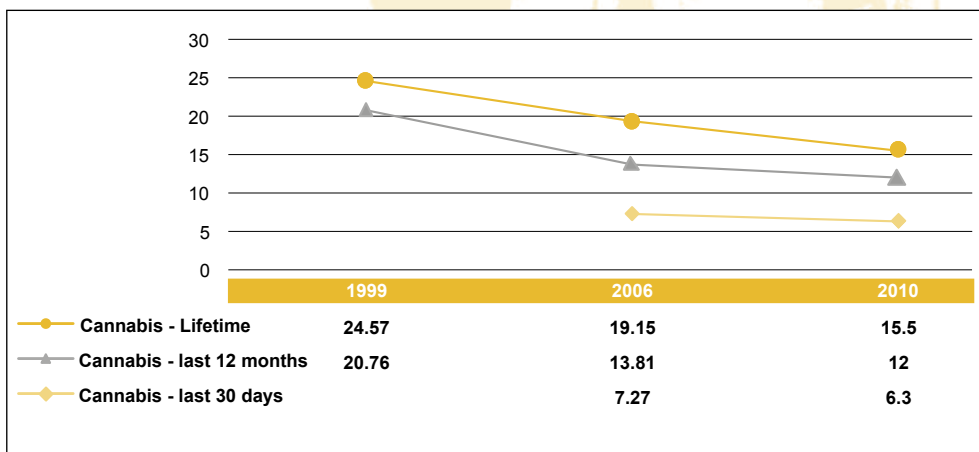
Fischer U. CH. (2000), Cannabis – Eine Analyse der aktuellen Situation, CePT, Luxembourg. **EN.:** Cannabis – Rapid assessment of the current national situation.

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

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. HBSC surveys did not include questions on last 30 days use of different drugs, except for cannabis. Last 30 days cannabis use is addressed below.

IN-DEPTH DATA ON CANNABIS USE PREVALENCE IN SCHOOL-AGED CHILDREN³⁵

Fig 2.19 Lifetime, last 12 months and last 30 days prevalence of cannabis use. Age 12-18 years (valid %) (HBSC 1999 - 2010)



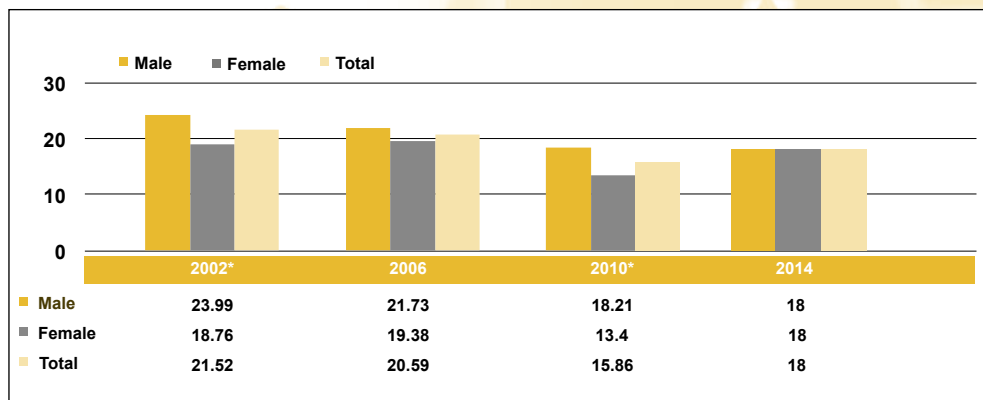
³⁵ Discrepancies between national data of 2010, presented in the present report, and the international HBSC report do exist and are mainly due to different procedures in age calculation, incoherent answers' management and supplementary data not yet available at the time of data submission for the international report.

Table 2.6 HBSC 2010: Cannabis prevalence rates according to age categories 11 – 15 years

	11 years			13 years			15 years		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Cannabis life-time	0.8*	0.0	0.4	2.7	2.5	2.6	18.2*	13.6	15.9
Cannabis 12 months	1.0*	0.0	0.5	2.4	2.1	2.3	14.2	12.2	13.2
Cannabis 30 days	0.8*	0.0	0.4	1.6	1.1	1.3	7.7	6.5	7.1

* Significant gender difference at p<0.05

Fig 2.20 Lifetime prevalence of cannabis use according to gender. Age: 15 years. (HBSC 2002 - 2014)



* Significant gender difference at p<0.05

Fig 2.21 Last 12 months prevalence of cannabis use according to gender. Age: 15 years. (HBSC 2002 - 2010)

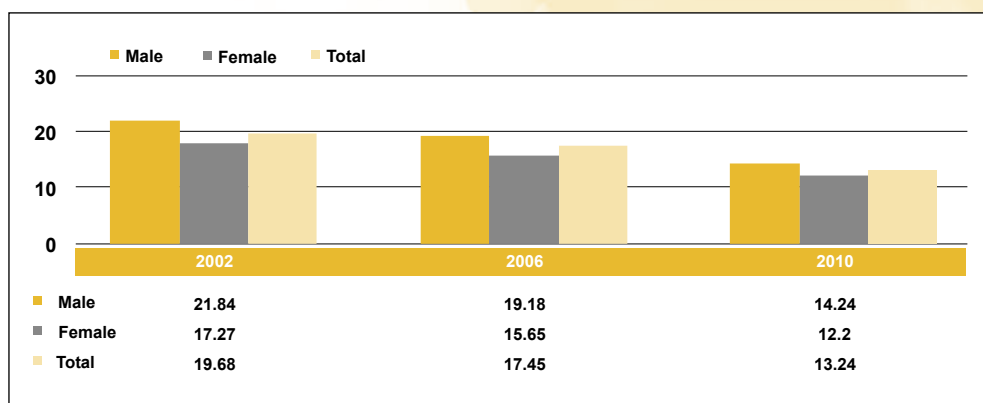
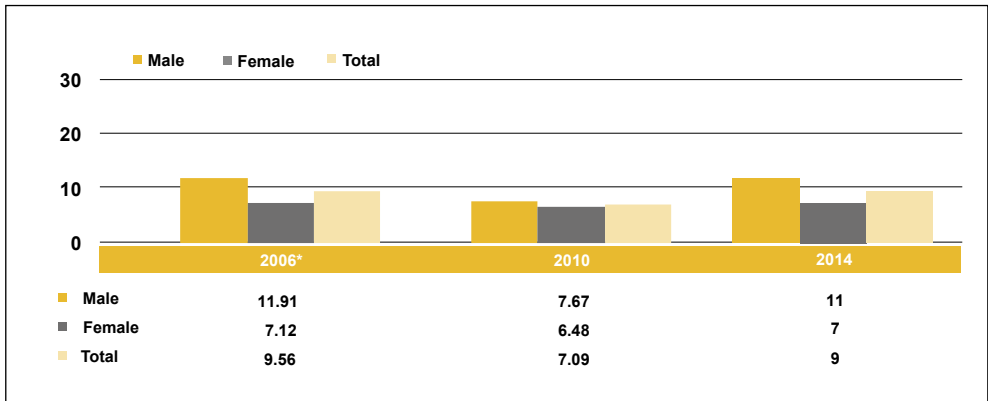


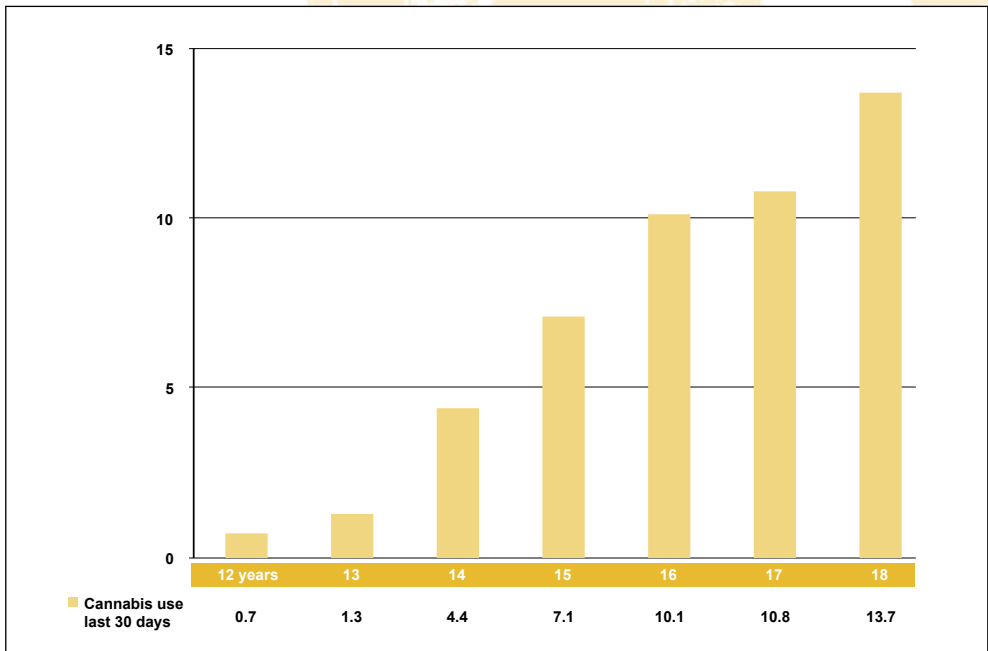


Fig 2.22 Last 30 days prevalence of cannabis use according to gender. Age: 15 years. (HBSC 2006 - 2014)



* Significant gender difference at $p < 0.05$

Fig 2.23 Last 30 days cannabis prevalence according to age (valid %) (HBSC 2010)



Lifetime, recent and current cannabis use prevalence rates in 15 years old youngsters have been declining remarkably during the first decade of the 21st century. The most relevant differences according to gender are lower cannabis prevalence figures for females. These differences appear to be statistically significant ($p < 0.05$) for lifetime and last 30 days prevalence in 2006 and for lifetime prevalence in 2010.

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 5 **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. Krippeler and F. Kittel, 2011)³⁶ 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.

36 Krippeler 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



A new Flash Eurobarometer N°401 (for more details see chapter 3) was carried out in June 2014 on the request of the European Commission among young people aged 15-24. Two items referred to self-reported use of cannabis and to the experience with legal substances that imitate the effects of illicit drugs ("legal highs").

Q12. 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	7 (7)	18 (10)	69 (77)	1 (2)
EU 28 (EU27)	10 (8)	14 (12)	69 (72)	0 (2)

Q3. 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 have never used	Yes, I have used such substances
LU	93 (93)	7 (7)
EU 28 (EU27)	92 (95)	8 (5)

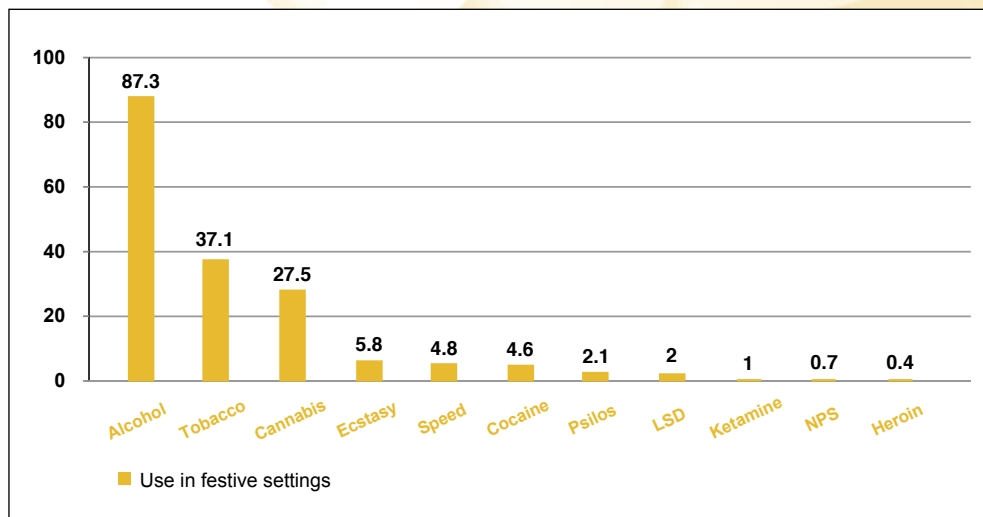
Source: Eurobarometer N°401 (330),2014

Concerning self-reported use of cannabis, the percentage of young people in Luxembourg (69%) reporting not having used cannabis is equivalent to the European average. All in all, self-reported last 12 months cannabis use among Luxembourg youngsters appears to be stable compared to the Eurobarometer N°330 in 2011.

8% of young people in Europe reported having used "legal highs" – new substances imitating the effects of illicit drugs. The self-reported use of respondents in Luxembourg figures 7% (stable).

In 2015, a survey was conducted among 3,770 partygoers (Duscherer, K. & Paulos, C. 2016). 3,676 questionnaires were validated. The median age of the participants was 21 years, so slightly older than in 2013. One question directly addressed participants' drug use during the last two weeks: as can be seen in figure 2.24, alcohol was again by far the most frequent psychoactive substance reported (87.3%), followed by tobacco (37.1%), cannabis (27.5%) and ecstasy (5.8%). All other drugs ranged below the 5% mark, such as speed (4.8%), cocaine (4.6%), psilos (2.1%), LSD (2.0%), ketamine (1.0%), NPS (0.7%) or heroin (0.4%).

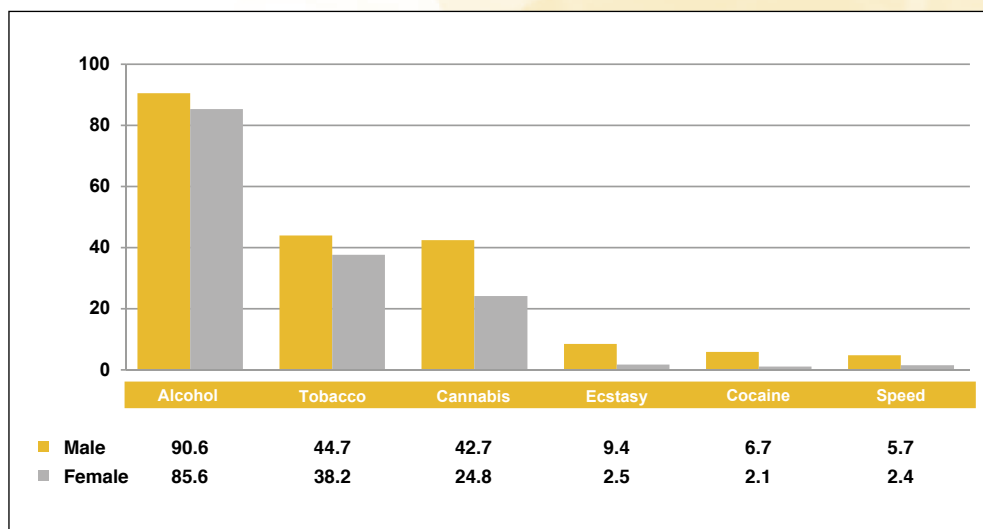
Fig 2.24 Use of psychoactive substances during the last two weeks by partygoers (valid %) (2015)



Source: Duscherer & Paulos, 2015

In 2016, the same survey was conducted in the framework of Pipapo offer among 1,823 partygoers (Paulos, 2017). 1,806 questionnaires were validated. The median age of the participants was 22 years, so slightly older than in 2015. One question directly addressed participants' drug use during the last two weeks: as can be seen in figure 2.28, alcohol was again by far the most frequent psychoactive substance reported (88.4%), followed by tobacco (41.7%), cannabis (33.7%) and ecstasy (5.8%). All other drugs ranged below the 5% mark, such as cocaine (4.3%), speed (4%), psilos (1.9%), ketamine (1.6%), NPS (0.6%) or heroin (0.6%).

Fig 2.25 Use of psychoactive substances during the last two weeks by partygoers (valid %) (2016)



Source: Duscherer & Paulos, 2016



3. PREVENTION

INTRODUCTION

Capacity building, awareness raising and mobilisation 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 2015-2019** addresses primary prevention as a main intervention area. The priority areas of drug prevention according to the national action plan and the Interministerial Group on Drugs (GIT³⁷) are as follows:

- 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 NPS use in youngsters and polyuse in general.
- Mass media campaigns.
- Multidisciplinary training programmes and training of multipliers.
- Documentation, monitoring and evaluation strategies

The National Addiction Prevention Centre (CePT), which has started its activities in 1995, covers drug addiction as well as the prevention of different types of addictive behaviour. Legally speaking the CePT is a foundation co-financed by the Ministry of Health.

Training interventions in drug demand reduction are increasingly developed at the national level. 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. More detailed information is available on the CePT website³⁸.

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.

37 GIT is an abbreviation for "Groupe Interministeriel Toxicomanies"

38 www.cept.lu

The overall coordination of drug prevention, counselling, treatment and low threshold interventions is within the competence of the **Division of Social Medicine, Dependence and Mental Health**³⁹ and the **National Drug Coordinator's office**. The Division of Social Medicine, Dependence and Mental Health 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 **national drugs action plans** (see 1.1).

ENVIRONMENTAL PREVENTION

Alcohol policies

The law of the 22th December 2006 prohibits the selling of alcoholic beverages or offering of a free alcoholic drink to adolescents under 16 years. This law expands the interdiction of vending alcohol to teenagers aged less than 16 years to all type of commerce (supermarket, service-stations, etc.). Before, the ban of alcohol sale to minors under 16 years was limited to cafes, restaurants and bars. In Luxembourg the legal age for alcohol consume is 16 years regardless the type of alcohol. There is no restriction on the hours of sale, days of sale nor on the density of alcohol retailers. The campaign 'Keen Alkohol ënner 16 Joer – Mir halen eis drun!' ('No alcohol under 16 years – We stick to it! ') is targeting the adult population and the promotion of their responsibility (for more details see recreational settings under 3.4).

If a bartender or salesman serves or sells alcoholic drinks to persons showing apparent signs of drunkenness, he can be punished by a fine from 251 to 1,000 euros.

To reduce the sale of alcopops to youngsters, Luxembourg has introduced on the 1st January 2006 a supplementary tax of 1.50 euros per 25cl on these drinks (600 euros per hectoliter). Products composed of a mix of soda or juice with beer, wine, another fermented drink, ethyl alcohol and fermented flavored drinks are also concerned.

Since the 1st October 2007, the legal blood alcohol concentration is of 0.5 g/l (before 2007: 0.8 g/l). An alcohol level of 0.2 g/l in the blood for new drivers and professional drivers has also been introduced in October 2007.

Anti-drink and driving campaigns are regularly organized by the road safety association and the responsible young drivers association.

The 2004 governmental programme puts emphasis on the phenomenon of binge drinking and its increasing prevalence in youngsters. Measures implemented according to recommendations from a national working group initiated by the CePT included the above mentioned actions as a significant raise of taxes imposed on alcopops and a minimum age of 16 years for the purchase of alcoholic beverages. It also included the implementation of the campaign 'Keen Alkohol ënner 16 Joer – Mir halen eis drun!' ('No alcohol under 16 years – We stick to it!'). The 2009 governmental programme and the 2010 national health conference initiated the elaboration of a national action plan on alcohol. A special working group chaired by the Ministry of Health has received a mandate to continue its work.

On the 29th February 2012, the Ministry of Health organized together with the national working group on alcohol a congress with the aim of awareness raising and mobilization of potential partners in the framework of the national action plan on alcohol. This colloquium, with international experts in the field of alcohol

³⁹ **The Division of Social Medicine, Dependence and Mental Health** was translated from the original French title "Division de la médecine sociale, des maladies de la dépendance et de la santé mentale".



policy, prevention projects and therapy, has addressed 3 main subjects: monitoring, prevention and therapy of medical and social consequences of excessive alcohol consumption.

Concerning the working plan development, 3 sub-groups were formed for each of the 3 main subjects of the congress. After some preparation work in 2012, a process of discussion was started in 2013 to elaborate concrete proposals with experts from different fields of prevention work e.g. pregnancy, children and youngsters, seniors, working place, road traffic. A national action plan on alcohol is currently under elaboration.

Jointly with the Ministry of Health, the CePT is participating in the CNAPA, the European Commission 'Committee on National Alcohol Policy and Action', to share information, knowledge, compare approaches of alcohol consumption at European level.

Alcohol consumption at the workplace also represents an important topic, as show the results from a study conducted by the national Luxembourgish council on alcohol ⁴⁰

- 25% of all the accidents at work are probably due to alcohol
- alcohol is responsible for every 6th dismissal
- an estimated 8.000 to 10.000 people are alcohol addicted in Luxembourg
- absenteeism at work is four times more frequent in persons showing problem alcohol use
- almost every 10th worker daily drinks alcohol at his workplace

A conference with the subject 'Alcohol a working problem?' was organized by the association for the well-being at work in the financial sector (ASTF) on the 12th October 2012.

Since 2013 the Ministry of Health and the CePT are "collaborating partners" in the Committee on National Alcohol Policy and Action (CNAPA). Set up in 2007 by the European Commission, the CNAPA encourages cooperation and coordination between Member States and contributes to further alcohol policy development. It plays a major role in implementing the EU Alcohol Strategy.

In 2014, the national ministers of health, work and social security officially communicated that the underlying determinants of alcohol consumption at work are due to psycho-social factors, such as stress and anxiety. They also emphasised that there is a strong need for more alcohol prevention at the workplace in the future. Luxembourg is very active within the Pompidou Group of the Council of Europe to promote prevention of drug-related problems in work environments.

To raise awareness on alcohol abuse at work, a conference was organized in Luxembourg in 2014. The Luxembourgish Chamber of commerce, in partnership with the Chamber of Trade and a supportive institution for enterprises (i.e. "Guichet Unique PME"), organized a one-day conference entitled "Alcohol and drugs at work"⁴¹. This conference was hosted by a lawyer, who explained the policies in alcohol consumption at the workplace, including the preventive roles and responsibilities of employers and employees, and how to add an alcohol-relevant clause in a work contract.

40 **Schackmann B. (2000).** « Alcool et lieu de travail » Guide pour responsables d'entreprise, cadres supérieurs, gestionnaires de ressources humaines, membres des comités d'entreprise et délégations du personnel (CNLA).

41 We translated the title from the original title initially expressed in French as "Alcool et drogues sur le lieu de travail"

Alcohol has been responsible for more than 40 cases of death in Luxembourg in 2012, according to the data of the WHO. Alcohol is responsible for the half of the dead on the road that is 17 victims in 2012. The average consumption of alcohol is estimated 11.9 liter of pure alcohol a year, between 2008 and 2012, for a resident aged 15 years or more. This is 1 liter more than the European average.

With regard to the consumption of alcohol (HBSC 2010), 15% of the 15-year-old girls and 26% of the 15-year-old boys indicate that they drink alcohol at least once a week. 17% of the 15-year-old girls declare that they were at least twice drunken, compared to 20% in boys.

A campaign 'Raoul: drink or drive' came out in 2012 with big hoardings along the main transport axis, small posters in cafes, pubs and discos, as well as a cinema spot.

In 2014, the 'Raoul' campaign was reissued. They used a picture of a tequila glass, with the slogan "a te-KILLA shot?" (translated from French "un shot de te-KILLA?"), which was communicated through posters in bus shelters, and elsewhere.

In addition, the promotion of a fake campaign 'Lux Drink Drive' - a drive-in for alcoholic and non-alcoholic beverages was launched in 2014. The slogan 'your cocktails straight to your car'⁴² was exposed with a picture of cocktails served from a drive-in window. The real purposes of this prevention campaign were revealed soon after the first promotion wave.

As a follow-up, the road safety association has hosted a press conference on their campaign "Lux Drink Drive", in December 2014. Their communication suggested that adults older than 25 years old are more aware and more sensitized, against the 16-25 year old people, who need to be further persuaded on the risks associated with drinking and driving behaviors.

In 2014, the TNS Ilres has studied alcohol consumption and driving in 503 participants aged between 15-29 years old. Of the total sample, 59% stated that they have already driven a car after alcohol consumption, and 70% of the sample admitted to have co-driven in the past with a driver who had consumed alcohol, whereas 91% of the sample have avoided alcohol consumption in the past, in order to safely drive home their friends.

The Ministry of Health introduced a new campaign in 2013 entitled '0% of alcohol during pregnancy and breastfeeding'. A national alcohol action plan is currently elaborated by the Ministry of Health.

Tobacco policies

The law of the 11th August 2006:

- The publicity in favour of tobacco, of its products, of its ingredients, as well as every free distribution of a tobacco product are forbidden. This ban includes the use of the emblem of the brand or the name of the tobacco, of tobacco products as well as every other use of representation or mention on common objects other than those who are directly linked to tobacco use.
- The sale of tobacco products to minors under 16 years (every carrier of cigarettes vending machines and other tobacco products is bound to take measures to prevent the minors under 16 years to access these machines) is forbidden.
- The smoking in certain public places (in schools settings, hospitals and site (except smoking room), public means of transport, sports centres, supermarkets, restaurants (except smoking room) as well as bars and cafes offering meals (interdiction between 12-14 and 19-21 hour) is prohibited.

42 We translated the title from the original French version "Emportez vos cocktails au volant"



The grand-ducal decree of the 31st October 2007 forbids smoking in all the State buildings, municipality buildings and public facilities.

If a person smokes in a place where it is forbidden, the police or custom office can issue a fine of 24 euros. If the smoker is not able to pay, refuses or if he/she is minor, the court has to set the penalty to pay (between 25-250 euros). Concerning the manager of a restaurant or cafe, if he/she neglects consciously the ban, a fine can be imposed ranging from 251 to 1,000 euros.

A new anti-tobacco law has been voted on the 2nd July 2013 and came into effect on the 1st January 2014. This new law has two major goals, namely to protect the health of the employees in cafes (from passive smoking) and to prevent the youth of smoking. The following changes were applied from the 1st January 2014, onwards:

- Total prohibition of smoking in discos.
- Total interdiction of smoking in covered buildings where sports and leisure time activities are practiced.
- Prohibition of smoking in cafes, restaurants and facilities of collective use in hotels with the exception of specifically designed smoking rooms.

The Luxembourgish government has adopted a grand-ducal decree increasing the tax on tobacco the 1st February 2014. This rise applies to cigarettes, tobacco, cigars and small cigars.

In 2009, a national tobacco plan has been developed to prevent and reduce tobacco consumption and related health risks by defining the 3 following major objectives:

- 1) To prevent the tobacco consumption (to reduce the prevalence in young girls and boys, to delay the age of the first consumption and to stop the progression of tobacco consumption)
- 2) To reduce the consumption of tobacco in current users (to promote the objective information on the product, to pursue a change of behaviour in the long term and to stimulate detoxification treatment)
- 3) To protect the non-smokers from passive smoking (to protect the health and rights of non-smokers)

7 strategies on 3 levels are included in this national tobacco plan:

Structural level

- Policy of prices and taxes on tobacco products
- Responsibility of the industry and control of tobacco products
- Protection against the exposure of tobacco smoke

Behavioural level

- Prevention of tobacco consumption
- Assistance to stop smoking

General level

- Research and evaluation of the actions made
- Development of the networking and collaborations

The Council of Government in its session of 16 December 2015 gave its principle agreement to an preliminary project of law transposing the DIRECTIVE 2014/40/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 3 April 2014 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products

and repealing Directive 2001/37/EC of the European Parliament; and modifying the modified law of 11 August 2006 regarding the anti-tobacco fight.

In July 2016, the Council of Government has adopted a new project of law reinforcing the fight against tobacco use and regulating different aspects of e-cigarettes, such as its commercialisation, the ingredients of e-liquids, customers information and advertising.

The project of law, adopted on 6 July 2016 also includes measures concerning the prohibition of flavoured tobacco and product advertising as well as the obligation to declare all ingredients to health authorities and to add health warnings on a surface of up to 65% on the packages. Supplementary measures concern the prohibition to smoke on playgrounds and in private means of transport carrying children under 12 years.

A law voted on 13th June 2017 and that has come into effect on 1st August 2017, reinforces the national anti-tobacco legislation of 2006 and transposes into national law the provisions of the EU Directive: 2014/40 / EU. The main focus of the referred law lies in health protection of non-smokers and the reduction of tobacco smoke exposure of children. The relevant amendments introduced by the law of June, 13, 2017 are the following:

- Smoking is prohibited on public playgrounds;
- Smoking is prohibited in private vehicles when children under 12 are on board;
- Electronic cigarettes fall under the same legal provisions than tobacco cigarettes;
- It is prohibited to sale tobacco or electronic cigarettes to children under 18 years of age.

The law of the 11th August 2006 regarding the security and the health of the employees emphasizes that the employer has to take all the measures to ensure and improve the protection of the physical and mental health of the workers, particularly by taking the appropriate measures to protect the employees effectively against the smoke resulting from the tobacco consumption of others. The law encourages the employer to protect the non-smokers from passive smoking at the work place. There are no mandatory instructions, but an obligation of a result. In practice, the aim is to have working places without smoke, but not without smokers.

A survey on the smoking habits in Luxembourg was conducted in 2016 by TNS Ilres for the cancer foundation including 3,772 persons aged more than 15 years. According to this survey Luxembourg counts 20% of smokers, of which 15% are daily smokers. 23% of the male population is smoking, compared to 18% of the female population. Concerning the age, especially young people between 18 and 24 (26%) are smokers. An increase of 3% was observed for this age group between 2015 and 2016 while a decrease was observed in the 25-35 years old group reaching its lowest rates ever recorded with 25% of smokers. Regarding the percentage of smokers willing to stop, 53% of the smokers would like to stop smoking. As to the quantity of tobacco consumption, 49% smoke half a packet of cigarettes a day, against 41% smoking half a packet to a packet of cigarettes a day and 9% smoking 1 to 2 packets a day. 20% of the population aged between 15 to 24 years reported shisha smoking, against only 4% in general population. As far as e-cigarettes are concerned, it is estimated that there are approximately 4,000 e-cigarette users in Luxembourg of which 79% smoke tobacco simultaneously. Only 24% of the e-cigarette users are using it to stop their smoking habit.

In the HBSC survey (2010), 26% of the 15-year-old girls declared that they already smoked at the age of 13 (or younger), against 29% in boys. 19% of the 15-year-old girls reported that they smoke at least once a week, versus 22% for boys.

The main objective of public health policies consists in the protection of the health of the citizens.



A series of associations (no exhaustive list) assist persons who decided to stop smoking:

- The Luxembourgish foundation against cancer has a helpline, called 'Tobacco-Stop' where people can get information (on the benefits of stopping to smoke, on the different existing methods to stop smoking,...), advices (test of motivation, test of dependency...) and help from an expert in tobacco detoxification.
- The "red cross" organization has a programme to assist at detoxification called "Smoke-free in 4 steps" for the youth on demand in all the youth centres.
- The CePT has organized advanced trainings on detoxification for the staff in schools, in cooperation with the SCRIPT.
- The "ligue médico-sociale" offers different services: motivational discussions and free counselling for smokers in their centres of Luxembourg, Ettelbrück and Dudelange to help them with their detoxification. Moreover, they provide sessions of awareness raising on detoxification in schools and assistance for detox in companies. Furthermore, they organize trainings for professionals in the health sector.
- Occupational medical services also provide detoxification courses of tobacco in the companies.

The Ministry of Health launched in 2014 a new campaign against tobacco with the following slogans: 'Starting to smoke, there is nothing more stupid', 'Be clever, never start!' and 'Choose a life without tobacco'. In addition, a photo contest with selfies was included, which was intended to show that smoking does not appear attractive or adult in any way.

In 2015 a new anti-tobacco campaign launched by the Ministry of Health consisted of a contest on Facebook to complete the sentence "Everyone wins..." by adding the gain to be won in case one stops to smoke.

Since 2011, an intervention campaign called "Ex-smokers are unstoppable" has been organized by the public health department from the European Commission. This campaign translates in form of a smartphone application named after "iCoach". It was reedited in 2012, 2013 and in 2015.

Since 1999 the Cancer Foundation organises the competition '*Mission smokefree*' to inform adolescents on the dangers of tobacco. The competition addresses to all the school classes of the country with students aged between 12 and 16 years.

UNIVERSAL PREVENTION

School

Addiction 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 – Service of Coordination of Research and of Pedagogical and Technical Innovations (SCRIPT)/Psychological Care and Educational Orientation Department (CPOS) and since 1995, 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. 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.

As far as measures addressing students are concerned, CePT's activities are focusing on project-specific measures and actions (such as the prevention days, health weeks, thematic oriented cycles).

In 2000, the CePT, in collaboration with the SCRIPT, started a pilot project called '*d'School 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 **CePToolbox**. This 'box' includes the necessary tools to understand and promote life competences of children and teenagers from 3 to 15 years and accompany them on their way to autonomy. The tools are designed for three age categories: 3-6, 7-11 and 12-15 years. The referred instruments are primarily meant to serve educators, pedagogues, psychologists and teachers to assist them in their professional activities. The CePT also offers trainings on how to use these tools. The CePT toolbox can be downloaded at: <http://cept.lu/fr/trampolin/formations/materiel-didactique> (see also section family).

From 2009 to 2012, in the context of the MAG-Net in school (which is a part of the INTERREG IVA project MAG-NET), two primary schools have participated in this pilot project. All in all, 13 members of the school staff, 120 students as well as students' parents were involved. Three modules of two hours were proposed to the students in class. The subjects addressed during these interventions were the following: emotions and empathy, needs and capabilities, the strict use of rules and limits, as well as personal decisions and opinions. Between the modules, the teachers have revised the new notions with the students by proposing them creative activities and practical exercises. The interventions in class were evaluated by meetings between educational staff and the instructor and by questionnaires for the students, the parents and the educational team. The final report with a documentation of the project MAG-Net in school and a collection of tools for schools was published in 2012. In this framework, an interregional conference of two days focussing on best practise examples and the exchange with 40 participants from the Greater Region has been organised in February 2012. http://cept.lu/wp-content/uploads/dmdocuments/Schule-MAG-Net_Luxemburg.pdf

In 2016, the CePT acted within the scope of different basic trainings. Most of these modules are in the meantime well-established in the appropriate education structures for several years.

For teachers and professionals from the educative, social and psychological fields at school the CePT-Trampolin-Department organized further trainings namely in the framework of the collaboration with the IFEN (Institut de Formation de l'Éducation Nationale). In 2016, there were several trainings on psychotropic substances, different methods and tools available for the prevention of addictions.

A new module was elaborated by the CePT in 2011, for professionals acting in non-formal youth work and dealing with children and adolescents. The aim of this training was the communication with youngsters regarding psychotropic substances.

In 2016, the CePT also offered introductory courses on prevention of addictions at the University of Luxembourg.



In 2015, a seminar on 'Addiction prevention in secondary schools in Luxembourg' was organised in collaboration with the "Centre de Psychologie et d'Orientation scolaires" CPOS. Psychologists, social workers and social pedagogues working in school settings discussed and exchanged about established school prevention offers run by the national addiction prevention centre (CePT), the IMPULS service specialised in orientation, prevention and treatment of youngsters in breach with the national drug law and prevention offers organised by the police.

Also in 2016 a basic training in all day-school (Maisons Relais)'Sprongkraaft am Alldag' focused on fundamental principles in addiction prevention in young children in all day-school. Age specific needs and resources have been analysed in regard to prevention in school setting.

At student level, CePT's activities are also focusing on project-specific measures and actions (such as the prevention days, health weeks, thematic oriented cycles, ...).

The CePT took part in various school project days in 2016 with workshops and performances for students in the context of a day of prevention at the Sportlycée "Journée prevention" or special theme days: at the Lycée Classique d'Echternach "LCOOLTOUR@LCE" or at the Lycée Technique pour Professions Éducatives et Sociales "Health Virus Day".

In the context of honorary office training courses were conducted in 2016 for the Luxembourgish Police academy and for youth leaders of the Luxembourgish Young Firefighters Association in the framework of their leadership trainings.

In 2012, a training workshop, called "Fairy tales on drugs", was organised for the staff of the Lycée Technique d'Esch-sur-Alzette, the Lycée Technique Belval. In many fields wrong or incomplete information on drugs and addiction are circulating. This workshop aimed at reconsidering the actual knowledge on the subject. The workshop was also proposed as advanced training by the SCRIPT for a group of teachers from different secondary schools and by the SNJ for a group of educators of different youth houses. Another advanced training which was proposed in 2012 had the following theme: "Legal Highs – Spice, Bath Salts & co."

Below are listed trainings provided in 2016⁴³:

The following trainings addressed common knowledge on substances:

Fairy tales on drugs (Drogemärercher, Nach méi Drogenmärercher)

A lot of wrong or incomplete information on drugs circulates at different levels. The referred workshop aims at reconsidering the current knowledge on the most commonly used drugs. Which psychotropic substances are concerned? What are their consumption mode and their effects? What about the current legal status? How to choose the appropriate information to provide to adolescents?

The training focused on the acquirement and the consolidation of basic knowledge on the most common psychoactive substances and should enable the participants to ask the questions they always had about drug consumption.

In 2016, this training was provided to CPOS staff. In addition, a follow-up training was provided. This training on the "Fairy tales on drugs" is meant to explore synthetic drugs in more detail. The training provides information on a current range of such products, their consumption patterns and their effects, their marketing methods and the legal framework in Luxembourg.

43 <http://www.cept.lu/>

Motivational interviewing in drug using adolescents ("Motivierende Gesprächsführung bei konsumierenden Jugendlichen")

During this training, methods and strategies were presented in order to learn how to talk with young people about their use of legal or illegal drugs. In terms of content, the program focused on the concept of „motivational interviewing“. The goal was to help the participants implementing targeted short interventions taking advantage of their educational „daily contacts“ in order to promote a change in behavior of young people. The training was addressed to the school staff from secondary education.

Recommendations on how to introduce cannabis-related preventive actions in schools ("Cannabis und Jugend – Handlungsmöglichkeiten um das Thema Cannabis in der Schule zu thematisieren")

This training aimed at explaining cannabis consumption in adolescents, and, more specifically, how to discuss it with young people. The emphasis was put on encouraging young people towards critical thinking on cannabis. This training was designed by the CePT and the IFEN (Institut de Formation de l'Education Nationale) for professionals at schools.

Topic: alcohol - Evergreen in the prevention! ("Thema Alkohol – Dauerbrenner in der Prävention!")

Alcohol bring-drinking among young people is associated with significant risks; therefore a responsible and health-conscious prevention approach is needed. The training was addressed to school staff from secondary education and dealt in particular with the following content:

- Information and facts on the subject of „Alcohol“ with a special focus on young people (consumer motives, consumer behavior), as well as on gender aspects,
- Presentation and discussion of the didactic material „Educational Pack on the topic of alcohol“ as well as by other specific exercises to the theming in the school.

Hugo, Trojka & co. – how to discuss alcohol consumption with adolescents ("Hugo, Trojka & Co – Wie mit Jugendlichen Alkohol thematisieren")

Hugo, Trojka & co. – how to discuss alcohol consumption with adolescents ("Hugo, Trojka & Co – Wie mit Jugendlichen Alkohol thematisieren")

Alcohol is legal and almost "normal" in our society. The CePT, in close collaboration with the SCRIPT has offered a training on alcohol and alcopops for socio-educative professionals. They were presented with the examples on best practice and recommendations on how to guide youngsters towards a reasoned alcohol consumption.

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Other professional settings

Wednesday's seminars

Every first Wednesday of the month, the CePT invites national and international experts to share their area of expertise with colleagues working in related sectors. The topics are, in some way, connected to drugs and dependencies, as well as to health promotion. In 2016, no Wednesday's seminars took place.

The STM has launched a prevention instrument and the medical aspects of the programme for collaborators of small and medium enterprises organised in partnership with the Ministry of Health.

In 2014, the CePT designed a campaign for laymen, who are newcomers to drug using clients in health settings. In order to complement the training, relevant posters, postcards and an informative booklet were



published and distributed to MDs, medical centres, conferences, and personnel from health aggregates at the Greater Region. They designed specific postcards with relevant information on most common drugs, which were tobacco, alcohol, cannabis, ecstasy, LSD, speed, cocaine and NPS. The booklet was edited in French and in German, and included a description on the physical and psychological consequences of drug abuse, how to react in case of a drug-related emergency and a list with useful addresses. In Luxembourg, 2,153 booklets and 48,416 postcards (i.e. 6,052 sets with 8 cards) were distributed to health aggregates, by the end of 2014.

The contents of the trainings and exchange meetings are based on the results of surveys, interviews and focused groups, which were conducted with users of the Greater Region on their current drug use. A particular attention was given to the consumption of alcohol, LSD and new synthetic products (NSP, or Legal Highs). In Luxembourg, 317 interviews were conducted with users in different contexts of leisure: the party scene (music festivals, concerts), the sports community (gym, football club), the school grounds (high-school, university), as well as community groups for elderly people. Also, focused groups with recreational users were organised in order to identify the social representations of drug consumption.

In the framework of its project party MAG-Net the CePT has been organising since 2010 surveys among party goers in Luxembourg. In 2016, this survey was for the first time conducted by the NGO Pipapo and 1,823 anonymous questionnaires were collected among 11 festive settings of which 1,806 have been validated. Results may be consulted in chapter 2.

Also in 2015 in the framework of the project MAG Net 2 the information campaign 'Talk about drugs' destined for medical and paramedical staff to promote the dialogue on (recreative) drug use among health professionals and their clients was pursued.

In 2016, the 17th edition of the competition 'Mission do not smoke' took place in Luxembourg to inform adolescents on the dangers of tobacco. The competition addressed to all the school classes of the country with students aged between 12 and 16 years.

The previous edition (from 2015) reached a rate of 79 smoke-free classes, from a total of 106 participating classes.

Coordinated by the Ministry of National Education-SCRIPT, a mobile interactive and prevention instrument called the 'Extra-Tour Sucht Lëtzebuerg' 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 the 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

The actual version of the "Extra-Tour Sucht Lëtzebuerg" was initiated in 2009 by KomPass and a workgroup (SCRIPT, Ministry of Health, Ligue Médico-sociale, CePT). "Extra-Tour Sucht Lëtzebuerg" was evaluated in 2012. 107 questionnaires, mainly completed by class teachers and staff from the SPOS of the different schools, were analysed (return rate: 81%). The main results are described in the following summary:

- The tool was deemed to be adequate as an academic instrument for prevention of addiction (91.4%) and the basic concept was considered to be appropriate (93.9%).
- 28% of the moderators were participating for the second time or more often in the “Extra-Tour Sucht Lëtzebuerg”.
- The assessments for the individual stations reached an average of 90% approval. The stations of tobacco and alcohol, newly developed in 2009, were considered to be meaningful at 94.5%.
- Related to questions about the moderator’s folder 76.4% indicated that they felt motivated to dwell on prevention of addiction. The didactic materials were considered to be a good facility for the post processing in class (78%).
- The reactions of the students were mainly positive, especially related to interactive methods (91.8%) and to the encouragement of the personal reflexion (89.3%).
- The tool motivates to discuss prevention of addiction and enables academic actors to act. Almost all participants (97.1%) indicate to recommend the tool respectively to participate again.
- 92.6% of the moderators were motivated to pursue such offers or to make own bids in future.

Analysing data on participation, the following numbers have been retained: per year 5 to 7 applications take place on average, so that approximately 1.500 students and 60 formed moderators are reached.

Jointly with the STSJ, the CePT developed a brochure on cannabis especially designed for teachers and other professionals of the educational sector: « **School and cannabis – Recommendations for School staff** ». The Ministry of National Education-SCRIPT published the second edition: «*The cannabis consumption among young people – a challenge for school staff*» in October 2012. It includes epidemiological data, recommendations on early recognition, prevention and intervention means and information on existing networks <http://cept.lu/>.

A further component of the CePT’s work is the promotion and implementation of addiction prevention projects in cooperation with schools and also youth clubs. The project ‘*Nach ëmmer Allc%ool*’ was developed jointly by the CePT, the National Theatre of Luxembourg (TNL) and SCRIPT for the secondary schools. 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. After the 1st edition in 2009, a new edition of the project ‘*Nach ëmmer Allc%ool*’ took place in November 2011. A DVD was produced by the Ministry of National Education in 2012, which is part of didactic material for alcohol prevention in school elaborated by the CePT as an educational workbook to be published by the SCRIPT.

Finally, trained police staff periodically visits various schools of the country, to inform students on drugs and their risks. These prevention officers meet every year around 6,000 students.

Moreover, the Luxembourgish Police has dedicated two sections on drug abuse prevention on their website, one for adults and parents, and one for adolescents and young people.

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 organisation of parents’ evenings during which educational and health topics are discussed.

Active collaboration between the CePT and parents’ associations at each education level does exist : Fédération des Associations de Parents d’Elèves du Luxembourg - FAPEL; Kannerschlass Foundation - ‘Parents’ School’; Ombuds-Comité fir d’Rechter vum Kand – ORK; Entente des Foyers de Jour a.s.b.l.- EFJ.



The cooperation between the CePT and the parenting classes Janusz Korczak (Kannerschlass foundation) continued in 2013. Some new recommendations for parent-teacher conferences for parents of children between 0 and 15 years are being elaborated. The parent-teacher conferences will be proposed after their completion and this by the programme of the parenting classes.

The first 'prevention box', targeting 3 to 6 years old children and including didactic material designed for potential multipliers as for instance teachers, parents and youth animators has been released in September 2001. In 2004, seminars on the 'prevention box' 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'. Due to its success, the CePT extended the 'prevention box' and finally published the CePToolbox in 2009 with three age categories: 3-6, 7-11 and 12-15 years.

Since 2013, the Ministry of Health has been promoting its campaign on alcohol consumption in pregnant women and young parents, named '0% of alcohol during pregnancy and breastfeeding'⁴⁴. The implementation took place in form of an informative brochure in German and French, and was promoted through GPs, pharmacies, health centers, and social institutions.

Since 2014, the national Police has shown increased initiatives in terms of drug prevention. Their information is mainly available for parents who would like to learn more about drugs, on the indicators and symptoms of drug use and abuse, the health consequences, the risks and crimes associated with drugs, and the relevant laws and policies.

Continuous training for parents aimed to promote educational skills for mothers in OST. In collaboration with the "Service Parentalité" of the Youth and Drughelp Foundation, the CePT has set up in 2015 a course for mothers on OST with children aged 0 to 6 years consisting of 7 modules focussing on the strengthening of self-esteem and dealing with the maternal role. In order to ensure a sustained offer of training for mothers in the OST programme of JDH, the CePT conducted, in 2016, moderator coaching for staff members of the JDH. This ensured that the all course modules could be provided independently by the JDH without the intervention of external trainers.

"To talk about drugs" – how parents can keep the communication going with youngsters on the topics of alcohol, tobacco and cannabis. This parent information meeting took place 4 times in 2015 in cooperation with different schools, parent associations and the parent school Janusz Korczak. Target groups were parents as well as directors of schools and the school staff.

Community

As most of drug-related interventions and strategies prevention in community settings are organised centrally and nationwide, 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 addiction 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. At present only one

44 The original text in French is '0% d'alcool pendant la grossesse et l'allaitement'

agency focuses on interventions in recreational settings, namely the CePT (community project⁴⁵).

In 2004 the CePT started the project 'adventure circuit' with more than 40 volunteers and developed an instrument for interactive and tangible drug prevention targeting general population. This itinerant exhibition finally called 'TRAMPOLIN – Sprongkraaft am Alldag' was presented from 2005 to 2007 in several places all over the country of Luxembourg. Since then 'Trampoline' is used by the CePT as a symbol and a model to explain the basics of addiction prevention e.g. in its trainings and its publications.

In 2013, for the European year of the citizens, which should be the year of all the citizens, including the most vulnerable, the representation of the European Commission in Luxembourg supported, together with the collaboration of the Ministry of Health, a project called 'All together'. The crucial date of this initiative was the 08 June 2013, the day of the Night Marathon ING. More than 200 runners were participating in this project. Partners of the project were the following associations: 'Jugend- an Drogenh elle', the therapy centre of Manternach and the 'Schaumberger Hof' of the Saarland in Germany. 25 former drug addicts trained during weeks to get into shape and to participate in this marathon. The goal of this project consisted in facilitating the social rehabilitation of former drug addicts through sport.

A prevention campaign against cannabis 'Drugs are uncool' with the slogan 'Your concentration. Your control. Your life.', was launched by the Luxembourgish Police in October 2013. Moreover, during the same period (i.e. October 2013), the Police launched another two-year anti-cannabis campaign. This campaign aimed at communicating with a larger public, including families, youngsters and socio-educative sectors. To this end, a TV- and cinema-spot was broadcasted at the national TV chains, on the radio, the web and at the cinema.

In 2014, the Police hosted a conference on drugs for parents. This conference was organised by a local association for parents of schoolchildren (APEH⁴⁶).

The campaign "Do you leave or do you stay?" (Gees de oder stees de?) is an initiative from a local youth club (Hesperange). It is the first edition of an art competition, where youngsters between 12 and 26 years conceptualise an awareness campaign, which addressed the risks of cannabis. The campaign aimed to foster dialogue and free expression for youngsters on the subject of cannabis. The goal of the campaign aimed at sensitising and at deconstructing false knowledge on cannabis and is based on a conceptual approach of addiction prevention in order to provide guidelines for youth workers. In collaboration with three youth clubs of Mamer, Kayl/Tetingen and Nordstadt the campaign was launched on the 1st February 2014. The campaign was assisted by the CePT, SNJ, JDH and "IMPULS - Aide aux jeunes consommateurs de drogues" (Solidarit  Jeunes a.s.b.l.). Until the 30th of June 2014 youngsters had time to come up with a constructive campaign on the topic in terms of pictures, videos, music, dance, poems or visual arts. They could participate as an individual or as a group. All submissions will be evaluated and used to improve the educational work together with the partners. The goal is to learn from the gained impressions. The organisers expect from the

45 In the beginning of 1995, a pilot project on community-based drug prevention has been launched by CePT (see EDDRA). The main idea was to focus prevention activities on the very environment and daily life experiences of young people. Various demand reduction activities have been undertaken, either developed by CePT, SNJ and several youth centres, or initiated by the respective District Councils. 13 district councils and 150 volunteers are currently involved in the project. The funding of this community project is jointly ensured by the involved district councils, the EU (Drug Prevention Program DG-V) and CePT.

The primary aim of the project is to improve communication skills on drugs, to increase participants' abilities in handling conflicts, stress and frustration (age range: 12 to 65 years) and to set up autonomous groups to continue implementing local prevention measures. In each participating municipality, prevention groups were composed of local volunteers who were asked to organise local drug-prevention activities related to their specific needs. Cornerstone concepts of the project are as follows: - Multidisciplinary drug prevention, - Tailor-made community solutions, - Health promotion with regard to risk and protective factors, - Holistic and systemic approach, - Target groups oriented, - Routine evaluation.

The community-based prevention network is an ongoing project, which is expected to develop its proper dynamic over the time. The idea was to switch from a centrally coordinated pilot project to routine and autonomous local programs.

46 APEH is an abbreviation for "Association des parents d' l ves des  coles de la commune de Hesperange", and refers to the association of parents and schoolchildren from the Hesperange community



campaign to better understand youngsters and to better inform them of the dangers and risks of cannabis use.

Community-specific work: Youthwork

The CePT "out of school" youth work was primarily related to a conceptual approach to addiction prevention and intended to design guidelines for youth workers. In 2016 the CePT went beyond the conceptual work by fostering partnership with 8 Youth centres. The project called Act R.I.C.O which stands for Reflected - Informed - Competent - Oriented intends to establish a positive festive and party culture with and between youngsters. Also, a youth peer education toolkit ("Charta für Drogenprävention bei Jugendlichen") was elaborated with the Red Cross Youth Centres to tackle drug issues with youngsters. In particular, the framework was enlarged to 8 Youth centres of the Moselle Region.

In 2014, the Statec⁴⁷ has conducted a study on the overall perception of the presence of drugs in Luxembourg. This study revealed that 35% of the general population have been directly or indirectly involved with drugs or drug resellers. In particular, 10% of residents are "frequently" in touch with drugs, or drug resellers, whereas 12% "occasionally", and 13% "quite rarely".

SELECTIVE PREVENTION IN AT-RISK GROUPS AND SETTINGS

At-risk groups

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

In 2012, « Youth Solidarity » elaborated a new intervention programme called "ProST – Programme for self-responsible drinking", a programme similar to the CHOICE programme, but specifically designed for alcohol misuse.

In 2014, the service was renamed: 'IMPULS - Aide aux jeunes consommateurs de drogues (Solidarité Jeunes a.s.b.l.)'. The dedicated website provides for more information (www.im-puls.lu).

In 2009, HIVberodung Croix-Rouge, in collaboration with the Ministry of Health and the CHL, launched a project called 'DIMPS' (Intervention mobile for the promotion of sexual health) in the framework of the

⁴⁷ Statec is the national centre for statistics, <http://www.statistiques.public.lu/en/actors/statec/index.html>

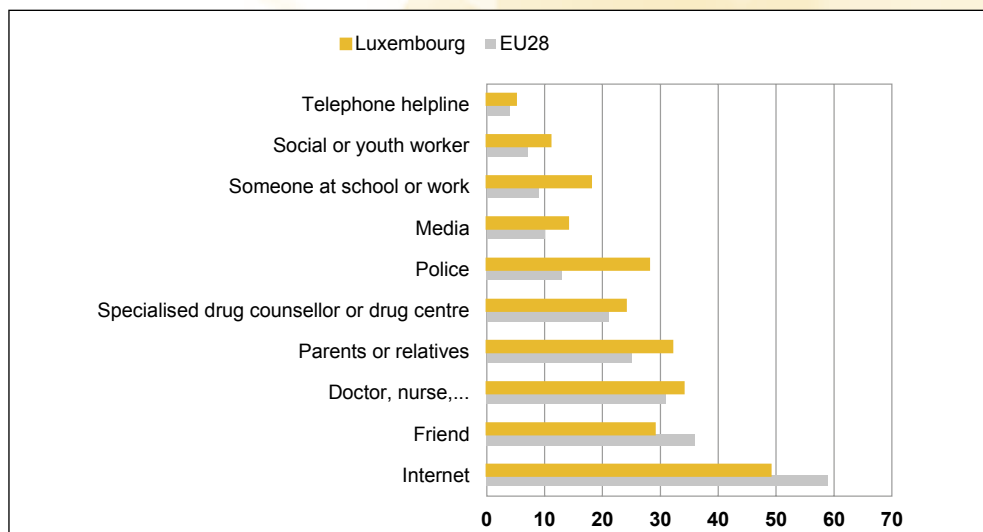
national action plan on HIV and Aids 2006-2010. *DIMPS* is meant to inform on risk behaviour and provide free and rapid infectious disease testing in difficult-to-access populations. Among other interventions, rapid tests for HIV and HCV and HBV are proposed. Currently the *DIMPS* van visits low threshold drug agencies, gay meeting places, red light spots and asylum seekers facilities. Their services are free of charge⁴⁸, and can be booked on their website (www.dimps.lu).

Finally, a targeted survey '*Young people and drugs*' (Eurobarometer, no 401) was conducted for the European Commission, from the 3^d to 23^d of June 2014. Telephone interviews were conducted in each of the 28 EU countries. Each national sample was representative of the general population between 15 and 24 years. Sample size varied between 200 and 500 respondents. The main results are briefly presented hereinafter:

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

Results from the previous 2008 and 2011 Flash Eurobarometer studies showed that **the internet** was the most popular source of information, with 59% (EU) (LU: 49%) 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: 36%; LU: 29%) and on third position, **a doctor, nurse or another health professional** (EU: 31%; LU: 34%). In the Luxembourgish sample, the internet was as well the first choice for information source on drugs, followed by doctor, nurse or other health professional in the second place and parents or relatives in the third place (32%).

Fig 3.1 Potential sources of information about illicit drugs and drug use



Source: Eurobarometer 401

● **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, 37% of respondents referred to **the internet** (LU: 41%), compared

48 <http://www.croix-rouge.lu/en/> and <http://www.dimps.lu/>

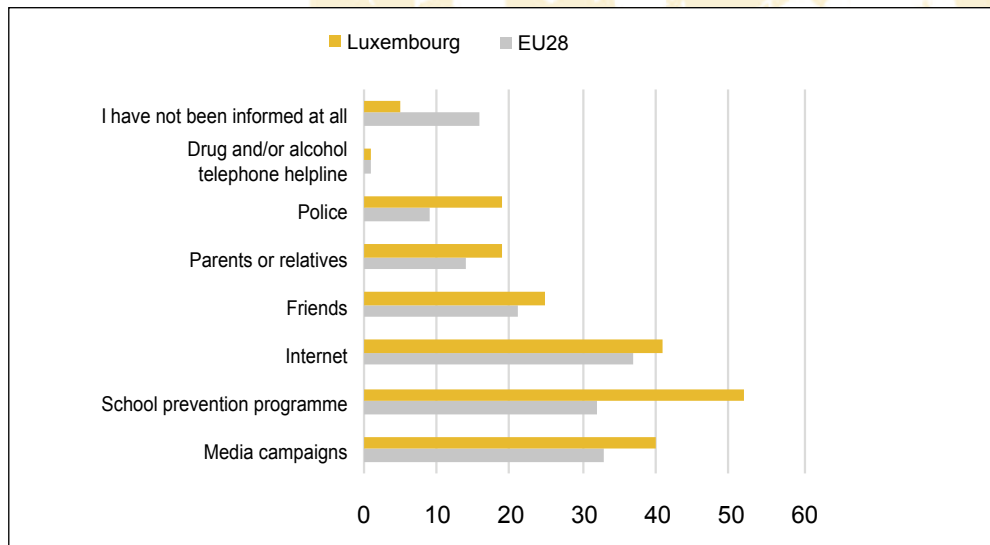


to 33% who reported **media campaigns** (LU: 40%) and 32% who mentioned **school prevention programmes** (LU: 52%).

Twenty-one percent said they had discussed these issues with **friends** (LU: 25%) in the past year, and almost a sixth (14%) of respondents had been informed by their **parents or other relatives** (LU: 19%). A minority of respondents said they have been informed on effects and risks of drug use by **police** (EU: 9%; LU: 19%) or via **drug and/or alcohol helpline** (EU: 1%; LU: 1%). Finally, 16% of respondents reported **not to have been informed at all** (LU: 5%) about the effects and risks of illicit drug use in the 12 months prior to the survey.

In the two surveys, conducted in 2008 and 2011, the most frequently mentioned information channel was media campaigns, followed by school prevention programmes and the internet. In 2014, however, the order changed and internet was the most frequently mentioned information channel, followed by media campaigns and school prevention programmes. Most popular information channels for the youngsters in Luxembourg are: school prevention programmes, followed by the internet and media campaigns.

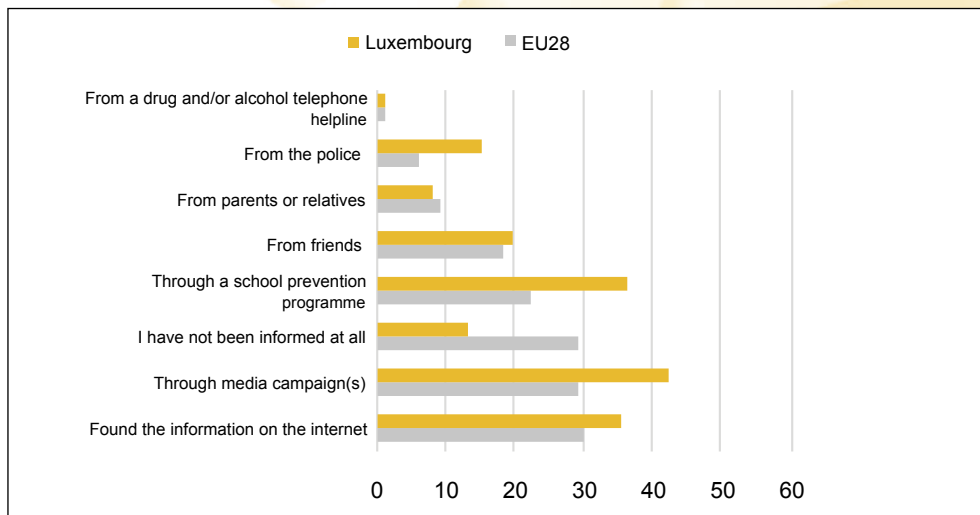
Fig 3.2 Information channels used in the past year to be informed about the effects and risks of illicit drugs



Source: Flash Eurobarometer 401

Main sources of information on new substances that imitate the effects of controlled drugs.

Fig 3.3 Information sources about new substances



Source: Flash Eurobarometer 401

In EU28 the internet was found the main source of information over the past year about the effects and risks of the use of new substances that imitate the effects of controlled drugs (EU: 30%) whereas in LU the most frequently mentioned information channel was through media campaign(s) (LU: 42%). In EU28, both answers, information channels namely through media campaigns and no information at all were reported on second place (EU: 29%) whereas in LU school prevention programmes (LU: 36%) (EU: 22%) came on second and the internet (LU: 35%) on third place (EU: 22%).

● How should drug problems be tackled?

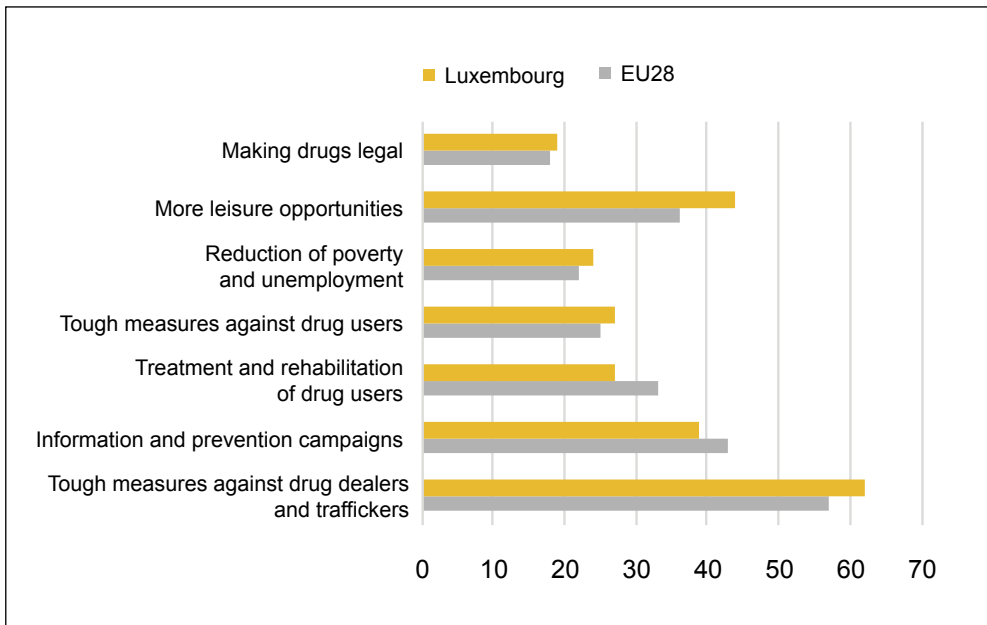
As in the 2011 Flash Eurobarometer, the largest proportion of respondents considered that public authorities should tackle problems on the supply side: 57% mentioned **tough measures against drug dealers and traffickers** (LU: 62%) as one of the most effective ways to reduce drug problems.

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. 43% of respondents referred to **information and prevention campaigns** (LU: 39%) as one of the most effective ways of reducing drug problems; the **leisure opportunities** followed, with 36% (LU: 44%) of respondents choosing this as an effective measure and **treatment and rehabilitation** with 33% (LU: 27%). By comparison, **tough measures against drug users** were considered to be a valuable way of dealing with drug problems by a quarter of respondents (EU: 25%: LU: 27%).

Reducing one of the possible primary causes of drug abuse – i.e. **poverty and unemployment** – was mentioned by 22% (LU: 24%) of interviewees. As in 2011, **legalisation of drugs** was thought to be the least effective way of fighting drug problems: 18% (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: Flash Eurobarometer 401

The CePT was partner of the European project 'Click for support' which concluded in September 2015. Various institutions from 13 countries participated. The aim of the project was to elaborate guidelines for web-based interventions in the prevention of addiction and addiction assistance for young illicit drug users aged 14 to 21 years.

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. An essential part of the project is outreach work. Meetings and interviews are held within the natural environment of the family (at home).

Moreover the CePT, in collaboration with JDH organized training courses for drug-dependant mothers in 2011 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). In 2012 the CePT finalized the train-the-trainer handbook for the parental project of JDH describing the topics and the methods of the courses. In 2013, preparation work for new sessions of the training courses took place in order to adapt the contents to the needs of this target group. In 2015, the CePT delivered a course for mothers in OST with children aged 0 to 6 years consisting of 7 modules focussing on the strengthening of self-esteem and dealing with the maternal role.

Recreational settings

Youngsters 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: art performances, theatre, and media supports (films, cartoons, etc.), seminars, ambulatory exhibitions, travel experiences, outdoor- and adventure education approach, etc. The CePT increasingly ensures the national coordination of such activities integrating the addiction prevention topic as one of the various components of **Health education**. 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**⁴⁹' do fit in a broader programme named 'Adventure pedagogy and primary addiction prevention'. With prevention concepts of adventure and nature pedagogy or cultural approaches such as theatre pedagogy and music or art education, the 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.

Between 2014 and 2016, the Mondorf Group has implemented an interregional training course for multipliers („Suchtprävention und Soziale Arbeit mit der Natur - Wildnispädagogik als Impuls für die Arbeit mit Familien, Kindern und Jugendlichen"). The target audience were socio-educative professionals. As such, they presented methods of working with animals and with nature awareness and how to use them in the field of addiction prevention work. (For more information <http://cept.lu/projets/mondorfer-gruppe/>). Furthermore a publication 'Theater as a medium in addiction prevention – theory and practice' was published in 2015. A new publication on addiction prevention based on adventure pedagogy to be used for the work with youngsters will be published in 2017.

Since May 2008, the CePT is an active member of several projects on the topic of health promotion and harm reduction in nightlife settings, as 'Democracy, Cities and Drugs II', the 'Club Health – Healthy and Safer Nightlife of Youth' (<http://club-health.eu>) project, or the 'Nightlife Empowerment and Well-being Implementation Project' (NEW-Net – <http://www.safernightlife.org/>). NEW-Net is a European network of community-based NGOs acting in the fields of health promotion and nightlife. The main objectives of these networks and projects are to improve existing interventions reducing drugs related harm in nightlife and party settings and to facilitate their transferability, evaluation and implementation. In the NEWIP project, the CePT co-authored in 2013 guidelines on good practice standards when developing peer projects in nightlife settings (Noijen, J., Duscherer, K., Schrooten, J., et al., 2013, available at <http://www.safernightlife.org/>).



In the context of his partnership with the project NEWIP, organizer of the 'European Party friends night', the CePT participated the 24th November 2012 in this European event and in particular in the action 'party friends tip', which provides advice on taking care of friends while celebrating, and this under the slogan 'Keep an eye on your friends'.

In 2015 a NEW Net international peer training was organised by the CePT in the framework of the call for proposal ERASMUS – Youthmobility for Youthworkers. Participants, professionals and volunteers, exchanged in a seminar experiences and intervention methods in cultural and festive settings.

As the nightlife setting provides a privileged environment for recreational drugs use, the CePT launched the project Party MAG-Net under the INTERREG IV A Programme: Great Region 2007-2013, Project 52 GR 3 3 100 (www.mag-net.eu) a harm reduction project targeted at recreational drug users in the party scene of Luxembourg and the surrounding Greater Region. 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. In the framework of the MAG-Net project, a directory of all the counseling and help services related to drugs and addictions was published for the Greater Region.

Party MAG-Net's booths are part of most national music festivals since 2011. These interventions in the party scene focus on keeping in line with the party spirit of the targeted events while adequately managing risky situations. Besides information on psychotropic substances, the recreational Mag-Net point of presence also provides earplugs and information on auditory risks, as well as condoms with and without lubricant, breath tests, but also disinfecting soap, sun screen and drinking water. The public can find time schedules of public transports or contact details of the facilities available in the region. The main focus is on information and is provided in situ by a team of trained peers. Trilingual postcards are made available to the public, including information on alcohol, cocaine, cannabis, synthetic cannabinoids, tobacco, XTC, LSD, ketamine, GHB/GBL, heroine, speed and information on road safety and risky sexual behaviours in relation to drug use.

In addition to the party MAG-Net, the CePT in close collaboration with the Ministry of Health, the Public Prosecutors' Office and the National Laboratory of Health (LNS) has launched in 2014 a pilot project named 'DUCK' (DrUg CheCKing) (CePT, 2014). The 'DUCK' service onsite drug testing in festive settings. 'DUCK' services are provided at the Party MAG-Net stand, at festive areas. In 2014, the 'DUCK' team was present at 12 events. In total, 53 samples of drugs were collected for toxicological analyses. In 2016, the DUCK team collected 21 samples in various festive settings. Since 2017 the DUCK project is managed under the generic name PIPAPO by an NGO, called *4Motion*, primarily active in the field of youth and training activities.

The project Party MAG Net has been associated to Party+ which is a project dedicated to the development of safer party labels in a network of European cities⁵⁰.

The campaign "Keen Alkohol ënner 16 Joer – Mir halen eis drun" ("No alcohol under 16 years – We stick to it!"), in collaboration with the Ministry of Health started in 2007 foremost in community settings and was re-launched with a press conference in June 2011. This campaign focused the adult population and the promotion of their responsibility. The focus was laid on the responsibility of the vendors of alcoholic drinks and the prohibition of selling alcohol to minors under 16 years. In 2011, the CePT appealed to the responsibility of the adults on the verge of the summer festivities and especially the festivity of the national holiday. The message was spread by the media and transported by several materials and a lot of collaborating partners. The campaign has continued his course consistently down to the present. The

50 The Party+ website <http://www.partyplus.eu/>

scientific evaluation of parts of this campaign especially in 4 communities was realized by the University of Luxembourg in the framework of the research project SORES ("Social responsibility as a strategic concept of prevention work", 2009-2012). The results were published and presented by the University of Luxembourg on the 11th December 2012 as a document called "Local network creation as strategic concept in the prevention – Evaluation of an awareness campaign to the alcohol consumption in adolescence". The Minister of Health and representatives of different ministries, experts, police members and members of associations acting in the field of alcohol prevention participated in this presentation. The study addressed topics of social responsibility, network strategy and intergenerational behaviour. A major objective of the campaign was to reach adults as multipliers to promote health and individual responsibility among children and youngsters.

Results show that, concerning the intergenerational behaviour, youngsters expect model behaviour and responsibility adoption from the adult generation. Overall, the research results confirm the effectiveness of the prevention campaign with regard to the network strategy and the multipliers. The conclusions of the evaluation will be important for the development of future prevention campaigns.

With the "European Action on Drugs" the European Union wants to approach a growing problem, concerning the whole European society, in a determined, balanced and coordinated manner. For this purpose a charter was created, signed by national and local public authorities, schools, public services, consortia or organisations of any size. In Luxembourg, the European action plan is coordinated by the "Responsible Young Drivers". Interventions do not only address youth, but also people at risk of dependence, of all age categories.

Occupational settings

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

The health service at multi-sectorial work (STM: Service de Santé au Travail Multisectoriel) is providing a toolbox to help companies willing to improve prevention of alcohol and drug consumption at work. This toolbox includes tools for the 3 prevention areas: primary, secondary and tertiary. Currently only the documents for the primary prevention are available. The support tools for the primary prevention developed by the STM are information leaflets for companies and employees as well as posters allowing the companies to introduce prevention campaigns. The leaflets contain general information on the psychoactive substance (alcohol, drugs and medicaments), self-evaluation or questions for reflection, recommendations from the accident assurance as well as useful addresses to get help.

INDICATED PREVENTION

Children at risk with individually attributable risk factors

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



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

NATIONAL AND LOCAL MEDIA CAMPAIGNS

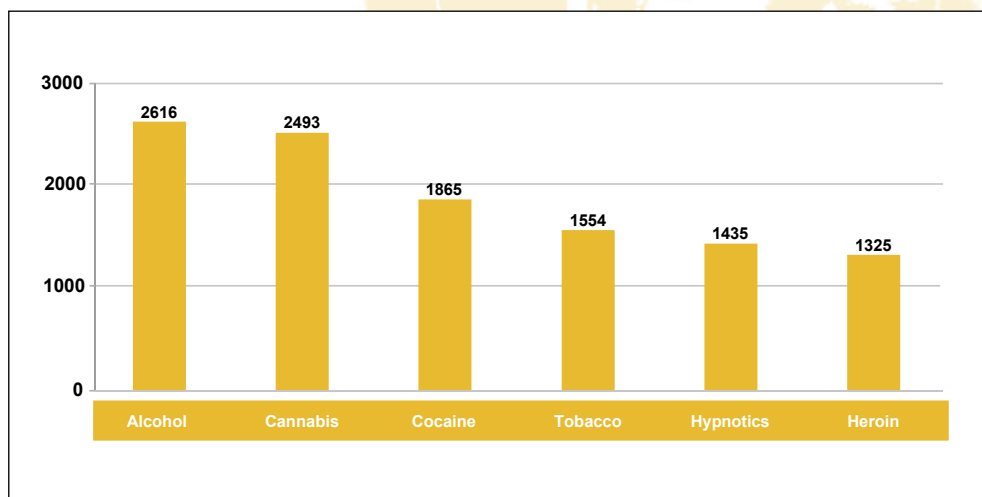
A special department of the CePT, called "Fro No" ("Check It"), offers since September 2007 a phone line (+352 49 77 77 55, accessible every working day from 9:00 a.m. to 1:00 p.m.) as well as an online service (frono@cept.lu). The Fro No department can be contacted concerning all matters related to drugs, addictions and prevention work. Fro No provides only information and is not a drug-advice center.

In total, the Fro No" service was solicited 194 times (287). As in previous years, the most frequent questions were related to cannabis and alcohol abuse.

Furthermore, a series of leaflets on drugs (i.e. alcohol, cannabis, cocaine, ecstasy, heroin, magic mushrooms, tobacco and on hypnotics and anxiolytics), informing the general public on the effects, legal issues and risks were diffused to a broad national public being dispatched through counseling services, MDs (i.e. general practitioners, neurologists, psychiatrists), secondary schools (SPOS) and Police academy. These leaflets are available in French and German since 2009 and are edited since September 2011 also in English and Portuguese. All the leaflets and a large collection of specialised literature on drugs, addictions and addiction prevention are available at the CePT or for download at: <http://cept.lu/fr/frono>.

All in all, 11,288 leaflets on drugs have been distributed in 2016.

Fig. 3.5 Number of dispatched leaflets on drugs and psychotropic medications in 2016



Source: CePT 2017

Additionally, the Fro No department edits two directories listing all the counseling and help services related to drugs and addictions (*Les services spécialisés dans le domaine des drogues et toxicomanies au Luxembourg*) and to childhood, youth and parents (*Les services de consultation pour enfants, jeunes et leurs parents*). These directories were updated and re-published in 2012 and 2014. All this information is also available through the CePT homepage <http://cept.lu/>, which facilitates the access to even a broader public.

In 2016, 1,555 directories listing all the counselling and help services have been distributed.

A rapid assessment survey within different professional groups conducted by a newly created department of CePT (m.e.s.h.) in 2009, provided a better insight in the phenomenon of solvent misuse in Luxembourg <http://cept.lu/>.



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 care sectors. 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 drug use prevalence study (Origer, 2017), performed on 2015 data, the national prevalence of **Problem Drug Users** (PDU) situates around 2,200 persons. A decreasing trend in the PDU prevalence rate in the national population aged 15 to 64 years has been observed from 2003 onwards. A similar evolution occurred also for **Injecting Drug Use** (IDU) prevalence since 2009. The prevalence rate of **Opioid Use** (OU) was estimated for the first time in 2017 on 2015 data at 4.46 users per 1,000 inhabitants aged 15-64 years.

Intravenous heroin use associated to poly-drug use has been reported as the most common consume pattern in PDU. Increased cocaine use in combination with heroin continues to be observed. Ecstasy-like substances and ATS are still popular as shown by seizure figures. Methamphetamine use in Luxembourg is very limited but ATS seizures have increased for the past years. No evidence exists thus far on the presence of crack (although freebasing has been reported sporadically by field agencies) on the national market. The use of '*New Psychoactive Substances*' (NPS) within PDU is currently not reported. Cannabis use of clients in contact with services (institutional contact indicator) have been on the increase for several years. Also, cannabis showing high THC concentrations is increasingly found on the national market.

PREVALENCE AND INCIDENCE ESTIMATES OF PDU

National prevalence data

Data presented in the present chapter have been provided by serial drug prevalence studies on PDU aged between 15 and 64 years performed on 1997, 1999, 2000, 2003, 2007, 2009 and 2015 data (Origer, 2001, 2012, 2017)⁵¹. The latest study, published in 2017, was performed on 2015 data and allowed to assess the evolution of PDU prevalence over 18 years, by means of comparable methodologies and data sources.

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 and was built upon the methodological assumption that data exclusively from drug treatment settings may not provide an accurate picture of problem drug use as these notably exclude out-of-treatment users whose drug use has generated conflicts with law enforcement only. Hence, to approach the genuine heterogeneity of the drug misuse phenomenon, RELIS routinely compiles data from all existing specialised in- and out-of treatment sources, in- and outpatient service sources, low threshold agencies, psychiatric departments of general hospitals, substitution treatment programme, prison, and law enforcement agencies. Also, RELIS relies on the 'institutional contact indicator', as an alternative to the more commonly used 'treatment demand indicator'. 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).

According to the 2012 serial and multi-methods prevalence study (Origer, 2012) performed on 2009 data, national prevalence of PDU situated at 2,070 persons (C.I. (95%): 1,553 to 2,623). A decreasing trend in PDU prevalence has been observed between 2003 and 2009. A similar evolution occurred also for problem opioid use (2007: 1,900 PDU; 5,90/1000). The prevalence rate of intravenous drug use (IDU) in the national population aged 15 to 64 years has stabilised during the same period. Most indirect PDU prevalence indicators reflect trends documented by in-depth PDU studies.

In 2017, a new serial study based on the so called Incremental OST multiplier Method (IOMM) has been conducted to estimate the prevalence of Opioid Users (OU), Problem Drug Users (PDU) and Injecting Drug Users (IDU).

The method referred to is based upon the exhaustive annual census of patients in Opioid Substitution Treatment (OST) at the national level provided by the national OST register: (N^{OST}) and the annual OST in-treatment rate provided by the national drug monitoring system RELIS: ($R^{OSTRELIS}$). Since patients undergoing OST are exclusively opioid users (OU) and exhaustively registered by the national OST register, the application of the OST multiplier, provided annually by the national RELIS system, allows estimating the number of OU (N^{OU}) as follows:

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



OU prevalence estimation

$$N^{OU} = N^{OST} / R^{OSTRELIS} \quad (1)$$

$R^{OSTRELIS}$ applied to year 2015: 0.62

$$N^{OU} = 1,078 / 0.62 = \mathbf{1,738}$$

which equals to a **national OU prevalence rate (R^{OU})** in 1,000 inhabitants aged 15-64 years of **4.46**⁵²

The coherence of this estimate may be cross-checked by an alternative method using the same original multiplier sources, namely the national OST register and the national drug monitoring system RELIS, both based on a unique and de-identified registration code (RELIS code), approved by the National Commission on Data Protection.

Disposing of the anonymous registration RELIS codes of opioid users registered by RELIS for a given year on the one hand and the RELIS codes of OST patients, provided by the national substitution register, on the other hand, allows to calculate the rate of OU receiving OST during a given year and use it as a crosscheck multiplier ($R^{OSTRELIS/REG}$) for $R^{OSTRELIS}$, provided by RELIS, as follows:

$$N^{OU} = N^{OST} \times R^{OSTRELIS/REG} \quad (2)$$

Both values obtained by applying $R^{OSTRELIS/REG}$ and $R^{OSTRELIS}$ respectively may be used as estimation margins. Data required for calculating the cross-check equation (2) was not yet available by the time of writing. Cross-check will thus be performed in due time.

PDU prevalence estimation

The RELIS monitoring systems is based on data collection from problem drug users in contact with national institutions (DR and SR) and provides data on drug use pattern of PDUs at the national level. Preferential drug use, including opiates' use, are routine items of the RELIS data protocol, which allows to calculate the proportion of PDUs showing opioid use (R^{OU}). Thus, the estimated number of OUs determined by the previous estimation steps (equations 1) can be used to estimate the number of PDUs by the following formula:

$$N^{PDU} = N^{OU} / R^{OU} \quad (3)$$

R^{OU} applied to year 2015: 0.77

$$N^{PDU} = 1,738 / 0.77 = \mathbf{2,257}$$

providing a **national PDU prevalence rate (R^{PDU})** in 1,000 inhabitants aged 15-64 years of **5.79**.

IDU prevalence estimation

A similar methodology may be applied to estimate IDU prevalence as RELIS provides the proportion of PDUs with injecting drug use (R^{IDU}). The estimated number of PDUs determined by the previous estimation step (equation 3) thus can be used to estimate the number of IDU by the following formula:

52 National population aged 15-65 years in 2015 : 389,371

$$N^{IDU} = N^{PDU} \times R^{IDU} \quad (4)$$

R^{IDU} applied to year 2015: 0.65

$$N^{IDU} = 2,257 \times 0.65 = \mathbf{1,467}$$

which equals to a **national OU prevalence rate (R^{OU})** in 1,000 inhabitants aged 15-64 years of **3.77**.

List of variables:

N^{OST} : Number of patients in Opioid Substitution Treatment (OST) at the national level provided by the national OST register

$R^{OSTRELIS}$: Rate (Multiplier) of OST patients in OU as determined by answers to the RELIS protocol

$R^{OSTRELIS/REG}$: Rate (cross-check) of OST patients in OU as determined OST registries in the national OST register.

N^{OU} : Number of opiate users

$R^{OURELIS}$: Rate of opiate users in PDU indexed by RELIS

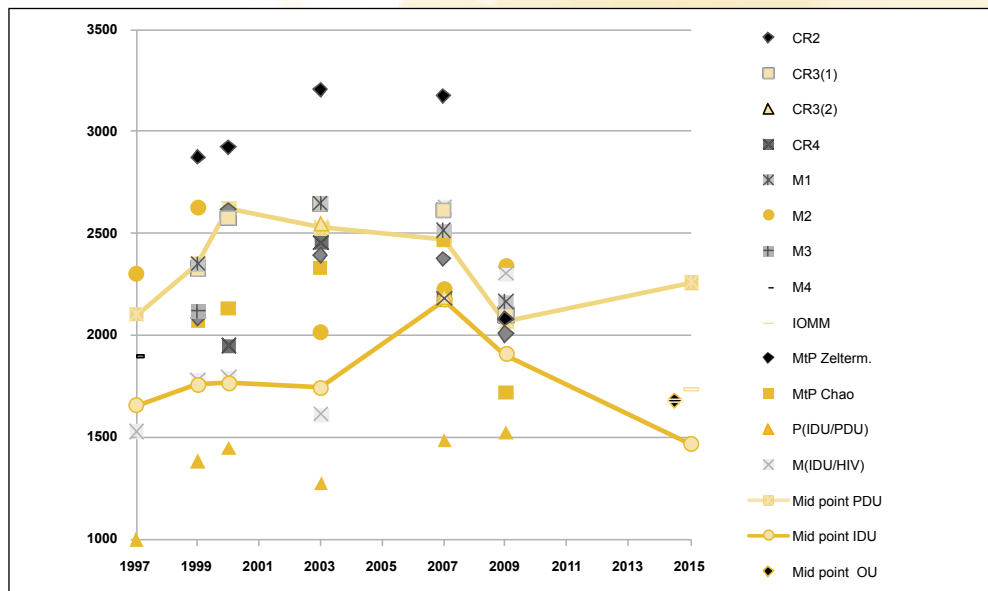
N^{PDU} : Number of problem drug users

R^{OU} : Rate of PDU with opiate use

N^{IDU} : Number of injecting drug users

R^{IDU} : Rate of PDU with injecting drug use

Fig. 4.1: Absolute prevalence estimates of opioid use, problem drug use and injecting drug use – Grand Duchy of Luxembourg (1997-2015)



Source: Origer, 2017

Note:

CR2 / CR3 / CR4: capture-recapture methods on 2, 3 and 4 sources.

M1: multiplier method; police and drug-related deaths registers.

M2: multiplier method: number of drug law offenders / law enforcement contact rate of drug offenders.

M3: multiplier method; number of fatal overdose cases / drug-related mortality rate.

M4: extrapolation from treatment data.

IOMM: Incremental OST Multiplier Method

P(IDU/PDU): multiplier method; PDU estimates / IDU rates.

M(IDU/HIV): multiplier method; number of HIV infected IDU / rate of HIV infections among IDU.

OU: Opioid Use prevalence estimate

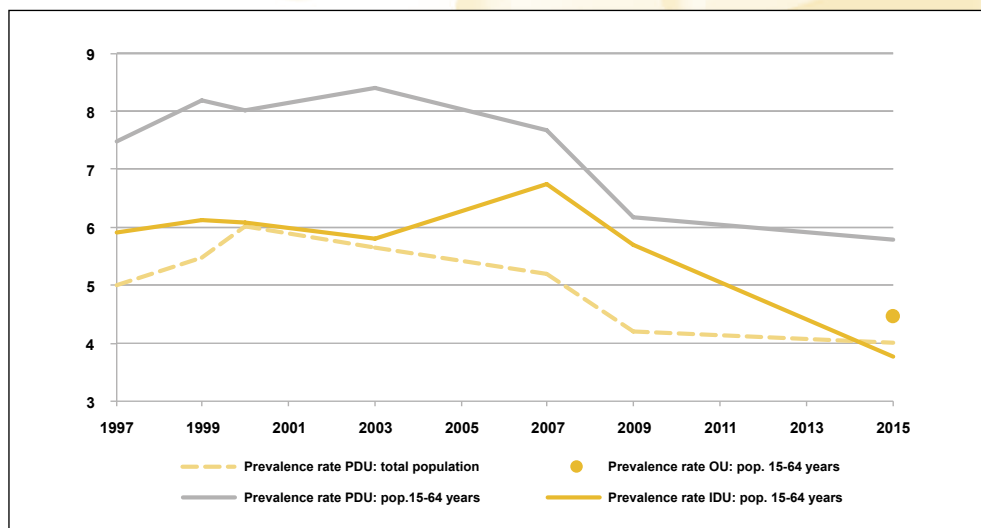


Table 4.1: Absolute national prevalence and prevalence rates according to selected sub-groups (1997 – 2015))

	1997	1999	2000	2003	2007	2009	2015
GENERAL POPULATION							
National population on 1 st January	418,300	429,200	435,700	448,300	476,200	493,500	562,958
National population aged between 15 and 64 years on 1 st January	281,100	287,100	291,000	300,800	322,000	336,015	389,371
PROBLEM DRUG USERS (PDU)							
PDU mean prevalence	2,100	2,350	2,625	2,530	2,470	2,070	2,257
Mean C.I. (95%)	1,900–2,300	1,994–2,758	2,246–3,295	2,144–3,293	1,945–3,343	1,553–2,623	/
Total mean prevalence rate - PDU	5 / ¹⁰⁰⁰	5.48 / ¹⁰⁰⁰	6.02 / ¹⁰⁰⁰	5.64 / ¹⁰⁰⁰	5.19 / ¹⁰⁰⁰	4.19 / ¹⁰⁰⁰	4.01 / ¹⁰⁰⁰
Total mean prevalence rate - PDU-age :15-64	7.47 / ¹⁰⁰⁰	8.19 / ¹⁰⁰⁰	9.02 / ¹⁰⁰⁰	8.41 / ¹⁰⁰⁰	7.67 / ¹⁰⁰⁰	6.16 / ¹⁰⁰⁰	5.79 / ¹⁰⁰⁰
INJECTING DRUG USERS (IDU)							
IDU mean prevalence	1,656	1,757	1,765	1,745	2,173	1,907	1,467
Estimate margins	1,528–1,785	1,686–1,828	1,610–1,920	1,735–1,755	1,924–2,422	1,524–2,301	/
Total mean prevalence rate - IDU	3.96 / ¹⁰⁰⁰	4.09 / ¹⁰⁰⁰	4.05 / ¹⁰⁰⁰	3.89 / ¹⁰⁰⁰	4.56 / ¹⁰⁰⁰	3.86 / ¹⁰⁰⁰	2.61 / ¹⁰⁰⁰
Total mean prevalence rate - IDU-age :15-64	5.89 / ¹⁰⁰⁰	6.12 / ¹⁰⁰⁰	6.07 / ¹⁰⁰⁰	5.80 / ¹⁰⁰⁰	6.75 / ¹⁰⁰⁰	5.68 / ¹⁰⁰⁰	3.77 / ¹⁰⁰⁰
OPIOID USERS (OU)							
Total mean prevalence - OU							1,738
Total mean prevalence rate - OU							3.09 / ¹⁰⁰⁰
Total mean prevalence rate - OU age:15-64							4.46 / ¹⁰⁰⁰

Source: Origer, 2017

Fig. 4.2: PDU prevalence rates according to selected sub-groups (1997 – 2015) per 1,000 inhabitants aged 15-64 years



Source: Origer, 2017

The mid-point estimation performed on 2009 data provides an absolute prevalence of problem HRC drug users (PDU-HRC) of 2,070 persons (C.I. (95%): 1,553 to 2,623). In terms of prevalence rates estimates for the same age categories, 6.16 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 2015, PDU prevalence rates witness a continuous downward trend 2000 onwards.

Absolute prevalence and prevalence rates of intravenous drug use (IDU) in the national population aged 15 to 64 years have been increasing between 2003 and 2007 to show first signs of decline in 2009, confirmed by 2015 data.

The stabilisation and subsequent decrease of the national PDU prevalence rate occurred within the implementation phase of the first, second and third national drug action plans, having started in 1999 (Ministère de la Santé 2005, Ministère de la Santé 2009), (Ministère de la Santé 2015). The observed trends are also confirmed by relevant indirect indicators related to demand and harm reduction. In order to validate drug prevalence estimates and follow up prevalence trends between two successive prevalence studies a set of indirect indicators have been compiled and are analysed routinely.

The number of fatal drug-related overdoses has peaked in 2007 and 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. Moreover, the absolute number of fatal overdoses has decreased compared to previous years. Changes in small figures may produce great variations in percentages. Comparison of overdose rates over the years would probably make the downward trend more obvious, which is in concordance with national prevalence figures. The number of clean syringes distributed by the national needle exchange programme has been showing an increasing trend which is partly due to increased NEP offers and syringes' availability at the national level.



Admission statistics in low threshold drug agencies depend of course on the capacities of low threshold offers and level of access to harm reduction measures at the national level. This said even though harm reduction offers have been further developed in Luxembourg, the number of contacts with the latter tend to decrease if compared to year 2010.

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 2018.

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 PDU person-contacts** indexed by national institutions in 2016 figured 5,846 (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 2016 the same agencies have indexed 2,974 and 2,872 persons respectively.

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

	2000	2004	2008	2010	2012	2014	2015	2016	TREND
Gender									
Male	77%	78%	77%	80%	84%	83%	84%	85%	=
Female	23%	22%	23%	20%	16%	17%	16%	15%	=
Nationality									
Natives	54%	54%	48%	49%	42%	52%	42%	37%	↘
Non-natives	46%	46%	52%	51%	58%	48%	58%	63%	↗
- of which									
Portuguese	51%	58%	38%	39%	38%	32%	27%	28%	↘
French	17%	11%	28%	23%	17%	11%	12%	21%	=
Others	32%	31%	34%	38%	45%	57%	61%	51%	↗
Mean age									
Male	29Y4M	31Y2M	31Y8M	32Y4M	33Y8M	32Y6M	35Y1M	35Y0M	↗
Female	26Y10M	28Y4M	28Y5M	28Y9M	30Y6M	31Y5M	34Y4M	34Y7M	↗
Total	28Y9M	30Y6M	30Y11M	31Y7M	33Y2M	32Y3M	34Y11M	34Y2M	↗
Primary drug									
Opiates	84%	76%	72%	80.6%	55.8%	53.8%	55.9%	46.1%	↘
Cocaine	7%	16%	17%	9.5%	12.2%	19.9%	19%	17%	↗
Others	9%	8%	11%	9.9%	3.2%	26.3%	25.1%	36.9%	↗
Polydrug use	87%	93%	89%	76%	54%	54%	61%	54%	=
Primary opiates administration mode									
Iv									
Non-iv	56%	55%	45%	59%	42%	50,3%	43%	47%	=
	44%	45%	55%	41%	58%	49,7%	57%	53%	=
Infectious diseases									
HIV									
HCV	4.3%	4%	4%	6%	4%	5%	8%	10%	↗
	40%	58%	65%	52%	54%	61%	56%	52%	=

In 2016, the male/female ratio of the PDU population is around 85/100. During the last ten years the proportion of indexed non-native PDU has shown strong variations but a clearly figure in 2016. The population of non-native drug users largely consists of Portuguese nationals, whose proportion is, however, currently lower than the one observed in the general population.

The mean age of indexed PDU evolved from 28 years and 4 months in 1995 to 34 years and 2 months in 2016. Mean age of male PDU has been increasing faster than for females. In reference to years 2004 to 2012, a discontinuous increase 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 but native still have lower mean age as well as women. 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 twelve 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** (54%) has been declining after a record level in 2004 (93%) and has still be generally decreasing between and 2016. The ratio of intravenous opiates consume to the inhalation mode was almost 1:1 in 2016. 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. Following a sensible increase in 2011, the previous trend of cocaine stabilising as primary drug is confirmed by 2016 data. 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.

The number of persons in contact with the national specialised network for (preferential) cannabis use has been showing a globally increasing trend 2016 (32.8%).

PDU show fairly stable infection rates of HIV between 2000 and 2014, whereas the HCV prevalence rate (56%) is fairly stable since 2004. In 2015 and 2016, however, infection rates of HIV show an increasing tendency.

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 at 67%. 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** (55%) tends to plateau. However, the proportion of professionally active respondents reporting a stable job situation (e.g. long term contract) has been stable in the 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 the 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 was almost identical to PDU from treatment sources in the last years. In 2016, the percentage of male offenders was 88%, 12% female offenders vs. 85% males and 15% females from treatment sources. The mean age of offenders has significantly dropped to 27.43 years (34.8 in 2015). Women being slightly younger than men. 27.55 years (34.9 in 2015) for male and 26.58 (34 in 2015) years for female offenders).

39% of the offenders are natives.

Most offenders 60% (74.5%) are recidivists (had more than one drug-related police record during their lifetime).

5% (27%) were arrested for illegal drug dealing. A vast majority of offenders 95% (73% in 2015) were charged with possession or consumption of illegal drugs. Drug-law offenders (being simultaneously problem drug users) are mostly arrested for heroin and cocaine related offences. A 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'.⁵³

Specialised drug treatment facilities are relying on state financing and on ministerial control and quality assurance 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 not⁵⁴;
- **Inpatient treatment:** the patient is staying overnight, pharmaceutically assisted or not (including detoxification);
- **Opioid Substitution Treatment (OST):** 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. OST may be provided in in- and outpatient settings.

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

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 law⁵⁵ 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.

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

54 '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'.

55 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 counselling agency (JDH) was created in 1986 and addressed both drug addiction and youth. Preliminary work done in the framework of the 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 a given type of substance or problems related to it. In recent years the national drug treatment strategies have been 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 assurance

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 terms of the above referred to 'ASFT' law (8/09/98) and the subsequent grand ducal decree of 10 December 1998⁵⁶, both regulating the relation (duties and rights) between State and NGOs or organisations 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 referred institution and at least one representative from the competent ministry. 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 2015-2019 national drugs action plan foresees to further develop these synergies.

The governmental quality standard certification, as foreseen by the law 'ASFT' of 8 October 1998, represents the main instrument of a standardised quality control of drug treatment offers. General guidelines on setting requirements and human resources/clients keys are set by a grand-ducal decree of 10 December 1998 regarding the accreditation of services from the medical, social and therapeutic field. The quality standard certification commits respective NGOs to undertake necessary evaluation measures of their activities. Drug treatment agencies have developed proper evaluation strategies mostly in collaboration with external evaluators. 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.

56 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. 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 situations, risk behaviours and treatment or law enforcement contacts, etc. In the long run, drug use '*careers*' can be analysed by means of the RELIS indexing system, which allows following up treatment demands and law enforcement contacts of indexed and de-identified 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 evaluations of the national drug action plans, which did greatly rely on RELIS data and ad hoc evaluation initiatives from field institutions.

Table 5.1 reports admission and contact statistics of national drug treatment agencies according to the applied typology from 1994 to 2016. 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 and re-integration facilities are spread over different regions. 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 'supervised drug consumption room' has been opened in Luxembourg City. It has been integrated in the ABRIGADO centre providing day care, night shelter and low threshold services to drug addicts. The opening of a second supervised drug consumption room in Esch/Alzette is foreseen for 2018.

It should be stressed that no national drug treatment service exclusively targets a given type of substance use and its correlates. Currently national services provide care for persons presenting various substance use related problems.



Map 5.1 Geographical coverage of specialised drug agencies in the Grand-Duchy of Luxembourg (status 2017)



- JDH : Counselling, substitution, low-threshold and after care
- ABRIGADO (CNDS) : Low threshold
- ABRIGADO (CNDS): Night shelter, Injection room
- IMPULS : Youth counselling
- ⊕ Quai 57 (Arcus asbl) : Counselling and referral
- CHNP : Treatment and referral
- CTM : Residential therapy, reintegration measures
- CTM : Aftercare, supervised housing (only main site)
- General hospitals providing detoxification treatment
- △ Stëmm vun der Strooss: Post-therapeutic centre

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. Quai57 (Arcus asbl) implemented in Luxembourg-City is primarily a counselling and referral agency.

A third specialised 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 drug-addicted clients in the development of a therapeutic project with orientation either towards the intermediate-term structures, or towards residential therapy centres.
- Organisation 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 (Impuls).

Outpatient: substitution treatment and HAT

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

Substitution treatment is provided at the national level since 1989 (JDH). Until the beginning of 2001, however, there has been no genuine 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, amended by the grand-ducal decree of 1st March 2016⁵⁷, 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

57 The decree of 30 January 2002 and the decree of 1 March 2006 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>



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

Until 2001, methadone and buprenorphine have been prescribed as part of a long-term treatment with a medium or long-term abstinence goal. There are, however, a series of cases in which substitution treatment has to be considered rather as a harm reduction or maintenance measure than an abstinence oriented therapeutic offer. 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. Heroin assisted treatment (HAT) is currently provided in an institutional setting.

The list of substitution substances may be modified within reasonable delays 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. OST licensed MDs may refer substitution patients to specialised treatment centres for more in-depth psychosocial counselling.

A central substitution register jointly implemented by the 'Surveillance Commission on Substitution Treatment'⁵⁸, the National Drug Coordinator and involved specialised treatment providers. Multiple prescriptions could be markedly reduced since the launch of the national substitution register. The substitution treatment surveillance commission has been reformed 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. The further development of harm reduction services in the North is part of the national drug action plan. In this context, a new low-threshold offer has been implemented in the North of the country in 2014.

Inpatient: detoxification services and offers

Physical drug detoxification is provided by 4 regional hospitals via their respective psychiatric units. The "Centre Hospitalier du Kirchberg - CHK" initially joined the list of national institutions providing detoxification treatment in 2005. In 2016, the CHK merged with another hospital in the centre of Luxembourg, the "Hôpital Ste. Thérèse", and both were renamed "Hôpitaux Robert Schuman" but remain on their respective sites. CHK has been renamed "Hôpitaux Robert Schuman - Kirchberg" and "Hôpital Ste. Thérèse" changed its name into "Hôpitaux Robert Schuman - Zithaklinik". Clients arriving at Kirchberg are referred to its addictionology departement situated at "Zithaklinik". Medical interventions and psychosocial support are provided to

58 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.

control and reduce withdrawal symptoms in the framework of a 1-2 week detoxification programme. Ideally, detoxified patients are referred to more psychotherapeutic oriented institutions.

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

Centre Hospitalier du Nord – Ettelbrück (North)

Centre Hospitalier Emile Mayrisch – HVEA (South)

Centre Hospitalier de Luxembourg – CHL (Centre)

Zithaklinik (Centre) - Fondation Hôpitaux Robert Schuman

Hôpital Kirchberg (Centre) - Fondation Hôpitaux Robert Schuman

Inpatient: services and offers for adults

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 also offers 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 disposed to employ ex-drug addicts and the active involvement of social services offer a fair social and professional framing to released patients.

In the framework of the national drug action plan an extension of CTM offers occurred 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 annex 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.

In 2014, Stëmm vun der Strooss asbl opened a new post-therapeutic centre for persons having been treated for addictive behaviour in Schoenfels. Time-limited housing and day-time occupation is provided with a medium term social an re-integration objective.

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.

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.



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 represent the national prevalence of PDU but they allow a trend follow-up.

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 peaked in 2010. Both, the number of drug treatment demands and the contacts with law enforcement agencies have been discontinuously increasing since 2000/2001. The number of substitution treatment (OST) demanders has been slightly decreasing since 2013. Since 2009, the most marked increase has been observed in outpatient drug free treatment demanders. The number of contacts in low threshold facilities has been increasing 2013 (124,048) onwards (2016: 150,937). According to 2016 RELIS data, around 15.5% (10%) of respondents are first treatment demanders, all treatment centres included. As far as **first treatment** demanders are concerned, 19.5% are females for 80.5% of males.

Of clients in drug treatment (all treatments and all types of units included), 81% (77%) are male for 19% (23%) females. The mean age of treatment demanders has been increasing during the last ten years (1997: 28 years/ 2015: 35.1 years/ 2016: 33 years), primarily due to an observed increase in average male age (1997: 28.2/ 2015: 35.3/ 2016: 33.45). The mean age of female clients is slightly lower (2015: 34.9/ 2016: 31.06) compared to their male peers. Respectively 55.1% (57.8%) of clients in treatment are natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French, Italian, Belgian, German and Cap-Vert citizens.

Regarding the educational level of the clients in treatment in 2016, 63% have completed primary or complementary school, 31% have completed secondary school and 6% obtained a higher degree. 16% of respondents reported stable employment (important decrease – 1997: 65%) against 54.8% who are inactive or unemployed. Furthermore, 20% are students or engaged in a training contract. 26.1% (44.1%) of indexed treatment demanders had experienced one or more overdoses. As far as the exchange of syringes is concerned, 68.3% (45.5% in 2015, 25% in 2012 and 32.9% in 2011) reported that they never shared syringes during their lifetime, 96% (83.9% in 2015, 44.6% in 2012 and 51.7% in 2011) during the last month. IDU combined to polydrug use 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:

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

SETTING	NUMBER OF ADMISSIONS NUMBER OF CONTACTS (Low threshold)												NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)											
	2000	2002	2004	2006	2008	2010	2012	2013	2014	2015	2016	2000	2002	2004	2006	2008	2010	2012	2013	2014	2015	2016		
DEMAND REDUCTION: SPECIALISED DRUG TREATMENT																								
OUTPATIENT																								
- Drug Free												636	828	916	928	1,162	980	1,294	1,307	1,296	1,586	1,477		
- Substitution											1,002	1,040	1,065	1,044	1,050	1,163	1,180	1,126	1,121	1,078	1,085			
INPATIENT																								
- Specialised											158	153	182	183	124	128	127	89	64	86	83			
- Hospital care											316	429	476	484	397	297	262	267	310	313	329			
LOW THRESHOLD AGENCIES (contacts)	13,083	29,536	39,526	55,808	78,415	140,093	127,080	124,048	131,375	142,054	150,937													
SUB TOTAL A: Number of drug treatment demanders (Multiple counts not excluded)												2,112	2,450	2,639	2,639	2,733	2,568	2,789	2,791	2,791	3,063	2,974		
SUPPLY REDUCTION: LAW ENFORCEMENT INSTITUTIONS																								
National prisons												161	101	92	243	332	232	306	226	223	240	306		
Police - Judicial Police - Customs												1,758	2,217	1,808	1,573	1,487	2,530	1,782	2,066	2,792	3,345	2,566		
SUB TOTAL B: Number of drug law offenders (Multiple counts not excluded)												1,919	2,318	1,900	1,816	1,819	2,762	2,088	2,295	3,015	3,585	2,872		
TOTAL NUMBER OF PERSONS SHOWING DRUG-RELATED INSTITUTIONAL CONTACTS (Multiple counts not excluded)												4,031	4,768	4,539	4,455	4,542	5,330	4,951	5,084	5,806	6,648	5,846		

Source: RELIS 2017 / CNS



Outpatient: services and offers for adults

RELEVANT TREND: Increase of male treatment demanders (80% male, 20% female). Decline of clients aged 30 and more (2016: 53% / 2015: 71% / 2014: 88% / 2013: 86%). 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.

National outpatient drug counselling centres have been showing increasing admission rates 2000 onwards. 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 showed a significant decrease in 2016 after having stabilised at high level during recent years (2016 : 53% / 2015: 71.4% / 2014: 88% / 2013: 86%). Treatment demands from underage clients tend to decrease until 2007 and increase since then, mainly because specialised agencies for minors have been implemented meanwhile. Cannabis-related demands have shown a clear upward trend since 2009 (2016: 45% / 2015: 29.4% / 2014: 25%). Treatment demands for problem i.v. opiate use associated to multiple-use remains a very frequent demand pattern (37% of all outpatients). The prevalence of cocaine use-related treatment demands also tends to increase (12% of all outpatient demands).

Outpatient: services and offers for minors

RELEVANT TREND: Increase of the number of counselling episodes. Cannabis-related problems are the main cause of consultation. A vast majority (2016: 79% / 2015: 66.6% / 2014: 83%) of minor clients are male. Cannabis use is the main reason of treatment demands witnessing a currently increasing 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: Overall stabilisation of OST patients for the last ten years. Between 2005 and 2012 decrease of number of patients in structured JDH substitution programme followed by a slow increase since 2014. Stabilisation of gender ratio (3 males/ 1 female) – Increase of average age of substitution treatment demanders.

The number of patients admitted to the national multidisciplinary substitution programme (JDH) has been sensibly decreasing from 2005 to 2012 and shows a slow increase since 2014 (113 patients in 2014, 119 patients in 2015 and 131 patients in 2016). 84.7% of the clients have been attending the program for less than 5 years and 7% for over 10 years. The proportion of female substitution treatment demanders (26.7%) is higher than the proportion of female PDU in the overall drug treatment population. 18.3% of the clients in substitution treatment are aged under 35; 50.4% are over 40 years old and the oldest client was 61 years in 2016. 47.3% of the clients are natives.

The total number of OST patients nationally has known a steep increase between 2008 and 2010 [(1,158 patients in 2010, multiple counts excluded (2008: 961)]. Since 2011 a stabilisation in the number of total number of OST demanders has been recorded (2016: 1,085). In 2016, 75% of OST demanders were male and the average age of all OST demanders was 42 years and 6 months.

The National Health Found (CNS) annually provides the number of OST patients as well as the number of OST prescribing MDs. A sound increase of substitution demands addressed to accredited liberal MDs was observed until 2013 and an overall decrease of the number of patients choosing the multidisciplinary JDH programme, more demanding in terms of treatment 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 (1999-2016)

YEAR	2000	2002	2004	2006	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of indexed patients (double counting controlled)	844	820	945	939	1,050	1,128	1,163	1,160	1,180	1,126	1,121	1,078	1,085
Number of licensed GPs (double counting controlled)									124	129	138	145	155

Source : CNS 2017

Table 5.3: Age distribution (%) of patients substituted by the national network of licensed MDs (2008-2016)

AGE CATEGORIES	2008	2009	2010	2011	2013	2014	2015	2016
< 15 years								
15-19 years	2	1	0.5	0.1	0.1	0.0	0.0	0.0
20-24 years	9	9	7	7	0.4	0.5	0.1	0.1
25-29 years	17	16	15	13	3.7	3.5	2.4	1.9
30-34 years	19	20	20	19.3	11.0	10.3	8.3	6.9
35-39 years	19	18	20	20.4	18.3	17.2	16.9	14.9
40-44 years	18	18	17	17	20.5	20.1	21.0	20.6
45-49 years	9	11	12	14.7	18.9	18.9	18.9	19.7
50-54 years	5	5	6	6.4	15.5	17.3	17.0	17.9
55-59 years	1	1	1.5	2	7.7	8.4	10.6	12.2
60-64 years	1	1	1	0.1	3.1	3.2	4.2	4.7
> 64 years								
Total number					1,111	1,121	1,085	1,078

Source : CNS 2017 – data reformatted by NFP

The proportion of patients aged less than 30 years has been decreasing and the proportion of patients aged 45 and more increasing between 2008 and 2016.



Outpatient: low threshold services and offers

RELEVANT TRENDS: The **number of contacts** indexed by low threshold agencies⁵⁹ (2016: 150,937) witnesses an increasing trend since 2013 (124,048). 423,060 sterile syringes have been distributed in 2016 by the same agencies with a re-collection rate of 94%. In 2016, 24% of the clients were younger than 35 years in low threshold services (50% in 2015). Mean age was 41.76. 77% of low threshold clients are male.

Inpatient: hospital based care

RELEVANT TRENDS: Hospital based detoxification and treatment units throughout the country have been showing a continuous increase regarding the number of patients until 2006 (484) and then onwards a steady decrease to 274 (277) patients in 2015. In 2016 though 329 patients have been registered, marking a new increase in hospital care. Gender distribution has remained fairly unchanged between 2002 and 2016. Multiple drug use, including heroin, is the main reason for hospital care demands.

Inpatient: services and offers for adults

RELEVANT TRENDS: The **number of inpatient treatment demanders (hospital treatments excluded) has been showing a fairly stable trend over the last 10 years. However, the proportion of first treatment demanders has decreased in 2016 and currently sets around 38% (48% in 2015).**

Heroin as preferential substance is reported by 63% of treatment demanders. 75% of patients are older than 30 years. 83% of patients are natives.

The vast majority of inpatient treatment demands are addressed for heroin problems (63%) followed by cocaine (29%), other opioids (4%) and amphetamines (4%). The i.v. consumption mode is the most frequently reported consumption mode (63%), inhalation mode and sniffing mode count both for 13% and 4% of clients report more than one mode of consumption. Polydrug use (meaning the consumption of two or more products) is a frequently observed consume pattern and reported by 79% of the clients.

59 Cumulative number of contacts registered in low threshold facilities and supervised drug consumption rooms nationally.

6. HEALTH CORRELATES AND CONSEQUENCES

INTRODUCTION

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

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.'

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 nationwide 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

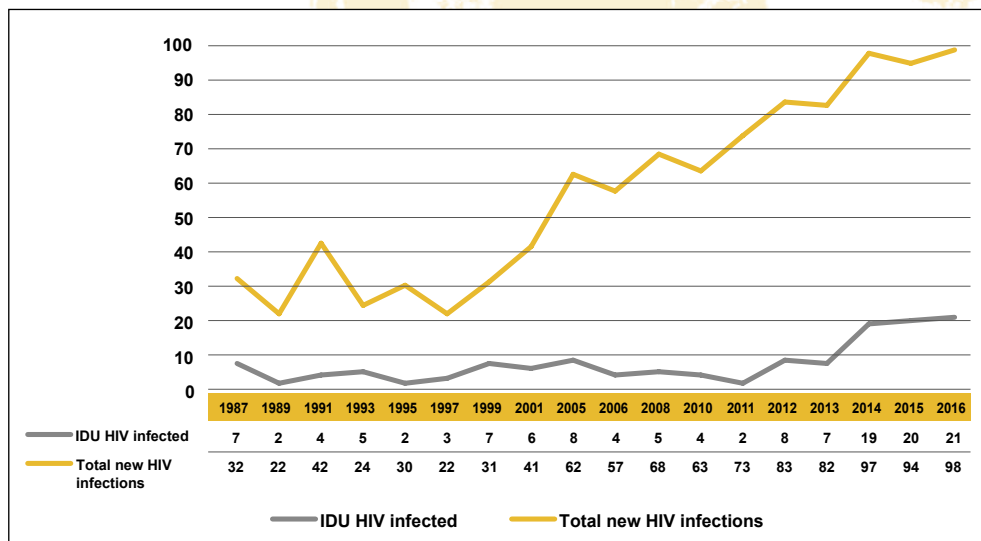
HIV/AIDS, viral hepatitis, STD, tuberculosis, other infectious morbidity

Injecting drug use continues to drive the expansion of the HIV epidemic in many countries around the world. In 2016, UNODC estimates that there are 12 million people who inject drugs worldwide, and of these, 1.7 million are living with HIV, representing a global HIV prevalence of 14% among people who inject drugs.

Data on drug-related infectious diseases are centralised at national level. Official data from the national Retrovirology Laboratory of the Luxembourg Institute of Health (LIH) provide the number and proportion of IDU in HIV infected patients. Between 1984 and 2016, 1,539 HIV infected persons have been recorded at the national level; 197 of the former were reported IDU, which leads to an average proportion of IDU in the national PLWHIV population of 12.8% since the reporting 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 infections since 1989 (heterosexual and homo/bisexual transmission are currently in first and second position respectively). The proportion of injecting drug use transmission has noticeably decreased between 1998 (23%) and 2011 (2.77%). The lowest proportion of IDU transmission mode ever recorded was observed in 2011 followed, however, by a subsequent increase confirmed by 2016 data.

Fig. 6.1 IDU in newly infected HIV patients and total number of new HIV infections (1987-2016)



Source : Laboratoire de Retrovirologie – LIH . 2017 (data formatted by NFP)

The proportion of IDU in newly detected HIV cases has been increasing since 2014. An expert group is working on this issue in order to understand reasons for this increase and possible responses. The recent increase in cocaine injections seems to be part of the bigger picture. Higher availability of cocaine, more frequent injections due to shorter effect-windows compared to heroin, marginalised user groups with no or poor service contact as well as an increased proportion of drug use related prostitution in new HIV

cases are some additional factors at play. Genotyping of new cases has been performed and results have been presented at the last EMCDDA DRID expert meeting. Research results are currently considered for publication. The HIV infection rates for all categories (PDU, DTR and IDU) show an increasing trend since 2014 as well as the AIDS prevalence rate since 2015. First related research has been published (Fischer A *et al.* 2017) and first response measures have been implemented in the framework of the current national drugs action plan and complementary offers will be included in the new HIV/AIDS action plan.

The Origer and Removille study (2007)⁶⁰ 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 appropriate medical treatment centres.

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 (Origer, A. & Schmit JC. (2012))

	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)			
Inpatient drug treatment centres	61	53 8	(15.1; 5.5 to 24.7)	61 46	(75.4; 64.6 to 86.2)	49 0	(0.0; 0.0 to 0.0)			
Prisons	135	110 35	(31.8; 23.1 to 40.5)	124 107	(86.3; 80.2 to 92.3)	65 5	(7.7; 1.2 to 14.2)			

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

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

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

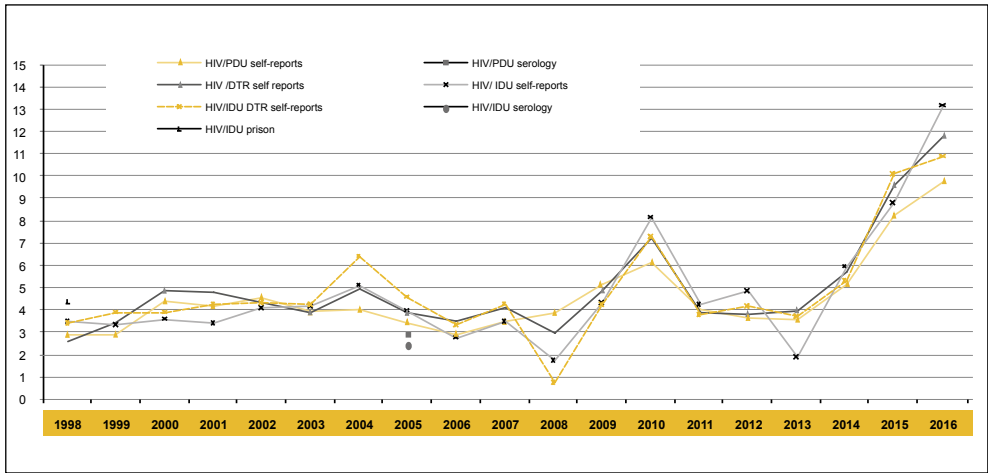
§ Respondents who have injected at least once in their lifetime a drug for non-therapeutic reasons

Source: Origer A. & Schmit JC. (2012)

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2016 (N=178), 78% of RELIS indexed PDU reported a HIV test during the last 12 months. The testing rates of female PDU were slightly lower than those of male PDU.



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



Source: RELIS 2017/ Origer A. & Schmit JC, 2012

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

YEAR	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
HIV rate in problem drug users (RELIS self-report)	2.9	4.3	4.49	3.98	3.31	2.9	3.39	3.82	5.08	6.09	3.94	3.54	3.5	5.07	8.19	9.77
HIV rate in problem drug users (serology-based) (Origer & Removille, 2007)	/	/	/	/	2.90	/	/	/	/	/	/	/	/	/	/	/
HIV rate in drug treatment demanders (DTR) (RELIS self-report)	2.6	4.87	4.32	4.93	3.84	3.49	4.13	2.96	4.83	7.22	3.85	3.76	3.92	5.66	9.56	11.81
HIV rate in current IDU (RELIS self-rep.)	3.5	3.6	4.08	5.10	3.96	2.76	3.48	1.75	4.32	8.14	4.26	4.84	1.9	5.94	8.8	13.18
HIV rate in current IDU treatment demanders (RELIS self-report)	3.4	3.9	4.32	6.41	4.59	3.33	4.27	0.76	4.24	7.29	3.77	4.14	3.7	5.31	10.07	10.09
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 2017

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

YEAR	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
AIDS rate in problem drug users (RELIS)	2.5	1.35	1.72	2.13	1.81	1.19	1.86	0.87	1.33	3.05	1.95	0.79	1.67	1.41	6.33	3.33
AIDS rate in drug treatment demanders	/	1.76	1.60	2.69	2.37	1.65	2.64	0.92	1.96	3.96	2.05	0.65	2.6	1.28	6.74	3.44

Source: RELIS 2017

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%. In 2011, 2012 and 2013, however, HIV rates stabilised around 3 to 5% to increase again in 2015 (8 to 10%) and 2016 (9 to 13%) for all categories.

From 2005 to 2010, the HCV infection rate decreased for all PDU and for drug treatment demanders, but the same rate shows variations for IDU. In 2013, HCV infection rates have increased for all categories, especially for all PDU and drug treatment demanders, and remained stable in 2014. In 2015 and 2016 HCV infection rates show a weak decrease for all categories. AIDS rates, after a decrease for both categories, PDU and drug treatment demanders in 2014, a significant increase is observed in 2015. In 2016, however, AIDS prevalence rates decreased again for both categories.

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

YEAR	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Self-reported HCV rate in drug users (RELIS)	25	46	49	64.55	64.94	64.95	64.06	63.39	50.55	49.61	61.45	54.19	61.71	61.49	56.13	51.77
HCV rate in PDU (Origer & Removille)	/	/	/	/	71.40	/	/	/	/	/	/	/	/	/	/	/
Self-reported HCV rate in drug treatment demanders	29	53	54	66.16	66.22	63.23	63.08	61.11	53.79	50.47	62.31	60.27	67.24	66.39	63.52	54.46
HCV rate in IDU prisoners (saliva tests)	37	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Self-reported HCV rate in IDU (RELIS)	45	53	53	74.14	74.38	69.58	72.02	65.48	58.94	62.63	74.81	74.21	77.78	76.61	73.86	69.69
HCV rate in ever-injectors (Origer & Removille)	/	/	/	/	81	/	/	/	/	/	/	/	/	/	/	/

Source: RELIS 2017 (Origer & Removille 2007)

Summarily, HCV prevalence in PDU show fair variations. After a marked decrease in 2009 and 2010, and later in 2012, it reached 61.7% in 2013, and remained stable in 2014, at 61.5%. In 2015 and 2016, however, a slight decrease can be observed for HCV prevalence in PDU, translating a high level stabilisation



OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

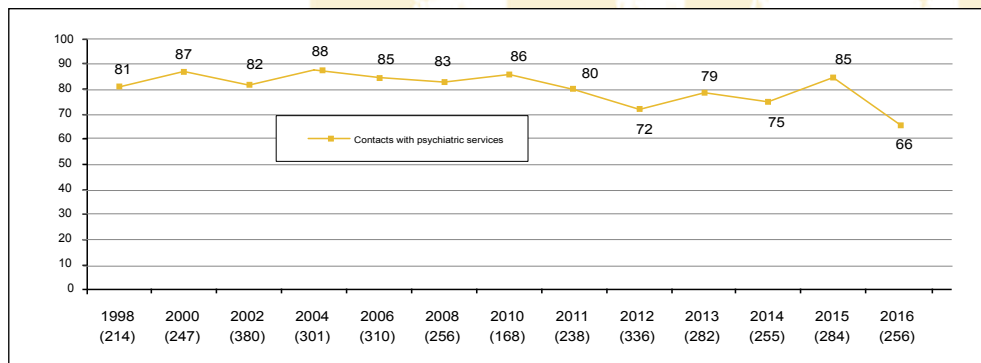
Psychiatric co-morbidity (Dual diagnosis)

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.

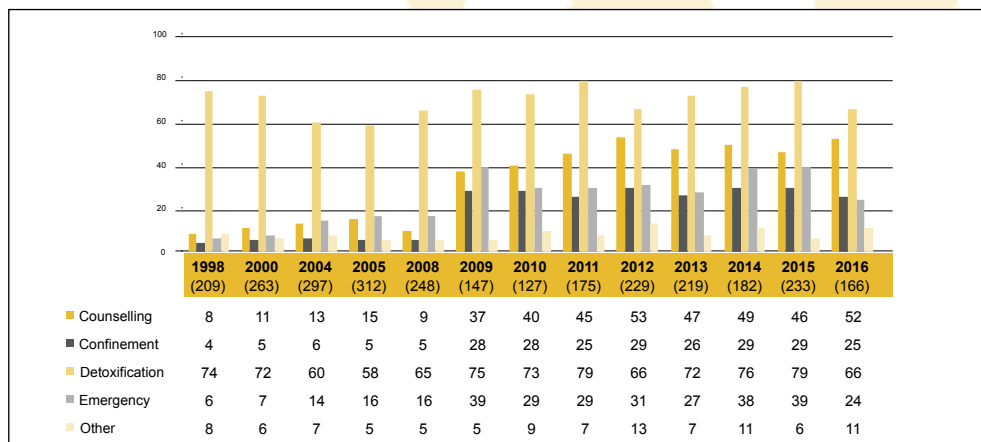
According to annual data provided by the national drug monitoring system RELIS the following picture can be drawn:

Fig. 6.3 Previous contacts with psychiatric services of RELIS indexed drug users. 1998- 2016



Source: RELIS 2017

Fig 6.4 Reasons for psychiatric care demands 1996-2016



Source: RELIS 2017

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

Data from 1996 to 2011 reveal a fluctuating but fairly stable long term proportion of PDU showing a psychiatric history, reaching, however, an historical minimum in 2012 to increase again in 2013 and 2015. In 2016 however, a significant decrease of the contacts with psychiatric services can be observed, reaching a new historical minimum.

No significant differences of psychiatric profiles in clients according to the type of institutional settings.

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.

Somatic co-morbidity

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDU except for HCV prevalence. In 2016, 87 (77) per cent of problem drug users reported a self-perceived satisfying general health condition against 53% in 1997. 74% (56%) report no non-fatal overdose(s) during lifetime which represents an increase compared with the previous year.

Pregnancies and children born to drug users

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



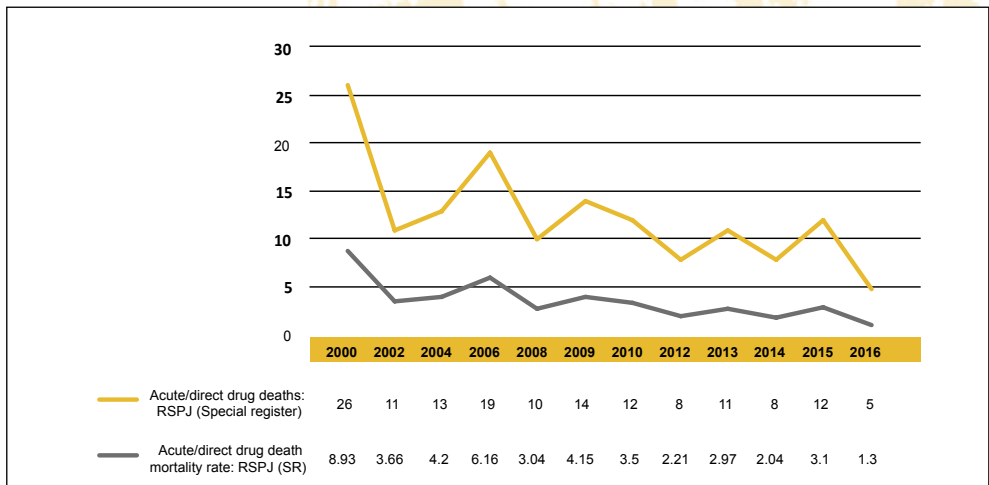
DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

Direct drug-related overdose deaths

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'.

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 5 cases were reported in 2016

Fig 6.5: Evolution of drug-related death cases and mortality rates per 100,000 inhabitants aged 15 to 64 from 2000 to 2016



Source: Origer 2017

Confronted to most recent national prevalence figures on problem drug users referring to data of 2009 ($N = 2,070$), (Origer, 2012), **overdose rate in PDU** situates at 0.24 % cases / PDU (1.1 % in 2000). The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants⁶¹ in 2000. In 2016, overdose rates of 0.9 and 1.3 per 100,000 inhabitants and 100,000 inhabitants aged 15 to 64 years respectively have been observed.

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 the number of direct drug-related deaths is to be associated to the implementation of the first national drug consumption room in 2005. Considering that since the opening in 2005 of the drugs injection room more than 2,100 overdose victims could be assisted and reanimated in this same facility, the life-saving effectiveness of such an offer is given.

61 All age groups

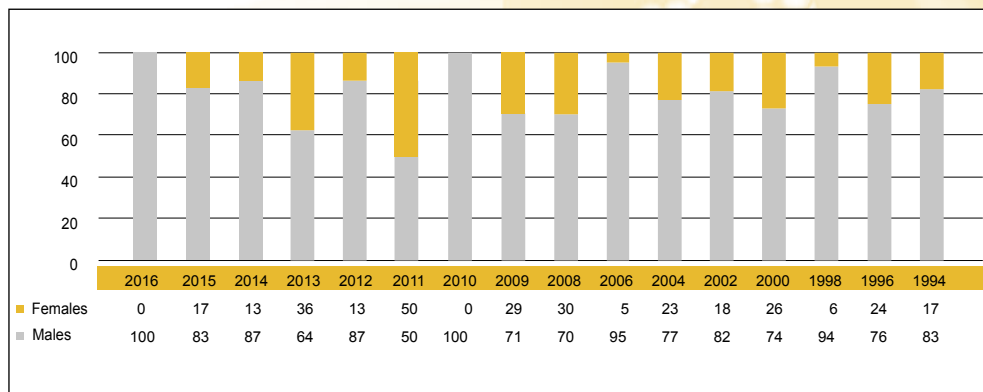
A retrospective study (1992-2006) on drug-related death cases performed in 2007 allowed a better understanding of risk and protective factors (Origer, 2008).

Forensic data by the department of National Toxicology Laboratory on Health⁶² show that the most frequently involved substance in overdose cases is heroin, followed by methadone and cocaine. To stress that since 2000, the presence of methadone in blood samples of overdose victims has been increasing.

All the victims are male and their mean age at the moment of death shows an increase over the past 20 years (in 1992: 28.4 years and in 2016: 41.1 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years has been remaining relatively unchanged during the referred observation period (0 case in 2016).

Also worth mentioning is that a majority of acute drug death victims are known by law enforcement agencies (80%). As far as the place of death is concerned, since 2004 approximately 50-65% occurred at the victims' home, followed by public places such as cars, trains or public bath rooms.

Fig. 6.6: Gender distribution of direct drug-related death cases (1994 - 2016) (%)



Source: RELIS 2017

Table 6.5: Age distribution of direct drug death cases indexed from 1992 to 2016

	2016	2015	2014	2013	2012	2011	2009	2008	2006	2004	2002	2000	1998	1996	1994	1992	Total
< 20	0	0	1			1	2		1			1		1	3		20
20-24	0	0					2	2	4	1	4	8	2	5	6	6	66
25-29	1	4			2	3	3	2	4	4	1	6	5	5	13	6	98
30-34	1	1	3	5	2		2	1	2	3	3	6	2	4	6	3	71
35-39	0	3	2	1			2	3	5	2	1	4	4	1	1		47
40-44	0	3		4	2	1	2	2	2	2		1	3			1	36
45-49	1	0	1		2	1	1			1	2	1				1	15
≥ 50	2	1	1	1					1					1			8
Mean Age	41.09	36.8	37.7	36.9	37.7	31.5	30.3	33.16	32.5	32.17	31.18	29	32.3	28.5	26.8	28.4	361
Male	41.09	36.3	40.35	39	38.3	33.6	32Y5M	32Y8M									
Female	na	39.5	19.74	33.2	34	29.3	25	33Y8M									

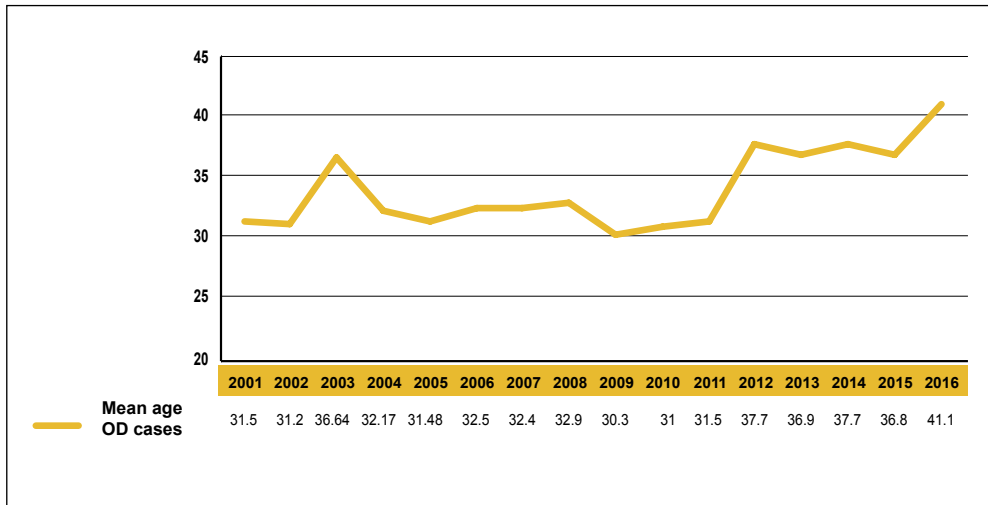
Source: RELIS 2017

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In 2012, the mean age of male overdose victims showed an important increase compared to previous years. In 2016 the mean age of male overdose victims shows again an important increase (41 years) following a 3-years stabilisation period. The youngest victim in 2016 was aged 25 years (26 years in 2015) and the oldest was 51 years (62 years in 2015). No underage victim was reported in 2016. Considering the nationality of overdose victims, the majority (60%) were natives.

Fig. 6.7: Mean age of acute drug overdose victims (2001-2016)



Source: RELIS 2017

Mortality and causes of deaths among drug users

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.

Recent peer reviewed research on fatal drug overdoses (2013-2015) - Abstracts

Origer A, Le Bihan E, Baumann M. (2015). A Social Gradient in Fatal Opioids and Cocaine Related Overdoses? *PLoS ONE* 10(5): e0125568.

Abstract

Background: To determine the existence of a social gradient in fatal overdose cases related to non-prescribed opioids and cocaine use, recorded in Luxembourg between 1994 and 2011. **Methods:** Overdose cases were individually matched with four controls in a nested case-control study design, according to sex, year of birth, drug administration route and duration of drug use. The study sample, composed of 272 cases and 1,056 controls, was stratified according to a Social Inequality Accumulation Score (SIAS), based on educational attainment, employment, income, financial situation of subjects and the professional status of their father or legal guardian. Least squares linear regression analysis on overdose mortality rates and ridit scores were applied to determine the Relative Index of Inequality (RII) of the study sample. **Results:** A negative linear relationship between the overdose mortality rate and the relative socioeconomic position was observed. We found a difference in mortality of 29.22 overdose deaths per 100 drug users in the lowest socioeconomic group compared to the most advantaged group. In terms of the Relative Inequality Index, the overdose mortality rate of opioid and cocaine users with lowest socioeconomic profiles was 9.88 times as high as that of their peers from the highest socioeconomic group (95% CI 6.49–13.26). **Conclusions:** Our findings suggest the existence of a marked social gradient in opioids and cocaine related overdose fatalities. Harm reduction services should integrate socially supportive offers, not only because of their general aim of social (re)integration but crucially in order to meet their most important objective, that is to reduce drug-related mortality.

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Origer A, Le Bihan E, Baumann M. Social and economic inequalities in fatal opiate and cocaine related overdoses in Luxembourg: A case-control study. *Int J Drug Pol* 2014. **25:**911-915.

Abstract

Background: To investigate social and economic inequalities in fatal overdose cases related to opioid and cocaine use, recorded in Luxembourg between 1994 and 2011. **Methods:** Cross-examination of national data from law enforcement and drug use surveillance sources and of forensic evidence in a nested case-control study design. Overdose cases were individually matched with four controls, when available, according to sex, year of birth, drug administration route and duration of drug use. 272 cases vs 1056 controls were analysed. Conditional logistic regression analysis was performed to assess the respective impact of a series of socioeconomic variables. **Results:** Being professionally active [OR = 0.66 (95% CI 0.45–0.99)], reporting salary as main legal income source [OR = 0.42 (95% CI 0.26–0.67)] and education attainment higher than primary school [OR = 0.50 (95% CI 0.34–0.73)] revealed to be protective factors, whereas the professional status of the father or legal guardian of victims was not significantly associated to fatal overdoses. **Conclusions:** Socioeconomic inequalities in drug users impact on the occurrence of fatal overdoses. Compared to their peers, users of illicit drugs with lower socioeconomic profiles show increased odds of dying from overdose. However, actual and self-referred socioeconomic characteristics of drug users, such as educational attainment and employment, may have a greater predictive value of overdose mortality than the parental socioeconomic status. Education, vocational training and socio-professional reintegration should be part of drug-related mortality prevention policies.

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Origer A, Lopes da Costa S, Baumann M. Opiate and cocaine related fatal overdoses in Luxembourg from 1985 to 2011: A study on gender differences. Origer A, Lopes da Costa S, Baumann M. *Eur Addict Res*. 2014;20(2):87-93. DOI: 10.1159/000355170

Abstract

Background/Aim: We analysed gender differences in national fatal overdose (FOD) cases related to opiates and cocaine use between 1985 and 2011 (n = 340). **Methods:** Cross-examination of national data from law enforcement and drug use surveillance sources and of forensic evidence. Bivariate and logistic regression analysis of male/female differences according to sociodemographics, forensic evidence and drug use trajectories. **Results:** The burden of deaths caused by FOD on the general national mortality was higher for men (PMR/100 = 0.55) compared with women (PMR/100 = 0.34). Compared with their male peers, women were younger at the time of death (t = 3.274; p = 0.001) and showed shorter drug use careers (t = 2.228; p = 0.028). Heroin use was recorded more frequently in first drug offences of female victims (AOR = 6.59; 95% CI 2.97-14.63) and according to forensic evidence, psychotropic prescription drugs were detected to a higher



degree in females (AOR = 2.019; 95% CI 1.065-3.827). **Conclusion:** The time window between the onset of illicit drug use and its fatal outcome revealed to be shorter for women versus men included in our study. Early intervention in female drug users, routine involvement of first-line healthcare providers and increased attention to use of poly- and psychotropic prescription drugs might contribute to prevent premature drug-related death and reduce gender differences.

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Origer A., Bucki B., Baumann M. Socioeconomic inequalities in fatal opiate and cocaine related overdoses: transgenerational baggage versus individual attainments. 28th Conference of the EHPs "Beyond prevention and intervention: increasing well-being", 26th – 30th August, 2014, Innsbruck, Austria.

Abstract

Background: To determine socioeconomic inequalities in opioid and cocaine related Fatal OverDose (FOD) cases and their implications in terms of prevention. **Methods** Cross-examination of healthcare and forensic data in a nested case-control study design. FOD cases (272) were individually matched with 4 controls (1,056), according to sex, year of birth, drug administration route, duration of drug use and compared through conditional logistic regression. **Findings** Employment [OR=0.662(95% CI 0.446–0.985)], legal salary as main income [OR=0.417(95% CI 0.258–0.674)] and educational attainment higher than primary school [OR=0.501(95% CI 0.344-0.729)] revealed to be protective, whereas parental professional status was not associated to FOD. **Discussion** Among peers, drug users with lower socioeconomic profiles show increased odds of FOD. However, self-referred socioeconomic characteristics, impacting on daily life quality, such as education, employment and revenue, were more predictive of FOD than transgenerational factors (e.g. parental social status). Thus, motivational interventions fostering socio-professional integration should be given due attention in dedicated harm prevention policies.

Origer A, Baumann M. Suicide attempts prior to fatal drug overdose in Luxembourg from 1994 to 2011. 21st World Congress Social Psychiatry, 29 June- 3 July 2013, Lisbon, Portugal, Volume: The bio-psycho-social model: The future of psychiatry.

Abstract

Purpose. To assess the prevalence of lifetime suicide attempts in opiate and cocaine related Fatal OverDose (FOD) cases and to analyze associations between suicide attempts and demographic, socio-economic and substance use profiles of FOD victims. **Objectives.** The findings of the present study may inspire care providers to pay increased attention to factors influencing suicidal behavior in the context of substance use. **Methods.** Triangulation of multi-setting data. Bivariate statistical analysis and logistic regression analysis. **Results.** In terms of lifetime prevalence, 16.8% of FOD victims reported a single suicide attempt, 37% multiple attempts and 46.2% declared none. After adjustment for sex and age, FOD victims who showed one or more lifetime suicide attempts were more likely to have experienced non-fatal overdoses [AOR = 5.755 (95% CI 1.633 – 20.278), $p=0.006$] and (licit or illicit) substance abuse of one or both parents [AOR = 2.859 (95% CI 1.250 – 6.539), $p=0.013$]. The greater likelihood of unmarried FOD victims to witness suicide attempts observed in bivariate analysis ($X^2:4.573$; $p=0.038$), compared with married decedents, was no longer observed after sex-age adjustment. **Conclusion.** Suicide attempts are frequent in fatal drug overdose victims and a strong association has been observed between the former and the frequency of non-fatal overdoses experienced by decedents included in our sample. Family contexts may be at stake when it comes to explain the likelihood of suicide attempts in victims of fatal drug overdose and increased attention should be paid to family histories in the prevention of drug overdoses and suicide, and the link between both.

Origer A, Baumann M. Opiate and cocaine related Fatal Overdoses in Luxembourg from 1985 to 2011: a time-stratified study. 21th IUHPE World Conference on Health Promotion. 25-29th August 2013, Pattaya, Thailand, Volume: Health Issues and Populations in Health Promotion.

Abstract

Objective. To describe trends in the national prevalence of Fatal OverDose (FOD) cases related to opiates and cocaine use between 1985 and 2011. To analyze male/female differences in FOD victims according to various time periods. **Methods.** Triangulation of multisource data, stratified according to 3 successive time periods. Statistical analysis of male/female differences according to socio-demographic and forensic data as well as drug use trajectories was performed. **Results.** National FOD prevalence has been decreasing from the beginning of this century to reach a historically low rate of 1.71 cases/100,000 inhabitants in 2011. The burden of deaths caused by FOD on the general national mortality showed to be higher for men compared with women. Furthermore, the pathways towards a FOD revealed to be different for male and female victims referred to various aspects including age of decedents, criminal records, drug use trajectories, drug use patterns and the involvement of psychotropic prescription drugs. **Conclusions.** The time window for intervention between the onset of drug use and its potential fatal outcome might be shorter for women compared with men. Early intervention in female drug users and increased attention to poly and psychotropic prescription drugs use should be considered in health promotion programmes to accelerate access to appropriate treatment, if required, and eventually contribute to prevent premature death and reduce gender inequalities.



7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

INTRODUCTION

Responses to health correlates and consequences of drug use aim at minimising risk and 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 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.

At present, national drugs action plans, the national HIV/AIDS action plans (downloadable at <http://www.ms.etat.lu>), and a national action plan on hepatitis exist or are being elaborated.

As far as availability of service is concerned, currently two national 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 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 are ongoing. A new harm reduction service has opened in the North of the country in February 2014.

Moreover, a new centre is currently under construction in the city of Esch/Alzette (i.e. in the South of Luxembourg). The centre will include the second national supervised drug consumption room offering the possibility of supervised drug injections and inhalation. The concept also includes medical and psychosocial care and referral to specialised services.

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

Research and recommendations

Research on drug-related deaths has been further developed and resulted in peer reviewed international publications and presentations at international conferences:

Origer A, Lopes da Costa S, Baumann M. Opiate and cocaine related fatal overdoses in Luxembourg from 1985 to 2011: A study on gender differences. *Eur Addict Res.* 2014;20(2):87-93. DOI: 10.1159/000355170

Origer A, Baumann M. Opiate and cocaine related Fatal Overdoses in Luxembourg from 1985 to 2011: a time-stratified study. 21th IUHPE World Conference on Health Promotion. 25-29th August 2013, Pattaya, Thailand, Volume: Health Issues and Populations in Health Promotion.

Origer A, Baumann M. Suicide attempts prior to fatal drug overdose in Luxembourg from 1994 to 2011. 21st World Congress Social Psychiatry, 29 June- 3 July 2013, Lisbon, Portugal, Volume: The bio-psycho-social model: The future of psychiatry.

Origer A, Bucki B, Baumann, M. Socioeconomic inequalities in fatal opiate and cocaine related overdoses: transgenerational baggage versus individual attainments. 28th Conference of the EHPS "Beyond prevention and intervention: increasing well-being", 26th – 30th August, 2014, Innsbrück, Austria.

Origer A, Le Bihan E, Baumann M. Social and economic inequalities in fatal opiate and cocaine related overdoses in Luxembourg: A case-control study. *Int J Drug Pol* 2014. 25:911-915. DOI: 10.1016/j.drugpo.2014.05.015

Origer A, Le Bihan E, Baumann M (2015) A Social Gradient in Fatal Opioids and Cocaine Related Overdoses? *PLoS ONE* 10(5): e0125568. doi:10.1371/journal.pone.0125568

Drug injection rooms 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 (ABRIGADO) 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 ABRIGADO centre which from then on has been providing the entire range of harm reduction services, counselling facilities, accommodation, washing and laundering facilities. It should be added that the night accommodation offer 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, nuisances' reduction being a secondary objective. 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 overnight. 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, literature 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' statistics of the ABRIGADO services since their opening and for 2009 to 2016, respectively:



Table 7.1: Clients statistics of ABRIGADO centre services (2005-2016)

Injection Room	June 2005 - December 2016	2009	2010	2011	2012	2013	2014	2015	2016
Number of user contracts signed	1,717	94	108	98	222	139	142	108	112
Number of users episodes	363,509	36,558	33,017	26,929	37,004	38,633	40,012	49,120	57,333
Number of injections	415,120	43,871	39,960	31,588	40,234	40,610	42,644	56,178	67,083
Number of non-fatal overdoses	2,059	198	327	283	313	378	226	79	69
<i>With loss of consciousness</i>	334	54	42	33	37	54	32	20	29
<i>Without loss of consciousness</i>	1,725	144	285	250	276	324	194	59	40
Number of fatal overdoses	0	0	0	0	0	0	0	0	0
Medical emergency interventions	343	46	33	31	43	42	37	31	38
Day care	December 2003 - December 2016	2009	2010	2011	2012	2013	2014	2015	2016
Number of clients	647,439	77,333	65,307	62,925	55,622	55,575	59,700	60,144	65,753
Night shelter	December 2003 - December 2016								
Number of different clients with overnight stay	2,938								

Source: Abrigado 2017

In January 2012, Abrigado moved into new premises and since February 2012 a blowroom has completed the existing offer. Currently the night shelter is open 7 days a week from 22:00 to 07:30 with a capacity of 42 beds. The ABRIGADO day centre, the injection room (8 injection tables) and the blowing room (6 tables) are open 7 days a week. ABRIGADO facilities are mostly used by men (85%); the most commonly used drugs were heroin (78%), cocaine (15%) or both of them (7%). Cocaine use has obviously decreased in 2011 and 2012, to stabilise in 2013 and 2014. In 2015 and 2016, however, an increase of cocaine use can be observed (2014: 6%, 2015: 13%, 2016: 15%). Concerning the administration mode, 57% of intravenous injections, 41% of smoking and 2% of snorting were reported in 2016. Age category 35-44 years (52%) is most representative.

No fatal overdose has occurred within ABRIGADO facilities until the end of 2016 whereas over 2,100 overdoses episodes 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 lives saved. A new centre was opened in the beginning of 2012. Its implementation site is the immediate vicinity of the previous centre. Architectural planning of the replacement structure has built upon past experience and a supervised drug inhalation facility (blowroom) was included in the existing offer in 2012. 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 consumption room) also in the city of Esch-sur-Alzette. Its opening is scheduled for 2018. The centre will include the second supervised drug consumption room nationally offering the possibility of supervised drug injections and inhalation. The concept also includes medical and psychosocial care and referral to specialised services.

As far as the northern region of the country is concerned, a needs' assessment, commissioned by the Ministry of Health, (JDH, 2011) clearly emphasised 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 has been reported to be more prevalent than IDU. 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. A new low threshold day centre, called Contact-Nord, opened its doors in Ettelbrück in February 2014. The Contact-Nord covers three main activity fields: health and hygiene services, social and psychological assistance and needle exchange programme.

In order to address the increased incidence of HIV in mostly marginalised IDU a new mobile outreach offer, specifically designed for drug users (MOPUD), has been launched in September 2017.

Complementary prevention and harm reduction measures have been and will be included in the upcoming HIV and viral hepatitis national action plans.

Heroin assisted treatment (HAT)

The implementation of heroin assisted treatment (HAT), as foreseen by the national **drug action plan 2015-2019**, occurred in 2017. It should be underlined that the HAT has not been designed as a low threshold measure. It has been implemented in the broader framework of the national drug substitution treatment strategy with clearly defined medical and psycho-social components and is currently provided in an institutional setting.

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. 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.

HAT, operational since June 2017, is currently in its pilot phase under the responsibility of the Directorate of Health and run by the foundation JDH as an extension of the national OST offer.

Moreover, in the framework of the decentralisation of specialised care and harm reduction offers, the creation of a second low-threshold centre in the South of the country is in process. This second harm reduction facility should become operational in 2018 and will include supervised consumption rooms (injection and blow rooms) similar to those of *Abrigado* in Luxembourg-City.



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 inclusion of a drug inhalation facility in the ABRIGADO centre is a sound example of the national approach. Furthermore infectious diseases prevention should not focus exclusively on IDU as shows a recent action-research project on HIV and hepatitis infection among PDU (Origer A and Schmit JC, 2010).

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 four different cities of the Grand Duchy.

Regarding the quantity of distributed syringes, table 7.2 shows that the number of distributed syringes peaked in 2005 and has been significantly decreasing from 2006 onwards, although the return rate remained consistently high. From 2011 onwards quantities of syringes distributed through NEP have been decreasing to increase again since 2014. The number of re-collected used syringes exceeded in 2009 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. From 2010 to 2016, the number of collected used syringes has been ranging between 80-97%.

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.

Table 7.2: National needle exchange programme (NEP) 1996-2016 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 (97%)
2011	246,858 of which 35,761 via injection room and 5,169 via vending machines	221,975 (90%)
2012	211,439 of which 29,362 via injection room and 1,336 via vending machines	201,510 (95%)
2013	190,257 of which 23,631 via injection room and 1,127 via vending machines	177,790 (94%)
2014	250,552 of which 24,256 via injection room and 358 via vending machines	235,542 (94%)
2015	359,340 of which 33,633 via injection room and 245 via vending machines	334,881 (93%)
2016	423,060 of which 45,449 via injection room	397,405 (94%)

Source: RELIS 2017

A syringe and needle exchange programme has started in the national prison (CPL) in August 2005. Inmates are seen by medical staff on request 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 program is placed under medical secret.

Table 7.3 Needle exchange programme (NEP) in prison (CPL) 2005-2016

	Distributed injection kits	Distributed syringes
08/2005 – 12/2006	64	300
2007	24	77
2008	36	178
2009	33	261
2010	34	328
2011	30	440
2012	48	1,383
2013	31	1,726
2014	46	2,101
2015	40	1,807
2016	31	1,612

Source: CPL 2017

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, who introduced nationwide distribution of low dead space syringes in 2014 in order to further reduce the spread of blood-borne infectious diseases via injecting drug use.



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 PDUs and IDU based on medical diagnosis data (blood testing) and to recommend the implementation of 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 builds 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 articles have been published in peer-reviewed journals since then.

Counselling and testing

The national HIV/AIDS action plan proposed the implementation of two new free testing sites in the North and the South of the country, thus regionalising free testing opportunities.

In the framework of the national HIV/AIDS action plan 2006-2010 a mobile intervention facility for sexual health promotion (DIMPS) has been set up jointly by the Ministry of Health, HIVBerödung (RED CROSS) and the CHL. DIMPS may be described as an outreach offer for specific target populations and vulnerable groups aiming to access difficult-to-reach populations and provide prevention counselling and infectious disease testing on site. The project, started in May 2009, provides free rapid testing of HIV and hepatitis and outreach counselling targeting among others drug users, sex workers and asylum seekers. In 2016, 788 counselling episodes have been reported by involving a total of 257 clients.

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 of infectious diseases. In case the patient has no or no valid health insurance, treatment costs may be covered by state.

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.

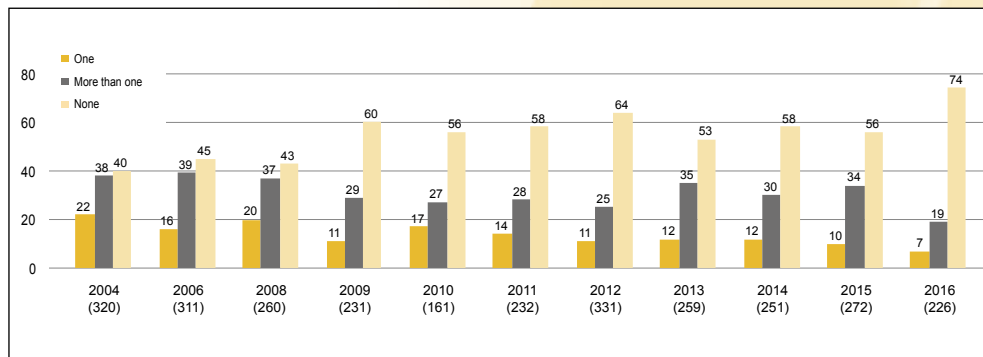
The vast majority of specialised out- and inpatient and low threshold drug care facilities include medical or paramedical care in their service provision. If needed, patients are referred to specialised treatment. Related costs are covered by health insurance schemes or by the Ministry of Health in case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

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

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) have stabilised in recent years and decreased in 2016. 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 2,100).

Fig. 7.1: Non fatal drug overdoses in RELIS respondents (2004-2016) (valid %)



Source: RELIS 2017

Prevention and reduction of road traffic 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 has been regulated by a grand-ducal decree of November 18, 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 context and promotes coordination and collaboration between different social and medical services.

Due to the improvement of, and the better access to drug-related treatment and especially the spread of substitution treatment, the birth rate in drug users has increased over recent years. 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).

The national drugs action plan 2015-2019 further focusses on new measures oriented towards pregnant drug using women and children of drug using parents.



8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

INTRODUCTION

Social correlates of drug use involve Justice, Health and Educational competences. The Ministry of Health and the Ministry of Family and of Integration both intervene by financing measures to reduce social consequences ranging from early detection of drug use to social-professional rehabilitation interventions. The reduction of drug-related crime drug supply involves the Ministry of Justice and the Ministry of Internal Security. The Ministry of Health implements besides treatment and specialised counselling offers, various measures targeting socio-professional re-integration 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 unanswered one. 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 Study⁶³. 55% of national respondents (N: 1,610) described drug addicts as most unwanted neighbours. In 1999 drug addicts occupied the second position (43%).

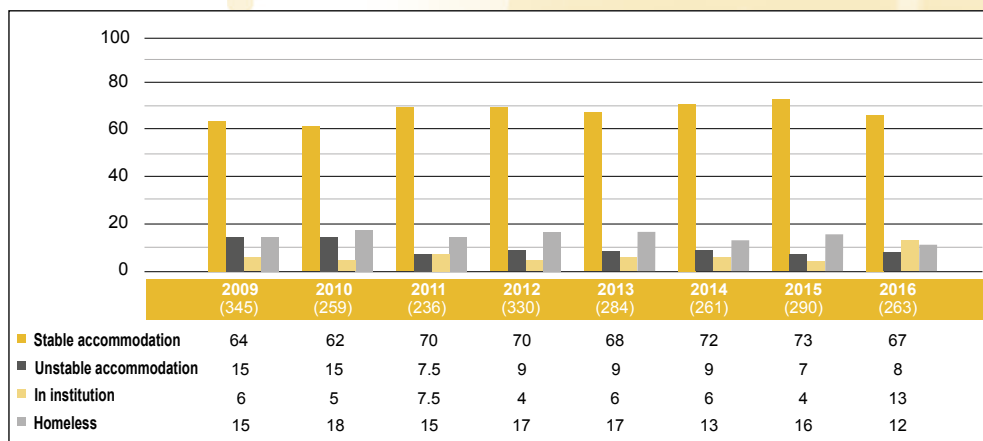
Also, providing medical and psychological care to drug dependent persons is not enough as the social situation of these people needs to be improved before sustained outputs in drug treatment is expectable. This said, the national strategy of care for socially excluded people is based on the principle of progressive reintegration through capacity building and the improvement of the social abilities and environment. Associations as 'Stëmm vun der Strooss' (Street voice) and Quai 57, 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.

63 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

Housing status of registered drug users has markedly improved during recent years and tends to stabilise over the last years. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Currently 67 percent of PDU report a stable housing situation (RELIS 2017). 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. 2009-2016 (% valid)



Source: RELIS 2017

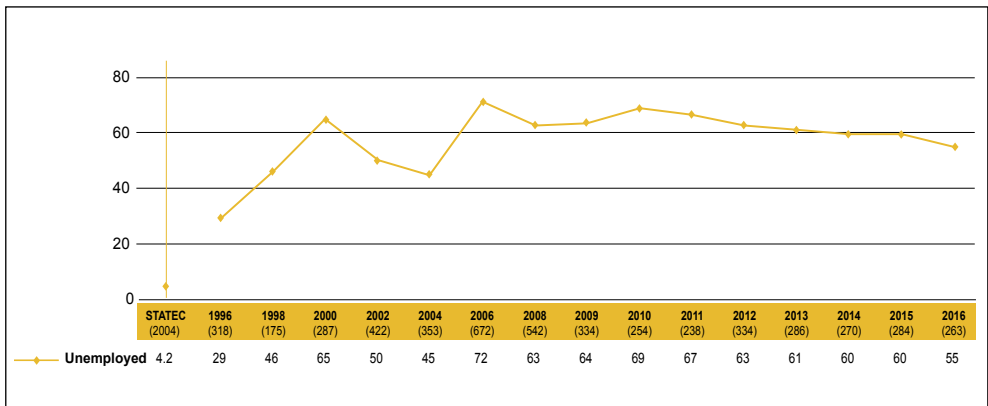
Youngsters aged less than 25 and living in the street are referred to as a quite new phenomenon. Societal changes as the increase of mono parental families, an increased number of divorces, increasing youth jobless rates and the necessity to work for economic reasons for the two partners of a parental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

Unemployment

The **professional inactivity rate** (55%) shows a weak decrease between 2011 and 2016. However, an in-depth analysis shows that the proportion of active respondents reporting a stable job situation (e.g. long term contract; 18%) seems to stabilise around 15-16% over the last years. In 2015, however, an increase of the proportion of active respondents can be observed (18%) to stabilise again around 16% in 2016.



Fig. 8.2 Unemployment rate in problem drug users (1996 - 2016)

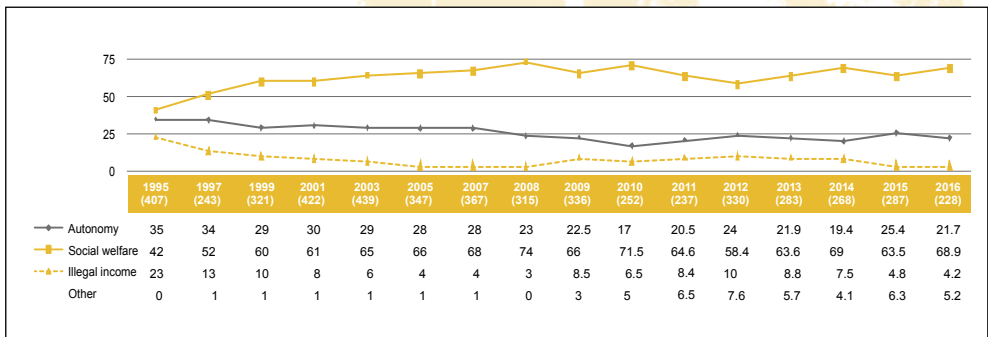


Source: RELIS 2017 Remark: STATEC: Statistical Department of State – Unemployment rate in active general population.

Data on revenues confirm observed trends in occupational status:

- a fairly stable majority of indexed drug users rely on social welfare. The Guaranteed Minimum Income constitutes the primary source of revenue of PDU. 20-25% the latter show **financial autonomy**.
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 2013.

Fig. 8.3 Primary source of income of problem drug users (1995 - 2016)

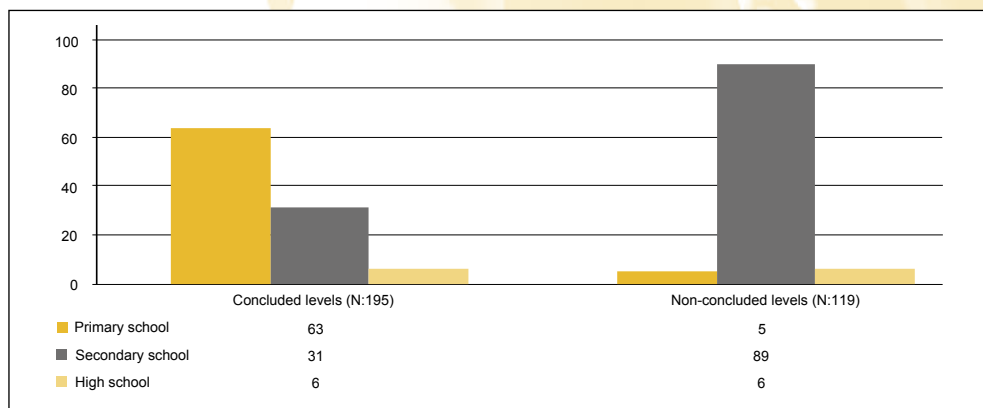


Source: RELIS 2017

School drop out

The study of 'School leave in Luxembourg'⁶⁴ (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 (2016)



Source: RELIS 2017

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. 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 increasing tendency over the last 6 years and currently situates at 18.1 years. Lower levels are particularly observed as regards acquired secondary and high school diploma.

Financial situation

The RMG (Guaranteed Minimum Income; 24%), financial resources from parents (23%) and the proper salary (22%) represent the main income sources of PDU. Between 1997 and 2015, strong variations have been observed in relation with these three revenue sources.

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



Concerning secondary income sources, 25% referred to 'illegal activities'⁶⁵ and 15% were provided money by parents.

In 2014 and 2016, the degree of social dependence shows an increasing tendency (69% in 2016 and 2014 – 63.6% in 2013 – 58.4% in 2012 – 42% in 1995) which correlates with an inverse trend as far as financial autonomy is concerned. period of decrease. However, in 2015, decrease of the proportion users who are provided with financial resources from parents (7%).

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 (ABRIGADO) including day and night shelter offers, accommodation and a supervised drug injection facility.

An offer called 'Les Niches' functions as a social real estate agency for drug addicts. Around 55 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 certain forms of criminality, 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 various municipalities.

The previously referred to NGO Stëmm vun der Strooss also manages around 30 supervised lodgings.

In all programmes, apartments are subcontracted by the NGO/agency 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-

65 Mainly selling of drugs.

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 professional reintegration, a series of residential drug care centres offer 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 led 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 writing 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. For the last years, 2 social workers, 3 educator and 30 clients have been working on average for 312 sports teams. Besides these two main work-opportunities, the service also offers a therapeutic workshop called '*Dressed for success*'. The service has been managed by 2 clients (offering them a job opportunity and responsibility). Their main task was to organise (collect, wash, store, etc.) clothes offered by donors.

An additional occupational offer run by the 'Street voice' ('Stëmm vun der Strooss') association and opened in the beginning of 2014 has been further closing the gap in occupational offers. The residential centre offers temporary accommodation and day jobs for homeless and addicted people in a rural setting.



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

INTRODUCTION

The main source of information for this chapter is the Judicial Police Service (SPJ) in Luxembourg.

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

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

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

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

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

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

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

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

Judgement by which the accused person is found guilty.

- *'Détenation'* (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 processes anonymous nation-wide data on drug-related offences provided by the law enforcement agencies required for the editing of the national report on drugs and to fulfil international data requirements (EMCDDA, UNODC, etc.).

Drug law offences

As can be seen in tables 9.1, the total number of arrests for drug-related offences (217) has increased in 2015 following a 4 years' stabilisation period. Heroin was the most frequent substance involved in drug-related *arrests*. Heroin is the main substance involved in those arrests, followed by cocaine.

Table 9.1 Arrests by type of reporting institution (2001-2016)

Year	ARRESTS												
	2001	2003	2005	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
S.P.J.	7	25	26	49	32	20	15	33	6	11	3	31	16
Police	45	82	94	79	102	92	166	97	119	128	138	165	206
Customs	40	28	35	41	54	33	48	51	44	36	26	21	12
Total	92	135	155	226	188	145	229	181	169	175	167	217	234

Source: RELIS 2017

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP) shows an increasing trend from 2013 onwards while a first decrease has been reported in 2016 (2,624 police records).

From 2003 to 2008, one observes a significant decrease in drug law offenders, but obviously a new increase in 2009 (1,963) and 2010 (2,530). In 2011 and 2012 a decrease is observed as regards the number of drug law offenders (1,782) as well as for the number of arrests (169). In 2016, the number of offenders decreased (2,566 offenders in 2016).

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 2016.

Table 9.2: Number of national law enforcement interventions (1995-2016)

Year	DRUG LAW ENFORCEMENT RECORDS															
	95	97	99	2001	2003	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
S.P.J.	123	137	343	216	239	190	177	110	121	134	165	44	17	9	80	45
Gendarmerie	198	255	782	/	/	/	/	/	/	/	/	/	/	/	/	/
Police ⁶⁶	199	177	189	1,126	1,326	824	998	881	1,465	1,969	1,643	1,526	1,849	2,651	3,192	2,531
Customs ⁶⁷	244	236	173	113	95	186	197	228	328	443	477	232	203	156	113	48
Total	764	805	1,487	1,455	1,660	1,200	1,286	1,219	1,914	2,546	2,225	1,802	2,069	2,816	3,385	2,624

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

67 The original report can be downloaded from: http://www.gouvernement.lu/publications/informations_gouvernementales/rapports_activite/index.html



Year	OFFENDERS															
	95	97	99	2001	2003	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
S.P.J.	152	182	434	321	369	248	203	128	121	131	164	44	17	9	77	44
Gendarmerie	319	335	916	1,272	1,753	1,007	1,160	1,009	1,459	1,960	1,632	1,517	1,846	2,623	3,158	2,481
Police ⁶⁸	371	280	283													
Customs ⁶⁹	421	408	306	182	148	320	324	350	325	439	407	221	200	471	110	41
Total	1,263	1,205	1,939	1,776	2,270	1,575	1,687	1,487	1,963	2,530	2,210	1,782	2,066	2,792	3,345	2,566

Source: Specialised Drug Department of the Judicial Police 2017

The population of drug law offenders is composed of 88% **males**; a proportion that has been varying between 80% and 90% during the past decade. Since 1997, **non-natives** (59% in 2016) have been representing the majority of drug law offenders. In 2010, the percentage of minors among drug law offenders increased (9.2% in 2010). This increase is confirmed by the most recent figures (10% in 2016).

Table 9.3 : Socio demographic data on drug law offenders ('prévenus') (1992-2016)

AGE	1990	1992	1994	1996	1998	2000	2002	2004	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
0-14	7	6	1	3	7	21	15	24	8	11	8	7	26	19	23	14	23	12	28
15-19	179	320	169	270	249	413	647	334	279	318	282	323	484	494	404	431	616	437	562
20-24	383	527	403	447	321	497	650	510	415	480	436	594	677	602	422	545	580	694	634
25-29	278	371	309	304	220	354	388	278	323	321	274	421	551	419	303	363	494	524	407
30-34	124	159	186	191	187	208	219	250	188	216	205	257	318	301	273	319	470	693	362
35-39	27	52	65	80	76	113	177	190	136	162	134	157	233	175	160	181	253	469	245
≥ 40	43	46	21	42	78	108	82	126	181	165	129	189	209	197	181	209	347	516	327
unknown	30	50	20	31	32	44	40	95	43	14	19	15	32	3	16	4	9	0	1
TOTAL	1,071	1,531	1,174	1,368	1,170	1,758	2,218	1,808	1,575	1,687	1,487	1,963	2,530	2,210	1,782	2,066	2,792	3,345	2,566
Male	851	1,248	938	1,138	958	1,415	1,905	1,581	1,319	1,484	1,263	1,645	2,144	1,900	1,562	1,773	2,428	2,906	2,566
Female	220	256	209	173	193	241	292	181	218	190	206	283	367	301	220	286	364	439	300
Gender unknown	0	27	27	57	19	44	21	49	38	13	18	35	19	9	0	7	0	0	0

Source: Specialised Drug Department of the Judicial Police 2017

68 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

69 The original report can be downloaded from: http://www.gouvernement.lu/publications/informations_gouvernementales/rapports_activite/index.html

Table 9.4: Distribution of drug law offenders ('prévenus') according to first offence and underage status (1992-2016)

	1992	1994	1996	1998	2000	2002	2004	2006	2008	2010	2011	2012	2013	2014	2015	2016
First offenders	697	382	508	422	608	828	585	471	546	949	913	720	854	1,066	1,069	938
Offenders underage	96	57	102	79	154	145	103	72	83	178	141	145	171	237	104	182
TOTAL (Prévenus')	1,531	1,174	1,368	1,170	1,758	2,218	1,808	1,575	1,487	2,530	2,210	1,782	2,066	2,792	3,345	2,566

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2017

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 2016:

- 74% of drug users indexed⁷⁰ by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime.
- 49% of the total PDU population show multiple law enforcement contacts (increase).
- The proportion of records for other reasons than presumed offences against the drug law (e.g. **petty crime** such as criminality linked to drug supply) has been decreasing since 1997 (38%) and has been fairly stable in recent years, except for 2010, where data on 'interpellations' for other reasons reported an important increase (2006: 34%, 2009: 35%, 2010: 65%). After 2010, the proportion of records for other reasons decreased (2012: 59%, 2013: 53% 2014: 55% and 2016: 50). In 2015, however, an important increase of the proportion of records for other reasons can be observed.
- 63% (69%) 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%) shows a slight decrease, after an increase over the last years.

PREVENTION OF DRUG-RELATED CRIME

The involvement of major cities in the management of drug-related problems and nuisances is developing. So-called municipal 'prevention committees' that include local authorities, police forces and specialised NGOs are in place in major cities. The setup of national drug consumption room also enhanced the involvement of municipal authorities. The Ministry of Health created a management group that is mandated to follow up developments with regard to the consumption rooms and to react promptly to emerging problems. The national drug action plan clearly emphasises the importance of a collaborative 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 **IMPULS** project (IMPULS - Aide aux jeunes consommateurs de drogues - Solidarité Jeunes a.s.b.l.) is financed by the Ministry of Health and intervenes in case a minor of age and youngsters have 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.

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



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 9.5: Clients core statistics IMPULS 2000 – 2016

		2000	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of episodes (n)		132	208	231	267	249	322	352	357	432	461	416	489	490	574	695	571
Referral from the criminal Justice system		41.4	44.2	37.2			46.2	44.4	43.4	44.1	50.8	49.7	46.3	47.3	60.2	53.3	51.2
Gender distribution (%)	Female	34.1	34.1	31.6	31.9	31.3	30.1	24.4	30.5	24.3	29.4	29.8	33.1	30	26.75	22.54	21.8
	Male	65.9	65.9	68.4	68.1	68.7	69.9	75.6	69.5	75.7	70.6	70.2	66.9	70	73.25	77.46	78.2
Age distribution (%)	< 14			9.5	4.9	2.0	4.7	4.6	5.9	4.6	4.6	5.3	3.5	4.4	4.6	3.2	3.7
	14-15			38.1	30.0	22.9	27.9	25.6	24.9	25.8	29.8	30.1	26.9	26.5	28.4	24.5	29.6
	16-17			39.8	46.4	43.4	46.9	46.6	50.4	52.4	47.5	46.4	49	53.6	42.9	42.1	41.4
	> 17			12.6	18.7	20.5	16.5	18.5	15.9	17.2	18.1	18.2	20.6	15.6	24.1	30.2	25.3
	Unknown					11.2	4.0	4.7	2.9	0	0	0	0	0	0	0	0
Main substance involved (%)	Cannabis			83.1	72.3	71.5	73.3	67.7	69.4	72.8	74.2	73.8	76.8	81.4	78.7	78.6	88.99
	Heroin			3.5	4.5	5.6	3.7	2.5	1.7	1.6	1.1	0.3	0.8	0.0	0.0	0.5	0.52
	XTC/Cocaine			1.3	2.2	0.4	1.6	1.1	0.6	0.9	0.8	1.0	0.4	0.2	1.3	5.3	9.55
	Legal drugs			2.6	3.0	2.4	3.1	5.1	7.8	6.2	5.4	8.2	9.9	4.4	4.8	18.3	1.9
	Polydrug			d.m.	1.9	3.2	3.7	5.4	4.5	5.8	5.1	5.3	3.6	0.0	4.6	65.5	66.4
	Other			1.3	3.3	2.0	2.5	2.5	1.7	1.1	1.2	0.6	1.8	0.8	2.7	1.13	
	None			8.2	10.6	10.4	10.2	9.6	8.7	6.1	9.7	7.3	7.2	5.5	4.6	3.38	3.99
	Unknown			0.0	2.2	3.7	2.5	6.1	4.8	4.9	2.6	2.9	0.7	6.7	5.2	0.16	0.81

Source: IMPULS - Aide aux jeunes consommateurs de drogues (Solidarité Jeunes a.s.b.l.), 2017

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.

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 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
- who are socially integrated and residing in Luxembourg
- who were working or undergoing training

DRUG USE AND PROBLEM DRUG USE IN PRISONS

The 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 9.6: Number of general admissions and the number of admissions according to drug-related convictions (DELIT 'STUP') in national prisons from 1989 to 2016.

YEAR	89	90	92	94	96	98	2000	2002	2004	2006	2008	2010	2012	2013	2014	2015	2016
New entries (Total)					685	796	767	794	1.078	1.043	990	927	950	818	904	951	962
New "STUP" entries	163	244	157	288	292 42.6%	167 21%	161 21%	101 12.7%	92 8.5%	243 23.3%	332 33.5%	232 25.02%	306 32.21%	226 27.63%	223 24.67%	240 25.24%	306 31.81%

Source: CPL, CPG. 2017

Drug treatment in prison

Following the law of 27 July 1997 concerning the modification of the penitentiary organisation⁷¹, a pilot project named 'Global Drug Care Programme in Prison' (2000-2005 – TOX project) was set up by a group of experts assigned by the Ministry of Justice in 1999. The concept was designed to implement, among other objectives primary prevention measures in regard to drug consumption and infectious diseases. The overall aim of the project was to integrate drug dependant inmates into a medico-psycho-social drug care network in order to reduce recidivism, risks and criminality after release from prison. The implementation of the project had to be adapted to the two different prison settings. Joint financing by the Ministry of Justice, the National Fund against drug trafficking and the EU (regarding evaluation) was ensured.

71 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.



The TOX programme 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 conventions national hospital to ensure psychitric care and 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.

Opioid substitution treatment is also provided in prison. The nursery and MDs are in charge of OST within prison. More detailed figures on this type of treatment can be found in respective sections. 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 15% of adult inmates who entered CPL and 13% of inmates who entered CPG in 2016 received drug substitution treatment, representing a total of 205 persons.

Table 9.7: Number of prisoners receiving opioid substitution treatment (2016)

YEAR	2016	
	CPL	CPG
Methodone	155	17
Subutex®	2 (SUBUTEX + METHADONE) / 22 (SUBUTEX only)	0 (SUBUTEX + METHADONE) / 11 (SUBUTEX only)
Total (persons)	177	28

Source: Comité de Surveillance SIDA: Activity report 2017

The average dose of distributed methadone was 23 mg per day (minimal dose 2.5mg and maximal dose 75mg). The average period of treatment was 146 days.

Of clients in treatment units in prison, 95.3% (93.7%) are male versus 4.7% (6.3%) of females. The mean age of treatment demanders is 35.23 (35 years and 3 months), whereas the average male age is 35.29 (35Y3M) and the mean age of the female clients is consistently lower (2016: 34Y, 2015: 30Y, 2014: 29Y6M, 2013: 33Y10M, 2012: 29Y6M, 2011: 29Y). Respectively 37% (35%) of clients in treatment are natives versus 63% (65%) of non-natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by Italian citizens.

Regarding the educational level of the clients in treatment, 66% (68%) have completed primary school, 29% (32%) have completed secondary school. 16% (29%) of clients in treatment units in prison experienced one or more overdoses. As far as the sharing of used syringes is concerned, 50% (46%) reported that they never shared syringes during their lifetime (94% during the last month, 2015: 85%, 2014: 95%, 2013: 85%).

Prevention and reduction of drug-related harm

Activities of the previously referred to TOX-programme in prison built upon 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.

The programme is currently part of the RELIS routine data reporting network and first data on treatment demand became available in 2010.



PREVENTION, TREATMENT AND CARE OF INFECTIOUS DISEASES

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

In 2016, approximately 933 (838 in 2015) HIV tests have been carried out in prison. 18 (23 in 2015) tests were positive (16 men and 2 women vs. 19 men and 4 women in 2015), 13 (11 in 2015) co-infections (HIV/HCV) were diagnosed (all were IDU). 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 MD. After counselling, the inmate is handed out a kit containing 2 syringes which may be exchanged at the nursery. As the consumption and possession of drugs are illegal, those inmates in possession with a syringe kit, are exempted from sanctions for detention of injection paraphernalia. In 2016, 31 kits (40 in 2015) have been distributed and 1,612 (1,807) syringes exchanged. The programme is under medical secrecy.

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.

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 (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 flyer addressing measures to be undertaken by witnesses of a drug-related overdose and the genuine legal situation is distributed among PDU in various settings.

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 further 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.



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 increasingly 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. Various groups joined 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.

In the last years, organised crime groups from Western African countries have been developing large-scale cocaine trafficking activities throughout Europe including in Luxembourg. These groups are mostly formed of cellular structures. The key to their effectiveness is their ability to operate independently while drawing on an extensive network of personal contacts. Their number has been steadily increasing in Luxembourg and Police have observed a strong inclination to violence.

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.

Over the last 10 years, purity of cocaine has been generally decreasing and average heroin purity has also been following a discontinuous downward trend.

In terms of seized quantities, important variations have been observed for heroin since 2000. As far as cocaine is concerned, increased quantities have been reported in 2012. The number of seizures also has been showing great variations during the same period, especially for cannabis.

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

AVAILABILITY AND SUPPLY

Perceived availability of drugs

In addition to availability indicators from law enforcement sources, perceived availability of the general public provides further 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.

Table 10.1: Ease of acquisition of drugs in Luxembourg (2002/2004)

QUESTION a: Is it 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%

Source: Flash Eurobarometer (158; 2004), Eurobarometer (57.2; 2002)

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?"

Table 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	

Source: Opinion poll "Young people and drugs among 15-24 years olds" (N°233; 2008)



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 to be difficult than the EU average (34%). 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.

Table 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
LU	Ease of access to cocaine (if desired)					
	22	33	32	9	2	2
EU27	19	28	26	14	8	5
LU	Ease of access to ecstasy (if desired)					
	21	33	31	9	2	4
EU27	20	28	25	14	8	4
LU	Ease of access to cannabis (if desired)					
	12	10	23	27	25	3
EU27	11	13	15	28	29	4
LU	Ease of access to tobacco (if desired)					
		2	2	14	82	
EU27		2	2	14	81	1
LU	Ease of access to alcohol (if desired)					
		3	3	15	79	
EU27		1	2	14	82	1

Source: Flash Eurobarometer N°330

In June 2014, the Eurobarometer study “Young people and drugs” (N°401) provided results summarised in table 10.1 quarter.

Table 10.1 quarter: Ease of acquisition of drugs in Luxembourg (2014)

2014	Ease of access to heroin (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
Luxembourg	28	34	20	12	2	4
EU28	30	31	24	9	4	2
LU	Ease of access to cocaine (if desired)					
	24	29	29	12	4	2
EU28	24	23	26	17	8	2
LU	Ease of access to ecstasy (if desired)					
	26	28	28	12	3	3
EU28	24	24	27	16	7	2
LU	Ease of access to cannabis (if desired)					
	10	16	15	34	22	3
EU28	12	12	17	29	29	1
LU	Ease of access to tobacco (if desired)					
	1	2	5	16	76	0
EU28	2	2	3	14	79	0
LU	Ease of access to alcohol (if desired)					
	1	2	4	13	80	0
EU28	1	1	2	15	81	0

Source: Flash Eurobarometer N°401

Concerning heroin, youngsters from Luxembourg considered it slightly more difficult (62%; 65% in 2011) to have access to heroin than the EU average (61%; 60% in 2011). Similar to the EU average, only 14% (10% in 2011) of interviewees thought that getting hold of heroin was easy.

Even if heroin was the substance considered to be most difficult to obtain, also cocaine was considered by 53% (55% in 2011) of young people from Luxembourg as more difficult to have access to compared to the EU average (47%; stable).

Ecstasy was considered being more difficult to obtain in Luxembourg (54% stable) compared to the EU average (48% stable). Only 15% (11% in 2011) of youngsters from Luxembourg considered the access to ecstasy as easy (EU average: 23%; 22% in 2011).

Access to cannabis was perceived slightly easier in the EU (58%; 57% in 2011) than in Luxembourg (56%; 52% in 2011). Two out of ten youngsters (22%; 25% in 2011) found it very easy to obtain cannabis (EU average: 29% stable).

EU's youngsters considered the access to licit substances such as tobacco and alcohol as easy as Luxembourgish youngsters do. Concerning tobacco, 76% (82% in 2011) of youngsters from Luxembourg found its access very easy compared to the EU average (79%; 81% in 2011). Also the access to alcohol was referred to as very easy (LU: 80%; 79 in 2011, EU: 81%; 82% in 2011).



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 difficult to obtain with, however, the notable exception of cannabis.

Origins of drugs

The national production of illicit drugs appears to be irrelevant in terms of quantities and quality. In 2016, no clandestine drug-manufacturing laboratory has been dismantled at the national level. Law enforcement sources⁷² 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. Typically, involved dealers carry small quantities of drugs hidden in their mouth ready to be swallowed promptly in case of police controls. Initially drugs of high quality have been sold at low prices. Progressively however, the quality and diversity of sold drugs have been decreasing. The national drug market has been flooded by a high proportion of low quality injection drugs, which has induced major changes in consume patterns of national drug users.

Distribution networks are highly organised and have managed to significantly increase the supply and availability of drugs at the national level.

SEIZURES

In terms of **seized** quantities, important variations are observed for heroin and cocaine since 2000. The number of seizures also has been showing great variations during the same period, especially for cannabis and lately also for heroin and cocaine.

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 2002⁷³. Since 2002, however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. However, this trend was not observed in 2009 and 2010 for heroin. Cocaine seizures (quantity) are highly variable since the beginning of the nineties.

Notwithstanding the quantities of cannabis and cocaine seized, the number of seizures has grown

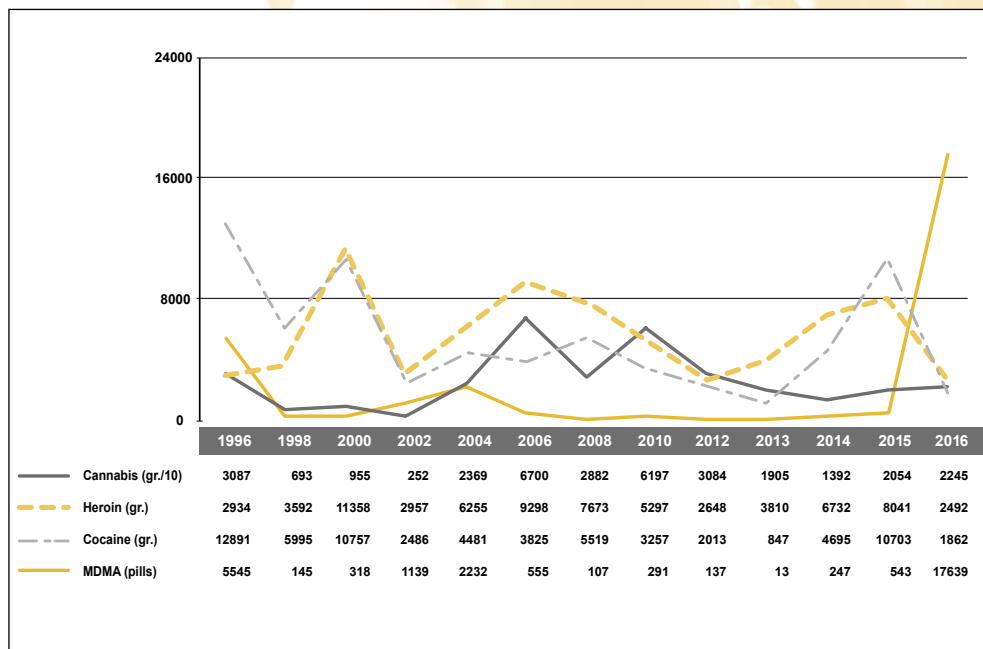
72 Non published information from the Specialised Drug Unit of the Judicial Police

73 Non-transit drugs destined to the national market

discontinuously since 1990. This suggests that more seizures of smaller quantities have been reported. Since 2008, the number of cannabis and cocaine seizures has clearly increased, while the number of heroin seizures discontinuously decreased. Markedly, the number of cannabis seizures has risen from 167 to 1,170 between 1994 and 2015 (1,048 in 2016). The total number of persons involved in traffic has followed a constant upward trend until 2002 and showed a decreasing trend line until 2013 followed by a marked increase in 2014 and 2015 and a slight decrease in 2016 (2016: 2,566, 2015: 3,345; 2014: 2,792; 2013: 2,066; 2012: 1,782; 2011: 2,210; 2010: 2,530; 2009: 1,963 persons).

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. After years of rather modest XTC type pill seizures, 2009 data revealed consistently higher amounts of seizures. In 2011 and 2012, however, the MDMA seizures showed again a decrease. In 2013, seizures of XTC type pills were very low, whereas an increase was observed in 2014, 2015 and 2016.

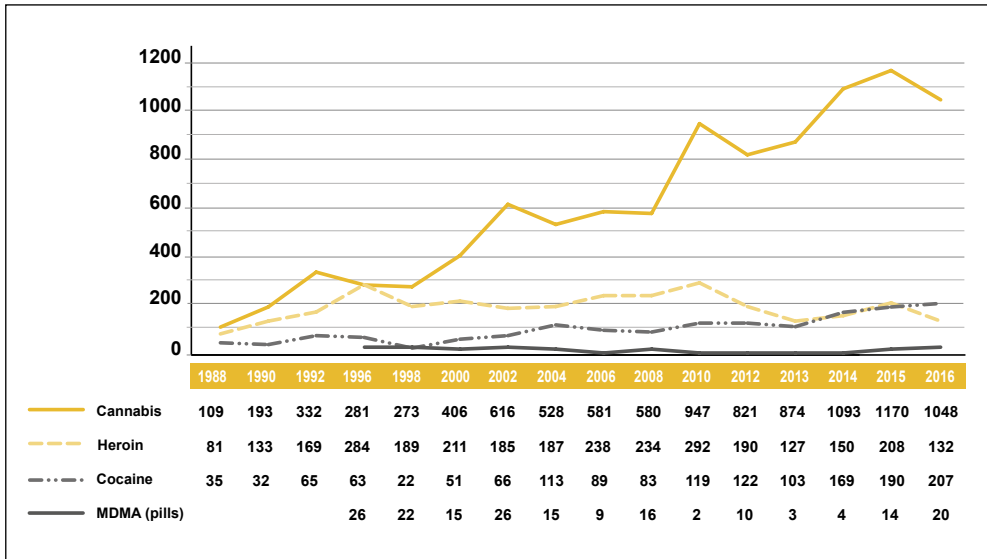
Fig. 10.1 Total quantities of national yearly seizures: heroin, cocaine, ecstasy substances (1996 - 2016)



Source: Specialised Drug Department of the Judicial Police 2017

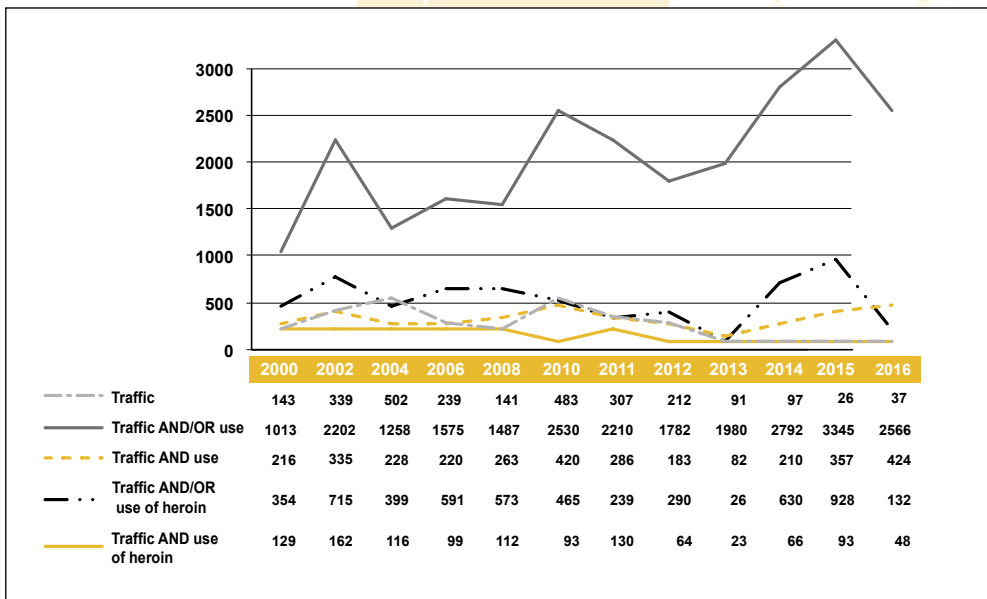


Fig. 10.2 Total number of national yearly seizures: cannabis, heroin, cocaine, MDMA (1988 - 2016)



Source: Specialised Drug Department of the Judicial Police 2017

Fig. 10.3 Number of offenders involved in seizures according to type of offence (2000-2016)



Source: Specialised Drug Department of the Judicial Police 2017

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, heroin and cannabis have been observed since 2004, which is due to a high variability of purity. Typical street retail cannabis is sold for 5-25 per gram, cocaine average price per gram is around 80 € and for heroin around 50 €.

Table 10.2: Price per unit evolution at the street level (1994-2016)

	1994	1998	2000	2002	2004	2006	2008	2010	2012	2013	2015	2016
Cannabis												
Hashish	5-6	5-6	7.4	7	7.3	8	8-10	4-10	5-17	6-15	8-10	8-13
Marijuana		2.5-3	6.2		7.3		5-10	7-25	5-25	12-20	8-25	8-17
Cocaine	100-150	120-170	90	50	20-120	30-100	70-100	50-250	40-250	40-133	50-100	40-150
Heroin (brown)	65-150	90-150	74.4	50	82	50-90	60-80	20-250	20-100	18-100	11-100	16-100
ATS		25-30	n.a.	25	n.a.	5	20	20	15-20	10	n.a.	13-15
Ecstasy		9-13	10.7	7	10	5	5-15	5-15	5-25	5-10	5-13	7-15
LSD	11-13	11-13	n.a.	n.a.	10	n.a.	5-15	12	10-20	10	15	10-15

Source: Specialised Drug Department of the Judicial Police (1994-2012), ABRIGADO (2008-2017)

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

Over the last 10 years, purity of cocaine has been generally decreasing (2006: 58.80% / 2016: 44.43%), and average heroin purity has also been following a discontinuous downward trend (11.04% in 2016). Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC in cannabis samples seized in Luxembourg. In 2016, the maximum concentration of THC in herbal cannabis was 34.9% (29.36% in 2012) showing a global increase since 2000.



Of concern are also the differences in maximum and minimum purities of other 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 resin samples seized in Luxembourg has been observed in 2014.

Table 10.3 Purity of drugs at street level (2000-2016)

	2000	2002	2004	2006	2008	2010	2011	2012	2013	2014	2015	2016		
Pur. (%)														
	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	MIN.	MAX.	AVRG.
Cannabis (THC)	8.03	7.96	6.94	7.36	9.82	11.32	10.99	9.09	8.7	11.59	11.99	0.00	34.90	10.90
<i>Hashish</i>					9.75	11.84	11.28	9.10	8.5	11.22	11.33	0.30	57.90	14.31
<i>Marihuana</i>					10.3	7.30	9.54	9.24	9.8	16.98	17.09	0.00	23.80	9.92
Cocaine	60.25	62.99	62.37	58.80	52.00	46.92	46.74	44.45	41	38.1	41.63	0.00	98.00	44.43
Heroin (brown)	17.59	9.97	17.07	15.80	16.10	24.02	10.08	9.60	13.9	13.52	11.93	0.20	55.50	11.04
ATS		15.09	9.44	7.1	18.2	10.43	15.58	17.03	23.1	11.44	25.13	2.70	45.20	16.16
Ecstasy⁷⁴ (MDMA)	35.5	71.11	29.77	26.44	23.52	53.14	77.88	42.89	77.3	53.55	42.29	15.40	51.30	49.69

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2017

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.

In 2011, S. Schneider and F. Meys⁷⁵ published a paper on analysis results of illicit cocaine and heroin samples seized in Luxembourg from 2005 to 2010.

Abstract: We assessed 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 anthelmintic 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.

74 Ecstasy : dose in mg/pill

75 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

Composition of illicit drug tablets

Information for this section was provided by the National Laboratory of Health (LNS) and formatted by the NFP. In 2016, 63 pills were analysed by the LNS, all of them (100% of the samples) were positive for MDMA as main active substance.

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



PART B:

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ANNEX II

RELEVANT DATA BASES AND INFORMATION SYSTEMS

a. RELIS drug monitoring system

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

The main objectives of RELIS are the following:

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

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

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

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

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

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

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

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

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

b. Register on drug law offenders (SPJ)

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

c. General Mortality Register (GMR)

The GMR is run by the Health Statistics Department of the Directorate of Health. The main impediment towards refined data provision on drug-related deaths and the application of the EMCDDA promoted DRD standard has been the 3-digit ICD coding applied by GMR until 1997. In 1998, ICD-10 standard was first applied by GMR. Currently, drug-related death data are extracted from GMR by means of a separate extraction routine. An integrated software based on the DRD ICD-10 standard allows to extract DRD cases from the GMR according to EMCDDA standards.

d. Special Overdose Register (SR) of SPJ

The SR is a paper-based register on acute drug-related deaths run by the SPJ. Over the past years, NFP relies on computer-based indexing procedure (SPSS[®]) of drug-related deaths by means of a comprehensive data form. NFP is maintaining a standardised database on acute drug-related deaths from 1985 to 2016. Anonymous drug-related death data is encoded at the SPJ and transmitted to the NFP according to approved standards.

e. AIDS and HIV register (LIH)

Official statistics from the national Retrovirology Laboratory of the LIH provide the number and proportion of IDU in HIV infected patients. Breakdowns by limited core socio-demographic variables are available. Provided data has public status.



f. Early Warning System on Synthetic Drugs (NFP / SPJ)

In the framework of the Joint Action on Information Exchange, Risk Assessment and Control of New Synthetic Drugs, the NFP has developed a nation-wide cross-sectional data exchange network.

Decision has been made to adopt a centralised structure relying on a nation-wide EWS partners' network (local contact persons) as well as centralised coordination of key data providers' activities. The national coordination unit of EWS is implemented within the NFP. The head of NFP has been appointed national EWS coordinator.

The new mandate of the **Inter-ministerial Group on Drugs** (November 2000), which represents the top decision level in the field of drug policies, expressly includes the follow-up of the national EWS system. Governmental delegates represented within the Inter-ministerial Group have disseminated information on EWS within their respective administration and have undertaken the required steps towards an effective inter-ministerial collaboration.

The implementation of EWS relies on a network of institutional **key-informants**. Currently all specialised drug agencies (low/high threshold) at the national level are involved in the data providing process in terms of routine data transmission on new trends. Recently two new agencies have joined the EWS network, namely a counselling centre for drug users underage and a low threshold project. The first does provide relevant data on new consume patterns and trends within youngster population and the second focuses on opiate users. One has to stress that the key-informants network does mainly provide data on trends in drug use but not on toxicological characteristics of substances since the referred agencies do not propose substance related services.

Currently, drug seizures are still one of the most important and the most reliable data source as to substance profiling and detection of new drugs. Samples seized by Customs or Police are either analysed (rapid tests) by the SPJ, or sent, via the Prosecutors office, to the National Laboratory of the Department of Health (LNS) for toxicological profiling. Respective results are not systematically transmitted to the department of Health or the NFP. However, effective bilateral co-operation between the NFP and the **national Europol unit** (SPJ) allow for rapid data transmission in case a new trend or substances should be detected by the latter. The active involvement of law enforcement agencies in the national monitoring system highly facilitates the implementation of Joint Action-related activities.

Agreements have been made between the *National Fund Against Drug Trafficking*, the NFP and the **National Health Laboratory** (LNS) on the funding of new technical equipment allocated the toxicology unit of the latter. This achievement has largely contributed to the improvement of the quality of toxicological analysis provided by LNS.

General practitioners have recently been involved in the EWS in terms of data provision on new substances and new consume patterns. All GPs and psychiatrists registered in the Grand-Duchy of Luxembourg have received a standardised data form allowing them to provide relevant information to the NFP in case they were confronted with an unknown psychotropic substance or unusual consume patterns. The NFP, as a counterpart, committed to provide GPs and psychiatrists with information on the detected trends or substances, as far as there is any information available.

Drug-related deaths have to be reported by **emergency services** to the Police and the SPJ. Non-fatal drug-related emergencies requiring medical intervention have not to be reported systematically. Moreover, emergency services do not index drug-related interventions separately, which means that no monitoring

of those cases can be performed. The referred situation is not likely to change and thus, the inclusion of emergency services in the EWS appears to be unfeasible at the present stage.

National drug legislation does not foresee a legal framework for **testing or profiling illicit drugs** in nightclubs, public events or rave parties. No such activities have been planned or carried out under the authority of public administrations. Taking into account that the first official seizure of 'ecstasy' has only been recorded in 1994, harm reduction and close monitoring activities in this particular field were previously not viewed as a priority.

In October 1995, a **new drug help line** was created, under the responsibility of the CePT. Given its easy access and the anonymity it guarantees, phone help lines often represent the first step with regard to further orientation or treatment demand proceedings and as such are able to provide high quality data on recent trends in drug use. The national Drug Help Line has been included in the EWS system in the course of 1999. In 2008 the drug phone help line has been replaced by a drug help on-line and email service (frono@cept.lu) run by CePT (Fro No).

The drug issue is largely covered by various **media supports**. Press, music, fashion and leisure industries are often the mirror of life styles and current trends in substance use. Information could be collected by screening the media targeted at young people and sub cultural groups. Radio, television, newspaper, magazines, fanzines, books, comics, announcement of events, opening of new clubs, etc., are to be viewed as complementary indicators towards the global monitoring of new drug trends. Since the resources of the NFP do not allow for an overall monitoring of media supports, decision has been made to compile, in collaboration with the information and press department of the State's Ministry, a monthly national and international press review on drugs.

g. Documentation Centres (NFP / CePT)

The **Centre Logistique de Documentation sur les Drogues et les Toxicomanies (CLDDT)** is a logistic documentation service run by the NFP since 1995. CLDDT runs the only computer-based national documentation management base specifically focusing on licit and illicit drugs. The CLDDT indexes about 2,900 documents mainly in French, German and English language. Users of information services provided by the CLDDT are mainly researchers, journalists, policy makers, drug treatment and prevention specialists, and general public. The majority of indexed documents are paper-based and abstracts are provided.

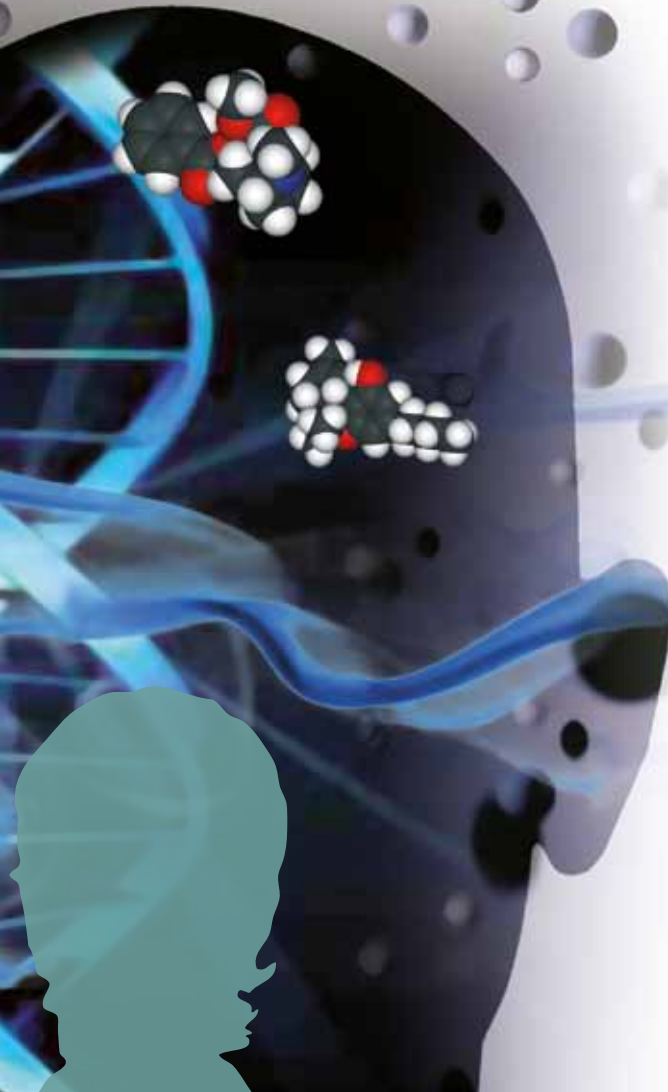
In addition to its function of documentation base, CLDDT also ensures the conceptualisation and execution of drug documentation dissemination strategies as required by the NFP. Topic-specific mailing lists have been developed and maintained by active contact making and demand response.

CLDDT is linked to the **Centre de Documentation du Centre de Prévention des Toxicomanies** run by CePT since 1996. The CePT documentation centre mainly focuses on primary prevention, training and evaluation in the fields of licit and illicit drugs. The current stock approaches 3,500 documents or media supports. Queries are handled manually and no computer-based consultation facilities are provided.



ALPHABETIC LIST OF RELEVANT INTERNET ADDRESSES

<http://www.cept.lu>
<http://www.chnp.lu/fr/Rehaklinik/Filiere-Poly-Toxicomanie>
<http://www.cnds.lu>
<http://www.ecbap.net>
<http://www.ec.europa.eu/health>
<http://www.etat.lu>
<http://www.gouvernement.lu>
<http://www.tns-ilres.com>
<http://www.im-puls.lu>
<http://www.jdh.lu>
<http://www.legilux.public.lu>
<http://www.lih.lu> (former www.crp-sante.lu)
<http://www.liser.lu> (former www.ceps.lu)
<http://www.mag-net.eu>
<http://www.msr.lu>
<http://partyplus.eu>
<http://www.relis.lu>
<http://www.sante.public.lu>
<http://www.statec.lu>
<http://www.unodc.org>
<http://www.who.int>



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