

**2004 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point**

“GRAND DUCHY OF LUXEMBOURG”

**New Development, Trends and in-depth
information on selected issues**

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REITOX

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Foreword

The present report on the drug situation in the Grand Duchy of Luxembourg has been compiled for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) by the Luxembourgish EMCDDA focal point.

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Summary

Annual National Report on the Drug Situation (Edition 2004)

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

Political, legal and organizational framework

In 1999, the government entrusted the Ministry of Health with the **overall coordination of drug-related demand and risk reduction interventions**. The strategic framework was set up by the newly appointed national drug coordinator mandated to elaborate the 2000-2004 **action plan on drugs and drug addiction**, that materialized the priorities stated in the governmental declaration of 1999.

The 2000-2004 action plan has also been based upon new achievements introduced by the **law of 27 April 2001**, modifying the basic drug law of 1973. In the framework of the execution of the 2001 drug law amendment the **grand ducal decree on substitution treatment** entered in force in February 2002 and the **grand ducal decree on syringes exchange modalities** was adopted in December 2003.

The **global budget of the Ministry of Health** granted to drug-related services and programmes went up from 1,270,169 EUR in 1999 to 4,861,841 EUR in 2003 indicating a **progression rate** of 283% since 1999. The draft budget 2004 foresees a budget of 5,847,938 EUR representing a supplementary raise of 20.28% in reference to the 2003 budget. This extraordinary raise stands in direct relation with the implementation of the 2000-2004 action plan of the Ministry of Health.

The governmental **programme issued following the parliamentary elections of June 2004** has introduced no changes concerning competences in the drugs field. The elaboration of a **new national strategy and action plan on drugs and drug addiction 2005-2009** has to be approved by the Minister of Health by the end of 2004. The strategy is based upon **two pillars**, that are demand reduction and supply reduction as well as **upon 4 transversal axes**: horizontal coordination mechanisms, risk reduction, harm and nuisance reduction, research and information and finally international relations. The elaboration of the future drug action plan builds upon the implementation evaluation outcome of the 2000-2004 action plan, on the orientations of the 2004 governmental programme and on priorities set by the Ministry of Health.

Epidemiological indicators

Worldwide the propagation of drug abuse tends to slow down. One major exception does, however, exist: the consumption of cannabis, the most commonly consumed illicit drug in the world, is spreading rapidly. In the last decade, the most important increase next to cannabis, applies to ATS (including ecstasy), followed by cocaine and opiates. A similar evolution is observed within the **EU** and at the micro-geographical level of the **Grand Duchy of Luxembourg**, however, accompanied by more or less pronounced local variations with regard to prevalence.

Comparable data from national school surveys conducted between 1992 and 2000, show increasing **lifetime prevalence in young people** (16-20 years) for all common illicit substances. The disproportional increase of cannabis and ATS deserves particular attention. In relation to younger school populations (13-14 and 15-16 years), one observes a similar trend, particularly

visible when it comes to lifetime prevalence of cannabis use. The use of opiates and cocaine by school-aged youngsters has been showing a low and fairly stable prevalence.

The **number of Problem Drug Users (PDUs)** indexed by national specialised institutions has witnessed a **progress rate of 70% over the last 9 years**. **8%** of PDUs are **first treatment demanders**, all treatment centres included. On average, a PDU has 1.8 (2.14) contacts/year with a specialised agency. **74%** (**69%**) of respondents have had at least one **substitution treatment** before being indexed in 2003.

The male/female ratio of the PDU population is 4:1. The proportion of indexed non-native PDUs has been decreasing over the last 4 years ranging between 48% and 35%. The **population of non-natives** drug users largely consists of Portuguese nationals (45%), a proportion which is consistently higher than the one observed in the general population. A sensitive increase of PDUs coming from eastern countries and particularly from the Soviet Union is observed.

The **mean age** of indexed PDUs has evolved from 28 years and 4 months in 1995 to 29 years and 7 months in 2003. The gap between the youngest and the oldest PDUs continues to grow. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to “new” PDUs. Worth mentioning is the significant increase of the average age of overdose victims and an increase of the proportion of minors and total population of PDUs among drug law offenders STUP (14%).

The multi-methods prevalence study on PDUs at the national level, published in 2001(Origer 2001), provides a prevalence rate of 8.42 per thousand inhabitants aged 15-54 (absolute figure 2,450 PDUs) According to post 2000 indirect indicators (Origer 2004), **prevalence figures** applied to the national population aged 15-64 currently situate between 2,500 and 2,800 PDUs.

Intravenous heroin use associated to **poly-drug use** is reported as the most common consume pattern in PDUs. The switch to **intravenous drug use** occurs earlier compared to year 1995. More recently **low quality cocaine use** in combination with heroin has become more prevalent. The ratio of **intravenous opiates consume to the inhalation** mode has stabilised at 2:1. The recent provision of ‘**blowing paraphernalia**’ (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns.

Ecstasy-like substances and **ATS** show an increasing demand even though seizure figures do suggest an inverse and currently stable trend.

All indicators on **cannabis use** (problematic and recreational) have been on the increase for several years. Cannabis showing **high THC concentrations** is increasingly found on the national market.

The **average age of first use of cannabis, ecstasy and i.v. heroin** tends to decrease. Also, the **average age**, applied to the total PDU population has markedly increased over the last 5 years. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders, in the total PDU population and to the percentage of students in problem drug users.

HCB (hepatitis B) and the HIV/AIDS prevalence in PDUs have not been increasing in recent years while the infection of HCV (hepatitis C) is clearly increasing and tends to approach the European average. It should be stressed that the **proportion of IVDUs in newly diagnosed HIV cases** has been decreasing significantly over the last 20 years.

The number of **fatal overdoses** indexed at the national level has shown an increasing trend from 1997 to 2000 (26 cases), followed by a slow and discontinuous decrease until 2003 (14 cases).

The **overdose rate in the national general population** figured 3.12 overdose deaths per 100,000 inhabitants¹ in 2003. In 2000 the same rate figured 5.9 cases per 100.000 inhabitants. Forensic data of 2003 confirms that nearly every drug-related death involved heroine use associated to multiple substance use.

In 2003, 14 **indirect drug death cases** have been indexed. Main causes of indirect deaths between 1996 to 2003 are, in order of importance: suicide, traffic accidents, undefined intoxication, associated cardio-vascular or pulmonary complications.

The overall number of indexed direct and indirect drug death cases informs about **drug-related mortality**. Drug-related mortality prevalence has been showing small variations since 1996 figuring roughly 26 to 33 cases per year.

Law enforcement indicators ²

Striking variations have been observed as to the **quantity of illicit substances seized** since 1984. The general trend of decrease in heroine and cocaine quantities seized since the beginning of the nineties has been confirmed by 2003 data, with the exception of cannabis (leafs and resin) showing an obvious increase for the last four years.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. The number of cocaine and heroine seizures has stabilised while the **number of cannabis seizures** has markedly increased. The total **number of persons** involved in traffic has followed a constant upward trend. A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. The availability of ecstasy appeared to soar between 1994 and 1996. Most recent data indicate however a stabilization at low level.

The **number of police records** for presumed offences against the modified drug law of 1973 has more than doubled between 1995 and 2003. The **number of drug law offenders** has increased discontinuously and figured 2,270 in 2003 (multiple counting included).

Since 1998, the proportion of **non-native drug law offenders** passed from 50% to 60%. 37% of the cases are **first drug law offenders** (increasing discontinuous tendency); the percentage of **minors** in drug law offenders has increased from 5.4% in 1993 to 14.2% in 2003.

National **prison data** of 2003 refers to 1,072 new admissions of which 12.8% were related to drug law offences; a proportion representing 42.6% in 1996 and constantly decreasing since then.

RELIS data witness a sensitive increase of **contacts with law enforcement** agencies between 1995 and 2003 and a continuous deterioration regarding cumulated penal past of indexed PDUs compared to previous years.

Profile of the national drug market

¹ All age groups included

² If not specified, data refer to 2002. Figures between brackets refer to 2002 if not specified.

A majority of **illicit drugs** consumed in the Grand Duchy of Luxembourg **originate** from the Netherlands, followed by Belgium and Morocco. Recently, **more structured and purely commercial distribution networks** have been developed by organized criminal associations. Notable is also the increase of the number of Cabo-Verde nationals involved in cannabis traffic which also increasingly involves North African offenders. As far as cocaine traffic is concerned a recent increase of asylum demanders from East Africa and Kosovo has to be stressed.

Drug supply indicators support **increased opiates and cocaine availability** on the national market. Since 1996 average street prices of heroine and cocaine have decreased.

At the beginning of 2003 a **clandestine laboratory** of amphetamine production has been discovered in the south of the country. **Local cultures of cannabis and magic mushrooms** are rather insignificant in terms of quantity and quality.

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen during the last 8 years. Cannabis and derivatives have known a slight increase during the same period.

As far as **purity** is concerned, quality of cannabis (% THC) products and ecstasy has been increasing during recent years. Purity levels of heroin and cocaine tend to decrease.

Demand and harm reduction activities

The number of **sterilised syringes** (2003: 333,213/ 1996: 76,259) distributed in the framework of the **national needle exchange programme** has been rising from the start of the latter. The same trend is observed with regard to the number of **used syringes collected**.

The **number of contacts** registered by low threshold structures has increased dramatically over the last 8 years (2002: 28,319/ 1996: 6,456), and so has the number of syringes distributed by the same agencies. The proportion of **new clients** within low threshold settings has, however, stabilised.

The national **methadone substitution programme** has been implemented in 1989 by the Ministry of Health and the JDH Foundation. The number of participants went from 30 in 1993 to 131 in 2003 (recent decreasing tendency). In addition to the methadone substitution programme financed by the Ministry of Health, an important number of PDU address substitution treatment demands to **independent general practitioners**. Data delivered by the Union of Health Insurance Funds refer to 913 patients (1999: 745) who did receive substitution treatment in 2003 by means of the prescription of methadone or buprenorphine containing medicaments (MEPHENON ®, METHADICT ® and SUBUTEX ®) and 154 prescribing GPs. During 2003 the 913 registered patients consulted on average 1,7 GPs prescribing substitution drugs.

Key issues

● BUPRENORPHINE, TREATMENT, MISUSE, AND PRESCRIPTION PRACTICES

Although substitution treatment has been provided at the national level for more than a decade, the respective **legal framework** has only been set between 2001 and 2002.

Substances legally admitted for substitution treatment provided to drug addicts are listed in the grand-ducal decree of 30 January 2002³. Methadone is by far the most prescribed substance in substitution treatment. Buprenorphine is perceived as a **treatment alternative** rather than a new

³ The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>

treatment option replacing methadone. Buprenorphine (mainly in form of SUBUTEX ®) is a legal prescription option only if the medication notice explicitly mentions substitution treatment as a therapeutic indication.

Diversion of buprenorphine based medications and **deaths related to buprenorphine** use are rare.

As the prescription of buprenorphine in substitution treatment is fairly recent, no **evaluation studies** have been conducted at the national level so far. A more accurate picture of the current situation may be provided by the results of **a regional prospective evaluation study** on the quality and impact of substitution treatment provided in non specialised settings in Belgium, France and Luxembourg, due for 2005.

● ALTERNATIVES TO PRISON TARGETING TO DRUG USING OFFENDERS

Alternatives to prison targeting offending drug users are **anchored in national legislations**. They are **part of the national drug policy**, even though they are not explicitly referred to in the national drug strategy.

The **implementation** of alternative measures to punishment and prison sentences applied to drug use offenders is centralised and involves a series of authorities and actors namely the Ministry of Justice, the Ministry of Health, Prosecution authorities, specialised treatment agencies and licensed MDs and finally the '*Multidisciplinary Committee*' established by the basic drug law of 1973⁴ and implemented within the Directorate General of Health. Both, the multidisciplinary committee and the MD responsible for the ordered or proposed alternative measure are in charge of the follow-up and report to the Prosecution authority. There are no regional or local coordination mechanisms.

A separate mechanism has been put in place with regard to **underage and juvenile drug use offenders**. An association accredited by the Ministry of Health intervenes in case a minor of age has been running in conflict with law enforcement forces due to a drug-related offence and has been referred by judicial and penal institutions.

Evaluation and treatment impact assessment with regard to prison alternatives are insufficiently developed.

● DRUG-RELATED PUBLIC NUISANCE

At the national level the concept of "Public nuisance" is **not approached as specifically related to drug use**. PDUs are only part of the population perceived as potentially nuisance generating. It is neither population specific nor substance specific if referred to PDUs.

Public nuisance refers to behaviours and situations that are perceived as undesirable, unpleasant, annoying, threatening or harmful by a person or a community which consider not to be involved in its generation process.

The historical link between drug use and public nuisance is best defined if referred to the complementary and gradual influence of **public health, public security and social/economical factors**.

⁴ Loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie. (Mém. 173, 319) (cf. ELDD)

Planning and managing of public nuisance prevention measures should build upon consensual need analysis, early involvement of potential local partners, reliable information to local residents and the involvement of PDUs in the nuisance prevention process.

Part A: New Developments and Trends

1. National policies and context

Overview

Drug use is defined as a behaviour potentially associated to health and social damage. Consequently national drug policies are based on shared political competencies and responsibilities.

The parliamentary elections of June 1999 can be described as a turning point in the field of drug policies in Luxembourg. The governmental declaration of August 1999⁵, and the subsequent coalition agreements, emphasised the need of further development and diversification of specialised health care, a more pragmatic approach towards law enforcement by means of the required legislative amendments and the promotion of harm reduction measures.

The Government thus decided to charge the Ministry of Health with the national drug co-ordination in the fields of demand and harm reduction. Accordingly, the Minister of Health has appointed a national drug co-ordinator and took the necessary steps to centralise collaboration conventions with drug-related NGOs, previously also held by other ministries (e.g. Ministry of Family). This decision witness the political will for a more centralised co-ordination of drug policies and to further develop a decision process based on reliable scientific data.

In October 2000 the Minister of Health presented for the first time a structured five-years drugs action plan in the field of addiction (2000-2004).

Parliamentary elections of June 2004 have resulted in a new coalition government of social democrats and socialists. Competencies and ministerial attributions in the drugs field have not been modified. Furthermore, the national drug coordinator's office will present a new drug strategy and action plan 2005 – 2009 to be approved by the Minister of Health by the end of 2004.

● LEGAL FRAMEWORK⁶

○ Laws (2001- 2003)

The **basic national drug law**, namely: 'Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie'⁷ regulates both, the selling of controlled medicaments and the fight against drug addiction and dates back to the 19 February 1973. It has been last amended by the law of 8 August 2000.

⁵ Governmental Declaration of 12/8/1999, <http://www.gouvernement.lu:80/gouv/fr/gouv/progg/declu.html>

⁶ The referred legal texts from 1971 onwards as well as English summaries may be consulted in the ELDD legal database

⁷ Official gazette A 1973, p.319

- **law of 27 April 2001**⁸ modifying the basic drug law of 19 February 1973. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of harm reduction and maintenance measures, namely, drug substitution treatment, needle exchange and other state accredited means, which, in addition to article 13 of the grand ducal decree of 30 January 2002 (see below) could materialise in shooting galleries or medically controlled heroin distribution programmes.

- **law of 14 June 2001**⁹ endorses the Convention on Laundering, Search, Seizure and Confiscation of the proceeds from crime of the Council of Europe (Strasbourg 8 November 1990) introducing amendments to the criminal code and the basic modified drug law from 19 February 1973.

○ **Grand ducal decrees (2003/2004)**

The **grand ducal decree of 30 January 2004**¹⁰ modifies the substance lists annexed to the grand ducal decree of 2 February 2003.

The **grand ducal decree of 23 December 2003**¹¹ regulates the national syringes distribution programme by defining facilities and professionals authorised to provide syringes to drug users.

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

- Grand ducal decree of 4 **March 1974** regarding certain toxic substances
- Grand ducal decree of 20 **March 1974** regarding certain psychotropic substances
- Grand ducal decree of 26 **March 1974** establishing the list of controlled narcotics
- Grand ducal decree of 8 **May 1993** regarding commerce of narcotics and psychotropic substances
- Grand ducal decree of 2 **February 1995** regarding the production and distribution of certain substances used in the illicit production of narcotics and psychotropic substances
- Grand ducal decree of 6 **February 1997** regarding substances listed in schedules III and IV of the UN Convention on psychotropic substances of 21 February 1971.

- The **grand ducal decree of 3rd October 2003**¹² includes **amineptine** in the list of nationally controlled substances used for the illicit production of narcotics and psychotropic substances.

The following substances are currently in the process of being included in national lists of controlled substances: 2C-I, 2C-T-2, 2C-T-7, TMA-2 and GHB. 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.etat.lu/memorial> or http://eldd.emcdda.org/databases/eldd_search.cfm.

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

⁹ Official gazette A 2001, p.1708 (Adoption: 14/06/2001, Entry in force: 17/06/2001)

¹⁰ Official gazette A 2004, (Adoption: 30/01/2004, Entry in force: 13/02/2004)

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

¹¹ Official gazette A 2003, (Adoption: 23/12/2003, Entry in force: 30/12/2003)

Règlement grand-ducal du 23 décembre 2003 portant exécution de l'article 8 sous 1d) de la loi modifiée du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie.

¹² Official gazette A 2001, p.771 (Adoption: 23/02/2001, Entry in force: 28/02/2001)

Règlement grand-ducal du 3 octobre 2003 modifiant l'annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques.

○ **Projects and propositions of law**

The following most recent projects or propositions of law have been deposited but not voted or taken further at the moment of the writing of the present report:

Proposition of law of 4th January 2001, regarding the **regulation of state controlled cannabis production, distribution and selling** by means of a national observatory on cannabis and local selling points.

Proposition of law of 28 August 2002 on the regulation on prescriptions of medicines containing cannabinoids (i.e. Marinol ®, Cesamet ®) to certain patients according to a detailed list of eligible diseases.

Project of law modifying the modified law of 21 November 1980 regulating the organisation of the Directorate of Health¹³ has been submitted to the State Council for notice in 2002. The project of law foresees the creation of a special division for social medicine and drug addiction in charge of drug addiction and psychiatry.

Proposition of law of 20 May 2003 on the modification of road traffic regulations in order to create a legal framework for (illegal) drug testing in drivers.

○ **Laws implementation**

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

The **law of 27 April 2001**¹⁴ modifying the basic drug law of 19 February by decriminalising cannabis use, and enhancing the differentiation of penalties according to the type of drug offences and the nature of controlled substances involved and the **grand ducal decree of 30 January 2002**¹⁵ on substitution treatment, have largely contributed to increase the congruity between drug legislations and prosecution routine.

Current drug legislation and prosecution policies put high priority on drug dealing and trafficking and lower priority on drug consumption and promote harm and risk reduction measures.

● **INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES**

○ **Coordination arrangements**

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

¹³ Loi modifiée du 21 novembre 1980 portant organisation de la Direction de la Santé. (Entry in force:: 27/11/1980)

¹⁴ Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001)

¹⁵ Official gazette A 2002, p.232 (Adoption: 30/01/2002, Entry in force: 12/02/2002)

aspects remains a competence of the Ministry of Justice and the Ministry of Foreign Affairs respectively.

At the national level, the co-ordination among the competent Ministries takes place in the *Inter-ministerial Commission on Drugs (ICD)*, chaired by the Ministry of Health (the national drug coordinator is vice-chair). It is composed of senior delegates from the main governmental departments and delegates from selected NGO's and constitutes the top decision level with respect to co-ordination and orientation of actions.

Both, the ICD and the Ministry of Health are responsible for the implementation of the 2000-2004 and the 2005-2009 drugs action plans, supervise field activities and are bound to guarantee an effective consultation process with other involved ministries (e.g. Justice, Foreign Affairs). The ICD meets regularly to exchange information. There are four permanent agenda items: the implementation of action plans, the early warning system on drugs, emerging trends and legal changes and international affairs.

The co-ordination between the Ministry of Health, the Ministry of Justice and the Ministry of National Education respectively occurs through the 'HEALTH – JUSTICE' and the 'HEALTH – EDUCATION' ministerial groups.

At the governmental level, there exists a Special Parliamentary Commission on Drugs, that functions as an advisory body to the government. At the level of the Ministry of Health, the national drug coordinator as well as the head of the Division of Social Medicine and Drug Addiction are the main advisors of the Minister in the referred field.

A close link between the EMCDDA national focal point and the policy level is ensured by the fact that the head of focal point has been appointed National Drug Co-ordinator. The national Drug coordinator is also the head of the national delegation within the Horizontal Drugs Group and the national permanent correspondent within the Pompidou Group.

At the micro-level the drug coordinator meets monthly with the NGOs involved in the field on a bilateral basis or in plenary in order to share information and elaborated responses to emerging trends.

○ **National plan and/or strategies**

The strategic framework of drug demand reduction interventions has been defined in 2000 by the **national drug coordinator**, by means of a **national action plan on drugs and drug addiction covering the period 2000 to 2004**. The drug action plan has been relying on six intervention areas, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and risk/harm reduction services. The strategy primarily focuses on illegal drug use and legal substances' use only if associated to the latter.

The action plan reflects priorities set by the government, namely, increased means for primary prevention activities, the development and diversification of therapeutic facilities, further implementation of drugs risk, harm and nuisance reduction measures with a special focus on infectious diseases.

A new drug strategy and drug action plan is currently elaborated by the national drug coordinators' office jointly with concerned ministries and field actors. Both cover the period from 2005 to 2009 and rely on two political pillars (demand reduction, supply reduction) and on four cross-cutting domains (Coordination, International Cooperation, Research and Evaluation, Harm Reduction). The draft document has to be approved by the newly elected Minister of Health in November 2004.

○ **Implementation of policies and strategies**

The outcome of a national drugs action plan highly relies on the way it has been elaborated. In 1999 the current national drug coordinator has launched a multilateral consultation process involving ministerial departments, NGO's and civil society. The priorities set by the Ministry of Health were discussed and, if necessary, complementary measures were added. A consensus on priority rankings of listed actions has been reached among involved parties. Finally all retained actions were structured in a clear, simple and output oriented way as follows:

Description/objective of action - responsibilities – budget – outcome – deadlines for outcome and evaluation.

The active involvement of specialised NGOs from the very start of the conceptualisation work and consensus making prior to the implementation phase have shown to be a major criteria to guarantee an effective implementation process. By the time of writing 87% of the measures retained by the national drugs action plan have been materialised within the retained deadlines. The measures not yet implemented (e.g. heroine distribution programme) have been delayed not for technical or administrative reasons but for political ones.

The drugs action plan 2000 – 2004 has been submitted to an internal evaluation exercise. On basis of those evaluation results the above mentioned new drug strategy and drug action plan is currently elaborated by the national drug coordinators office jointly with concerned ministries and field actors. Both the strategy and the action plan cover the period 2005 to 2009.

○ **Impact of policies and strategies**

As the 2000 - 2004 drugs action plan was the first of its kind to be implemented at the national level any comparison with previous achievements must be considered with care. However, it is a fact that budgetary means and the implementation of new drug-related facilities and programmes have been consistently more important during the referred period than ever before. Implementation progress of the drugs action plan have been kept on the political agenda since its start in 2000 and consequently the pressure to perform was continuously high. Media also contributed to this enhanced awareness and activity boosting, especially since they have been able to identify a central personalised key actor in the person of the national drug coordinator. Another positive side effect of the drugs action plan is an increased commitment of NGOs and civil society in the drug policies as they have been involved since the very beginning of the process.

As far as the final output of the action plan is concerned there is no doubt that implemented measures have largely contributed to increase the availability and diversity of and the access to treatment and post-treatment facilities, reduce drug-related harm and mortality, reduce propagation of infectious diseases among PDUs and to promote drug-related research activities.

● BUDGET AND PUBLIC EXPENDITURE

○ **Law enforcement, social and health care, research, international actions, coordination and national strategies**

The structure of the national state budget does not allow for a comprehensive drug budget allocation analysis since several budgetary subsections include both, drug specific and other activities. The same comment applies to the funding of drug treatment activities that are ensured by specialised agencies and general health care services and to research and training centres. Therefore, in accordance to national needs and the work plan of the EMCCDA, **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*). (<http://www.relis.lu>).

In 1999, the direct economic costs of national policies related to illicit drug use (all categories included) reached approximately 23.345 million euros, which represents an annual per capita

expenditure of 54.- €. Based on the results of the latest national drug prevalence study (Origer 2000), an average annual cost per problem drug user of 9,934.- € has been calculated.

39% (9.105 million euros) of estimated expenditures are related to supply reduction measures against **59% (13.774 million euros) that are devoted to demand reduction interventions**. Annually 1% (0.233 / 0.232 million euros) of public resources are invested in drug research and international cooperation respectively. The total annual costs the collectivity has to stand for annually represents 0.013% of the gross national product and 0.05 of the total state budget in 1999.

The original research report can be accessed under: <http://www.relis.lu>.

As a national study on drug related expenses is highly time and cost intensive, the NFP has decided to follow-up the budgetary evolution between two consecutive national studies by means of the most representative indicator which is the annual budget of the Ministry of Health allocated to drug-related activities:

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

Year	2000	2001	2002	2003	2004
Budget (EUR)	2,066,000.-	2,702,000.-	3,644,000.-	4,862,000.-	5,848,000.-
Progression rate	Reference year	30.8%	76.4%	135%	183%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2004. Volume 1. (Ministère des Finances 1999-2003)

○ Funding arrangements

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

The Ministry of Health guaranteed financial and human resources required for the implementation of the drugs action plan 2000 – 2004. The **funding of the 2005 – 2009** action plan has still to be agreed on according to the ultimate priority setting of the Minister of Health.

Specific local projects designed by non-governmental actors requiring external financial support are generally submitted to respective ministries or to other national funding sources (Fund Against Drug Trafficking, Foundations, private funds, etc.) or international bodies (EU, EMCDDA, etc.). Proposals are analysed and might be supported by short-term state subventions.

One may add that the **EDDRA** questionnaire is applied as a standard application form for drug-related projects' funding requests addressed to the Ministry of Health.

● SOCIAL AND CULTURAL CONTEXT

○ Public opinions of drug issues

No large-scale national public opinion survey focusing on drugs and drug addiction has been conducted thus far. Several surveys however have included items on public perceptions on legal and illegal drugs at the local or regional level.

Several local or community based surveys on public opinions and attitudes towards drugs and drug

use has have been conducted in recent years. Results of these surveys have been produced in the 2003 report.

Within the scope of the Eurobarometer 57.2, a public opinion poll named “Attitudes and opinions of young people in the European Union on drugs” was carried out in the 15 Member States between April and June 2002 at the request of the European Commission. This survey included a representative sample of the national population aged 15 to 24. In Luxembourg this public opinion poll was performed by ILRES in 2002 in the framework of EUROBAROMETER wave surveys.

REFERENCE	EORG (2002). PUBLIC OPINION REGARDING ATTITUDES AND OPINIONS OF YOUNG PEOPLE IN THE EUROPEAN UNION ON DRUGS
Year of data collection	2002
Single/repeated study	Repeated study
Context	Eurobarometer
Area covered	National representativity
Age range	15-24 years
Data coll. Procedure	face to face interviews
Sample size	189 valid cases

Tab. 1.1 Ease of acquisition of drugs in Luxembourg (2002)

	QUESTION a: It is easy to get drugs?			
	Near where I live	In or near my school/college	At parties	In pubs/clubs
Luxembourg	62.2	60.5	74.7	73.2
EU	61.9	54.9	76.0	72.3

The results among the population of young people in Luxembourg lie within the scope of the European average, which considers that access to drugs is easy in each places mentioned. The perception of ease of access to drugs in schools in Luxembourg is higher than the European average.

Tab. 1.2 Main reasons for trying drugs, stopping use and consequences of drug use (2002)

	QUESTION a. Main reasons for experimenting				
	1. Curiosity	2. Peer pressure	3. Thrill seeking	4. Problems at home	5. Expected effects
Luxembourg	58.5	44.2	17.6	45.6	26.7
EU	61.3	46.4	40.7	29.7	21.5
	QUESTION b. Main reasons why it is hard to stop using drugs				
	1. Dependence	2. Lack of willpower	3. Effects of drugs	4. Peer pressure	5. Loneliness
Luxembourg	66.6	44.0	45.3	24.6	21.1
EU	73.9	50.5	40.5	27.4	16.2
	QUESTION c. Consequences of drug use				
	1. Dependence	2. Problems with the law	3. Mental problems	4. Communicable diseases	5. Relief from pain or stress
Luxembourg	52.3	32.1	33.2	32.4	26.5
EU	63.0	38.3	35.4	33.7	26.4

a.: Major differences from the European average are that young people in Luxembourg seem to consider to a lesser extend thrill seeking as an argument for experimenting and rate problems at home as a major reason for experimenting drugs.

b.: There is no significant variation in the ranking of the reasons most often chosen.

c.: The perceptions of dependence and problems with the law among young people in Luxembourg are lesser marked as the European average.

Tab. 1.3. Perceived dangerousness of different substances (2002)

	Assessment of danger of the three substances: % of “very dangerous” responses		
	1. Heroin	2. Ecstasy	3. Cannabis
Luxembourg	87.2	60.6	16.2
EU	88.8	63.5	20.6

The percentages of responses among young people in Luxembourg approach to the ranking of the European average. One can note that cannabis is considered less dangerous than does the average of the European Union.

Tab. 1.4 Priorities in management of drug-related problems (2002)

	Most effective methods of management		
	1. Measures against dealers and traffickers	2. Treatment and rehabilitation	3. Information campaigns
Luxembourg	70.2	34.2	46.4
EU	59.1	53.3	38.9

The opinions from young people in Luxembourg differ from the European average. Priority is given to measures of repression against dealers and traffickers. Luxembourgish youngsters believe in the effectiveness of information campaigns more than the average European(second place). Treatment and rehabilitation measures are seen as lesser effective methods in the management of drug related problems compared with the average EU figures.

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

○ Debates and initiatives in Parliament and civil society

The Governmental declaration and the subsequent coalition agreements as well as the drugs action plan of the Ministry of Health put emphasis on the need to develop harm reduction activities as a current priority. Both documents are considered to be the first official political statement on the need of such measures, even though the term ‘harm reduction’ is not expressively referred to.

The cannabis topic still is in the front line of public interest, especially when it comes to increasing THC purity levels in cannabis used by youngsters. Several members of parliament have raised questions on the impact of the new drug law on an increasing prevalence of cannabis use among youngsters and the need to implement new strategies to detect illegal substance use among drivers. The amendment of the national driving code is currently envisaged in order to allow police forces to use new drug detection devices.

As regards the future implementation of injection rooms and heroin distribution programmes as retained by the drugs action plan 2000-2004, public opinion largely split leaving absolute opponents (e.g. inhabitants or trade unions of the concerned area) on the one side and practical oriented non-opponents on the other side. The site where those infrastructures will be implemented is of utmost importance as well as the objective and progressive public relation work aiming to inform the general public on possible consequences (pro and cons) of such measures.

○ Media representations

A national and international press review on drugs, jointly compiled by the State’s Press Service and the NFP since 1998, has allowed a close follow-up of the media approach towards the drug phenomenon.

Most of national media fit to objective information although a few more socially oriented radio stations and newspapers put further emphasis on controversial, yet constructive, analysis of the current situation. During 2003 and the 2004, the topics most currently covered by national media are, cannabis use, banalisation of prescribed psychotropics' use and low threshold or harm reduction facilities for drug users. The debate around the distinction between ministerial and community competences in the field shelter providing and the potential problems raised by the implementation of a night shelter and injection facilities in Luxembourg City is still ongoing.

2. Drug Use in the Population

Overview

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

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

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

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

● DRUG USE IN THE GENERAL POPULATION

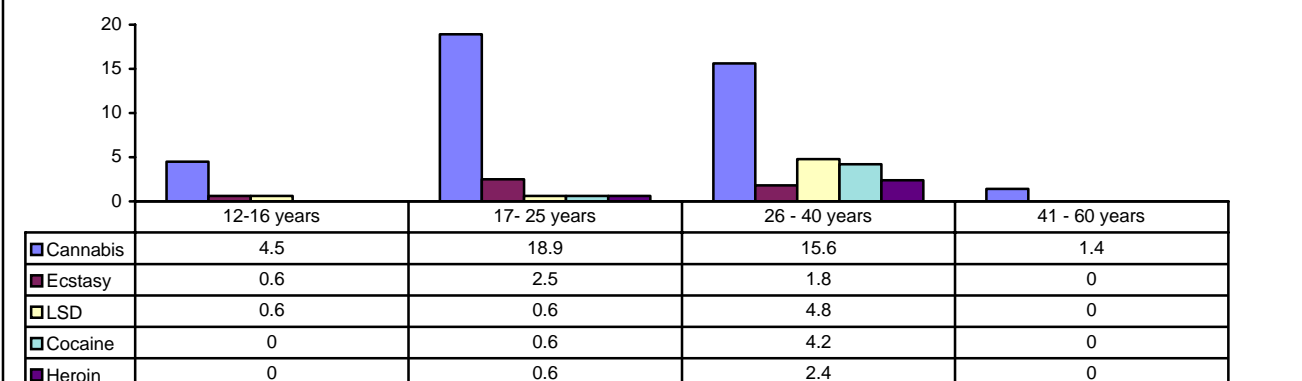
To date, no national, large-scale (representative) general population survey on drug use has been conducted. Several community or targeted population surveys should however be referred to:

REFERENCE 1. Fischer U. CH. Et Krieger W. (1999) Suchtpräventioun an der Gemeng – Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg.
EN: Drug prevention at the communal level

Year of data collection	1998
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	7 council districts of the Grand Duchy of Luxembourg
Age range	12-60 years

Substance	LIFETIME PREVALENCE (15-34 years)	LAST 30 DAYS PREVALENCE (15-34)
Cannabis	15.8%	5.6%
Ecstasy:	1.2%	0%
Heroin	1.9%	0.3%
Cocaine:	0.3%	0.3%
LSD:	1.3%	0.0%
Magic mushrooms	2.6%	1.3%

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



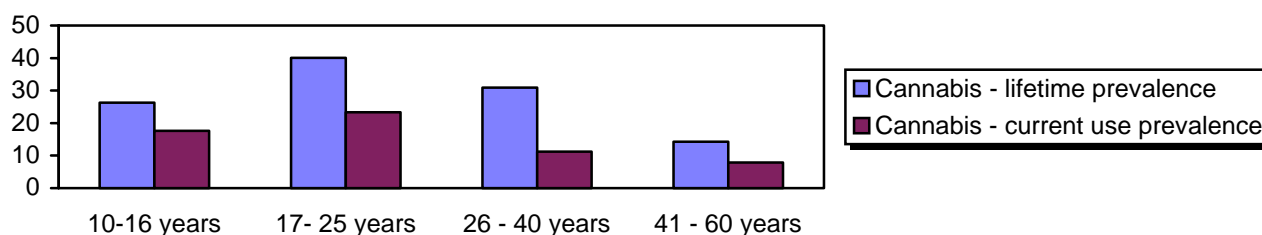
Data coll. Procedure: Anonymous self-administrated questionnaires
Sample size: 667 valid cases

Source: Fischer 1999

REFERENCE 2: Fischer U. CH. (2000) Cannabis in Luxemburg – Eine Analyse der aktuellen Situation, CePT, Luxemburg.
EN.: Cannabis in Luxemburg

Year of data collection	1998
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	Cinemas in Luxemburg-City
Age range	15-64 years
Data coll. Procedure	On-site interviews
Sample size	991 valid cases
Sampling procedure	Random sampling of cinema customers
Remark	Detailed results of both surveys are provided in EMCDDA standard tables

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



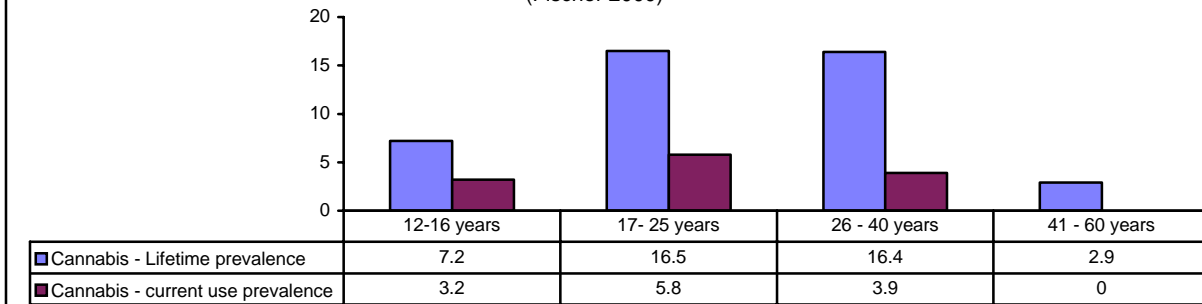
(Fischer 2000)

REFERENCE 3: Fischer U. CH. (2000) Cannabis in Luxemburg – Eine Analyse der aktuellen Situation, CePT, Luxemburg.
EN.: Cannabis in Luxemburg

Year of data collection	1999
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	6 district councils
Age range	12 to 60 years

Data coll. Procedure	Mail questionnaire
Sample size	486 valid cases
Sampling procedure	Random sampling
Response rate	27.7%

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



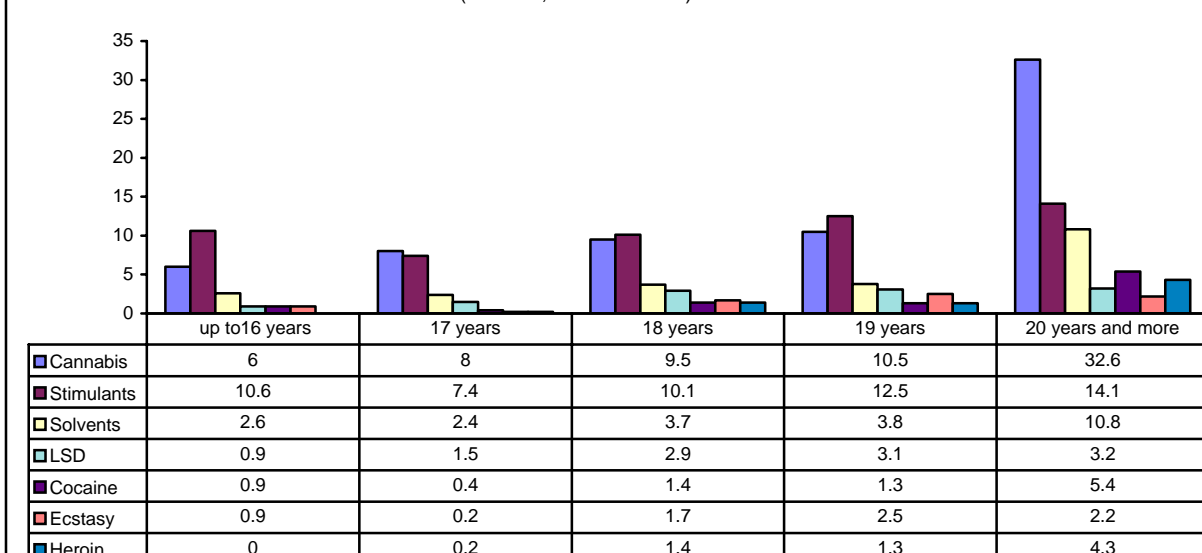
● DRUG USE IN THE SCHOOL AND YOUTH POPULATION

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

Surveys: category 1

REFERENCE 1:	Matheis J. et al. (1995) 'Schüler an Drogen', IEES, Luxembourg. EN.: Students and Drugs
Year of data collection	1992
Single/repeated study	Repeated study 1983 – 92
Context	Public Health
Area covered	Nation wide
Type of school	5 th years of all types of secondary school classes at the national level
Age range	16-20 years (AGE ENTERING 5 TH CLASS)
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	1,341
Response rate (M, F, T)	96%
	Matheis and Prussen (1985) have conducted a survey on 1983 data relying on the same methodological criteria than the 1995 survey. The referred study will be addressed in the comparative analysis part.

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

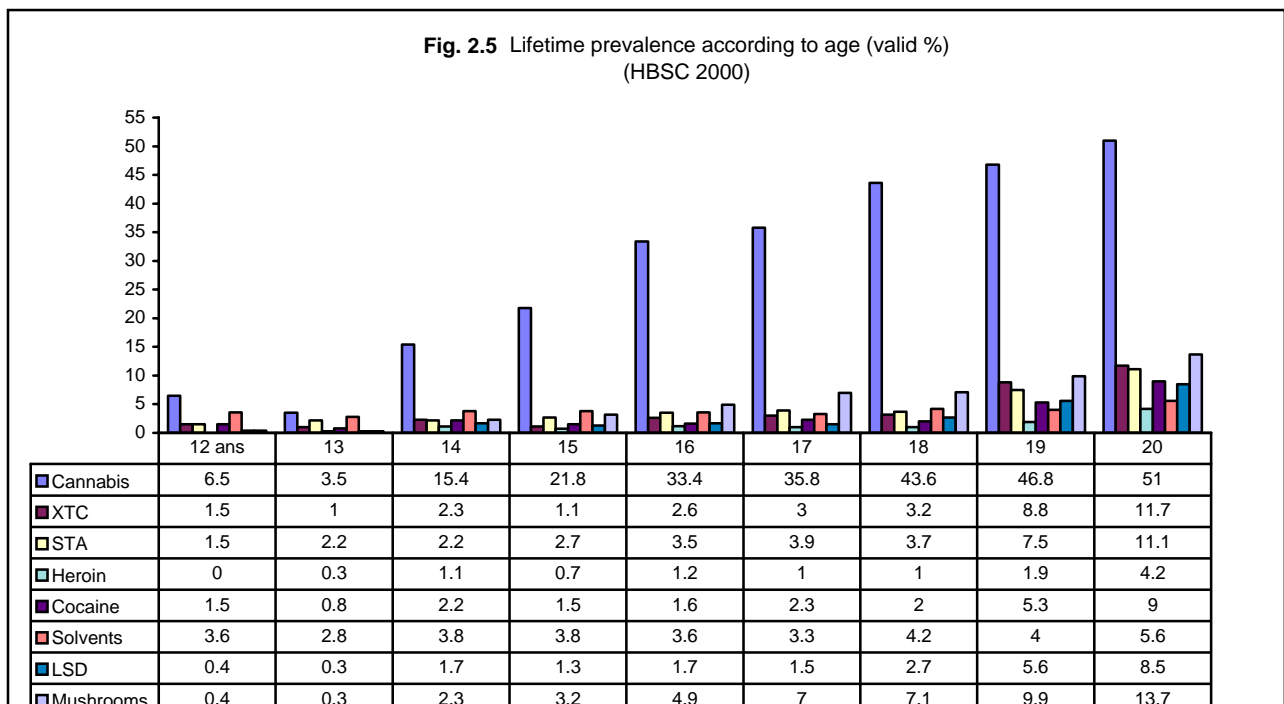


REFERENCE 2:	Dickes P. et al. (1996), La consommation de drogues légales et illégales des élèves des 6 ^{ème} de l'enseignement secondaire et des 8 ^{ème} de l'enseignement secondaire technique, CEPS/INSTEAD. Luxembourg. EN.: The use of licit and illicit drugs by students in 6 th and 8 th classes of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

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

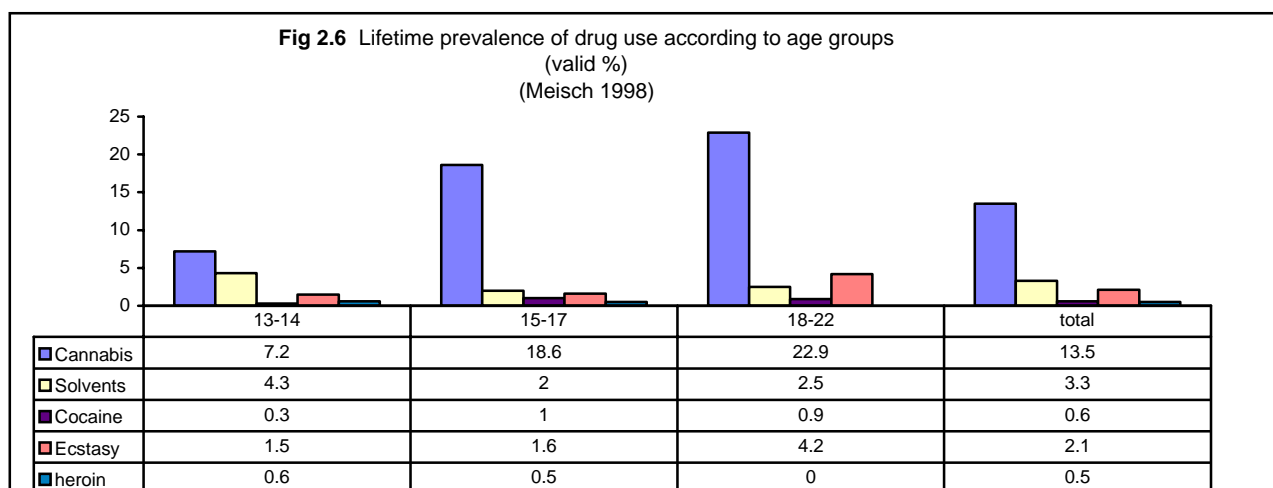
Source : Dickes 1996

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

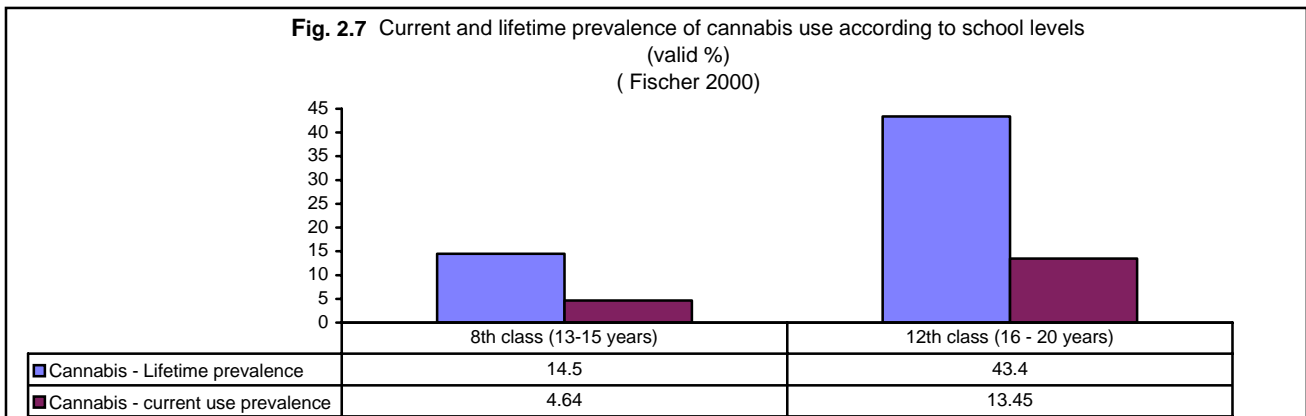


Surveys: category 2

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



REFERENCE 5:	Fischer U. CH. (2000), Cannabis – Eine Analyse der aktuellen Situation, CePT, Luxembourg. EN.: Cannabis – Rapid assessment of the current national situation.
Year of data collection	1999
Single/repeated study	Single
Context	Cannabis prevalence
Area covered	Nation wide
Type of school	2 nd and 6 th years of secondary schools
Age range	13-20 years
Data coll. Procedure	Self-administrated questionnaires
Sample size	562
Sampling frame	Schools selected on basis of their geographical situation (national representativity), exhaustive student sampling within the selected schools.
Response rate (M, F, T)	100%



SYNOPSIS OF MAIN COMPARABLE RESULTS AND OBSERVED TRENDS

LIFETIME PREVALENCE: SCHOOL POPULATION:

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

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

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

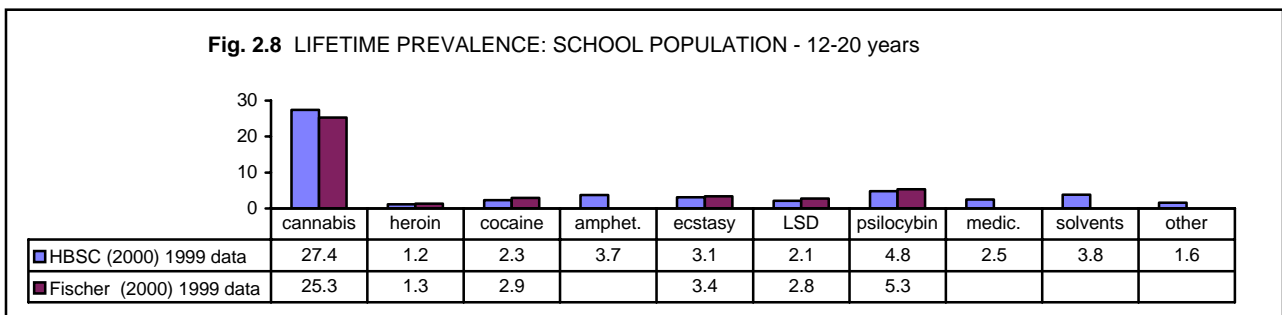


Fig. 2.9 LIFETIME PREVALENCE: SCHOOL POPULATION - 16-20 years

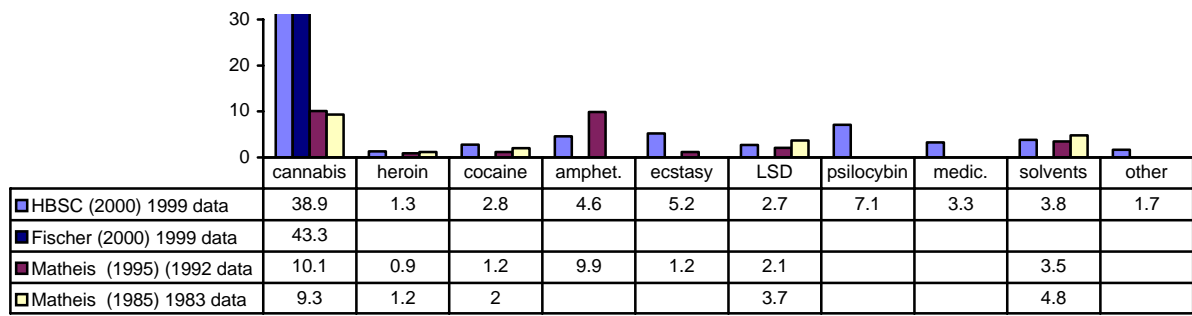


Fig. 2.10 LIFETIME PREVALENCE: SCHOOL POPULATION - 13-14 years

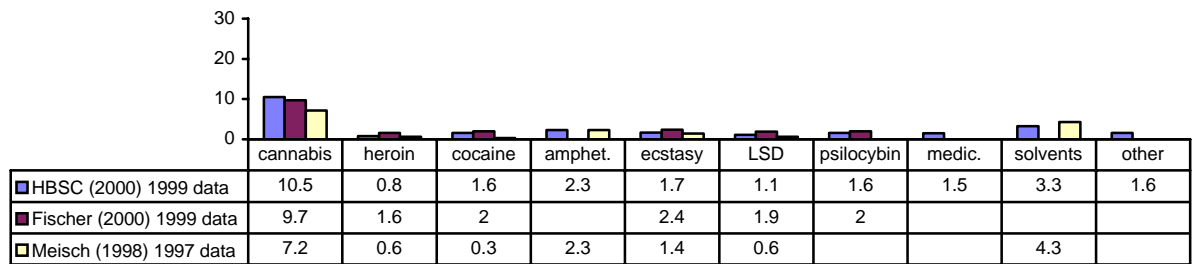
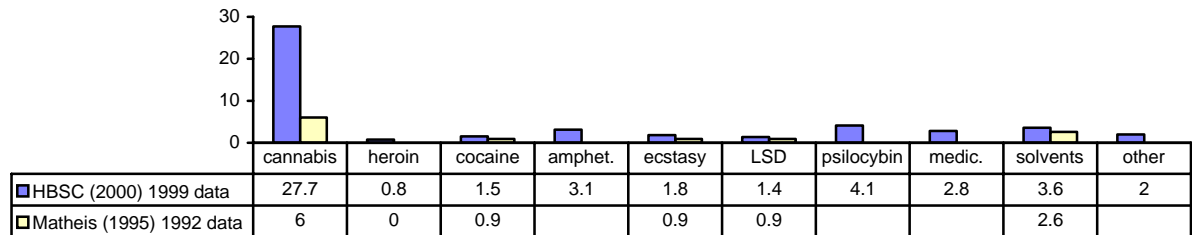


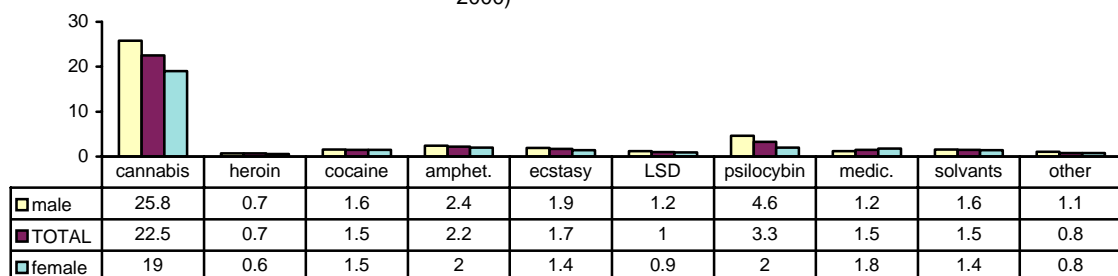
Fig. 2.11 LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years



LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

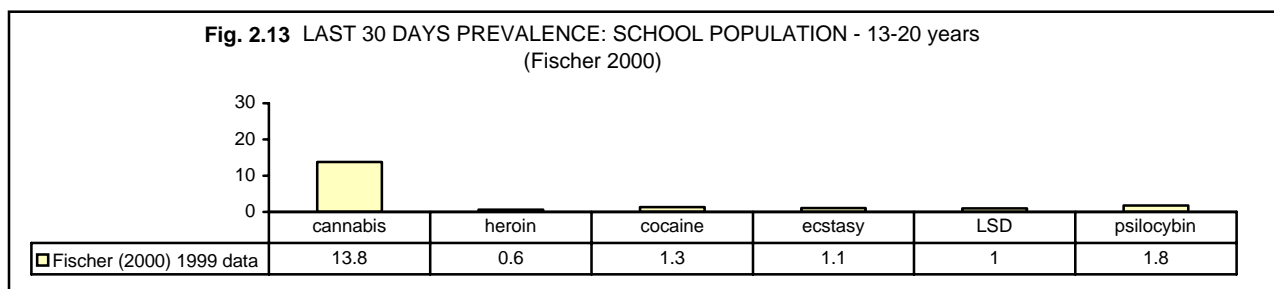
The HBSC survey (2000) is the only to provide last 12 months national prevalence figures in 12 to 20 years aged schoolchildren. Results mirror respective proportions of lifetime prevalence rates with particular emphasis on high cannabis (22.5%), psilocybin (3.3%) and amphetamines (2.2%) prevalence. Gender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

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



LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

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



● DRUG USE AMONG SPECIFIC GROUPS:

In 1998, the Ministry of Justice commissioned the medical department of the state prison (CPL) to perform an epidemiological study on HIV and HCV prevalence in prison population (ref. c.2). The research protocol included a self-administrated questionnaire on health behaviour and injecting drug use prior and during prison sentence. HIV and HCV status were determined by on site saliva tests. Data have been collected during two days on the current stock of prisoners (convicted and in custody) in all national prisons.

REFERENCE c.2	Dr. Schlink J. (1999), Etude épidémiologique des infections à l'HIV et à l'hépatite virale C dans les prisons luxembourgeoises, CPL, Luxembourg. EN: Epidemiological study on HIV and HCV prevalence in prisoners
Year	1998
Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence in prison
Area covered	All national prisons
Type sample	Stock of prison population on 4 September 1998
Age range	> 17
Data coll. Procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES
Sample size	362
Sampling frame	Exhaustive
Response rate (M, F, T)	90%

MAIN RESULTS:

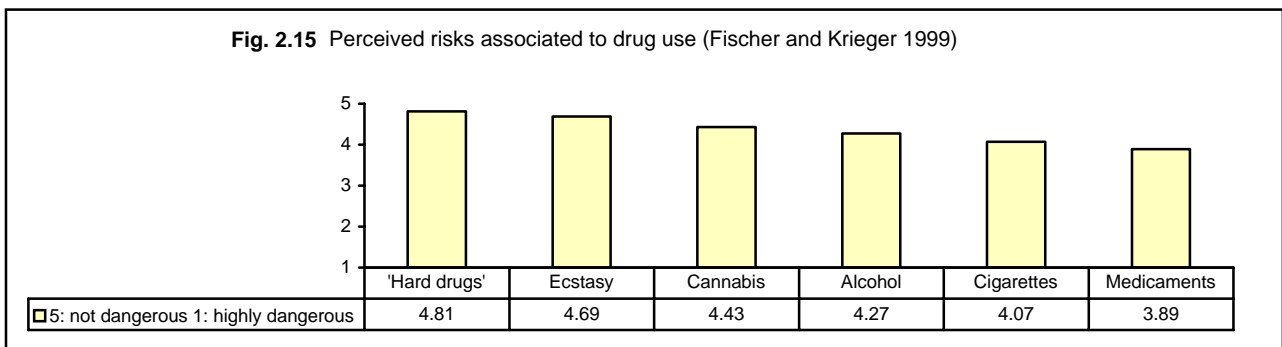
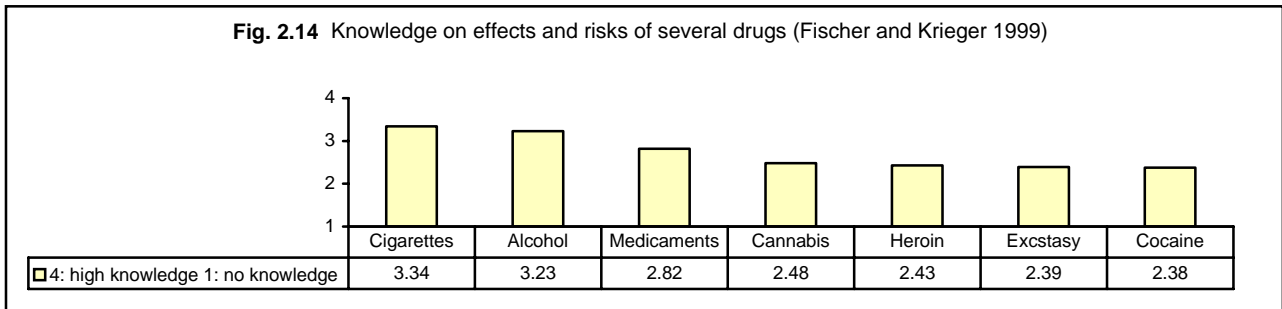
- 32% of prisoners qualified themselves as injecting drug users;
- 28% reported current drug injection in prison;
- 9% have been initiated to injecting drug use in prison;
- 8% report used needle exchange with other prisoners;
- IVDUs have served more prison sentences than non drug users (control group);
- IVDUs showed lower average age than non drug users;
- a majority of imprisoned IVDUs were natives

In 2003, the National EMCDDA focal point started an action research on HIV and hepatitis infections in drug users. Collected data should allow to analyse the links between drug use and referred infectious diseases. First results will be presented by the end of 2005.

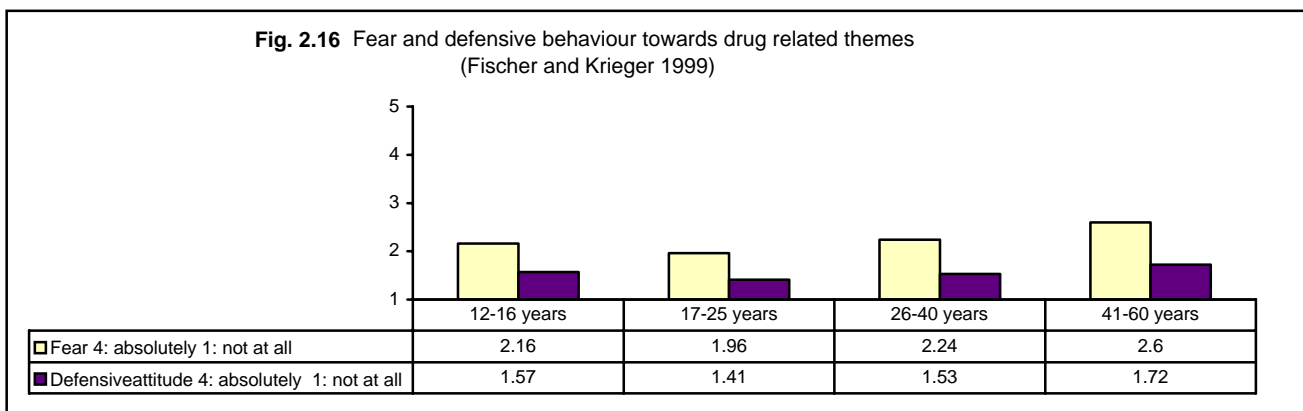
● ATTITUDES TO DRUGS AND DRUG USERS

No large-scale national public opinion survey focusing on drugs and drug addiction has been conducted thus far. Several surveys however have included items on public perceptions on legal and illegal drugs at the local or regional level.

The study ‘*Drug prevention at the communal level*’ (Fischer and Krieger 1999) refers to 1998 data collected in 7 representative regional districts on 667 subjects aged between 12 and 60. The following results can be stressed:



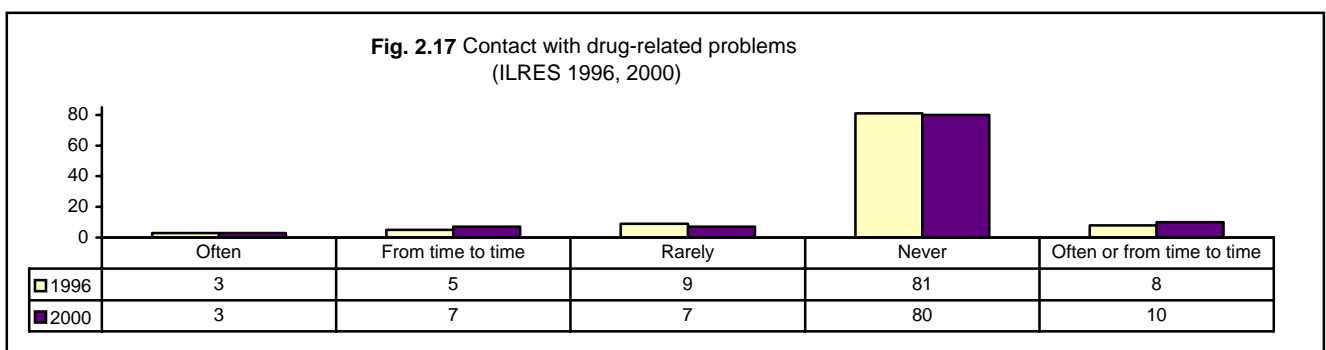
One may note that the hierarchy of perceived risks associated to the above-mentioned drugs is independent of respondents' age. Respondents showing higher educational levels report higher knowledge and tend to attribute higher risks to all referred substances.



A second group of surveys worth mentioning refers to the serial surveys performed by ILRES in 1996 and 2000 in the framework of EUROBAROMETER wave surveys n°44.3 (1996) and 54.4 (2000) (EC 2001).

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

Figure 2.17 presents the distribution of answers to the question: 'Over the last 12 months, how often were you personally in contact with drug-related problems in the area where you live? (e.g. seeing people dealing in drugs, taking or using drugs, finding used syringes, etc.)'



Although the observed percentages are low compared with most of the other EU Member States, a slight increase of the number of respondents reporting contact with drug-related problems has been observed in 2000.

3. Prevention

Overview

The present chapter provides a summary of recent universal and selective prevention measures undertaken at the national level.

More detailed information and examples of good practice can be found in the EDDRA database of the EMCDDA under: <http://www.reitox.emcdda.org:8008/eddra/>

In 2002 a specific section on primary drug prevention has been formally included in the **national drugs action plan 2000-2004 and will be reconsidered in the 2005 – 2009 action plan.**

The priorities of the drug prevention action plan as approved in 2002 are as follows:

- Interventions in school and youth environments, peer education and multipliers;
- Drugs at the workplace;
- Cannabis, Alcopops and XTC use in youngsters;
- Primary prevention intervention methods and impact assessment;
- Mass media campaigns;
- Multidisciplinary training programmes;
- Documentation strategies.

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

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

The overall coordination of **prevention, treatment and low threshold interventions** is within the competence of the **AST** (Department of Directorate of Health, future division of Drug Addiction and Social Medicine) and the **national drug coordinator's office**. The AST has coordination and financial control missions (supervision of financial contract implementation of subsidised NGOs) in the field of drug addiction and psychiatry. Furthermore, the national drug coordinator is responsible for the conceptualisation and the implementation of activities included in **the drugs action plan 2000 – 2004** (see 1.1).

According to Origer (2002), **drug prevention expenditures** during 1999 reached 583,000.- euros and 672,000.- euros in 2000. These figures include staff and operating costs of agencies and ministerial department specialised¹⁶ in drug prevention. The total expenditure has known a slight increase in 2001 mainly due to an increase in financial resources allocated to the CePT. If the drug prevention action plan previously mentioned is approved, the budget related to primary drug prevention has known a significant raise (\pm 100.000.- EUR) in 2003, due to the implementation start of the primary drug prevention action plan.

EDDRA has largely contributed to the promotion of a more scientific oriented evaluation approach at the national level. The Ministry of Health has implemented a modified version of the EDDRA questionnaire as a standard for funding requests for and evaluation of drug related projects.

Training interventions in drug demand reduction are increasingly developed at the national level. The CePT publishes an annual training directory including training activities ranging from evaluation methodologies to demand reduction action-research strategies targeted at **drug prevention and public health actors, educators, youth animators and teachers**. The 'Recherche et Innovation Pédagogiques et Technologiques (SCRIPT) department is actively involved in the referred training activities.' The Department for Scientific and Applied Research may finance training activities following request.

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

● UNIVERSAL PREVENTION

○ School

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

¹⁶ The exact estimation of prevention related costs is hazardous since multiple factors influence the development of a youngster. Education, leisure activities, sport, etc may have a positive impact on resources building; they however cannot be quantified in terms of exclusive input.

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 trained social workers that are supposed to detect, at the very early stage, problems or behaviours in relation to substance abuse.

Drug and addiction topics are included in more general courses as for instance, hygiene or ethics, which might not be mandatory. However, on the school director's demand, trained staff from the CePT or from the specialised drug department of the Police ensures information courses within secondary schools. Additionally, parent's organisation do periodically organise information evenings on drug-related topics.

In 2002, CePT in collaboration with the pedagogical innovation department of the Ministry of Education has further developed a project called ' d'Schoul op der Sich' (**School on quest**) (see EDDRA and standard table 19). The project includes interested educational institutions on a voluntary basis and targets primary and grammar schools. The CePT is providing training on site interventions and documentation to participating schools. The project has started in 2000 and will be concluded in 2003. Evaluation results will be reported in the annual report in 2005.

MSF (Youth Solidarity Project) is associated to the project in terms of complementary service providing at the level of crisis intervention. The project is called "**Solution finding in case of drug abuse in school**" (see standard table 19). As school directors might see no other choice than to dismiss students showing drug consume, the MSF project is meant to act as a mediator between concerned students, parents and school direction, by proposing counselling and a series of alternative measures.

In the framework of the partnership '**European Healthy School and Drugs**' (EHSD), coordinated by the Trimbos Insitut (NL), the CePT actively participates in the development of improved and innovative instruments and approaches in the field of drug prevention in schools. Specific workgroups address concepts such as multiplicators, evaluation or monitoring systems. An European manual on drug prevention in schools will document the final outcome of the EHSD project.

The project '**OUT-TIME**' jointly implemented by the CePT and the SNJ links drug prevention to adventure pedagogical instruments and focus on pupils in 5th and 6th classes of primary schools. Target groups are educational staff, pupils and parents. The methodology of the project is based on the hypothesis that youngsters who are physically in a good shape, are mentally challenged and who can rely on stable orientation marks such as empathic parents show a lower probability to use (abuse) drugs. A possible way to do drug prevention could therefore consist in providing opportunities for the latter experiences in a secured framework so as to transmit the message that numerous of these emotions can be reached without using drugs. Stress and frustration management, experience of personal limits, relaxation after physical and mental efforts are some of the targeted experiences. During 2003, 14 primary school classes have participated in the project which takes place in a Youth centre in the countryside. The 'OUT-TIME project has been evaluated by the University of Koblenz.

○ Family

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

Active collaboration between the CePT and parent's association at each education level does exist.

In 2001 CePT has released the so called '**prevention boxes**' (see standard table 19) including didactic material destined to potential multipliers as for instance teachers, parents and youth animators. The first prevention box, targeting 3 to 5 years old children has been released in September 2001. Due to its success, the 3-5 years prevention box will be reedited and a second one for children aged 11 to 15 years has been released in 2002.

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

○ Community

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

Generally speaking, local and regional communities do rarely dispose of a comprehensive drug prevention strategy. Commonly, a given national agency initiates projects, defines the general intervention framework and seeks active collaboration with community authorities in order to meet local needs. The observed situation is mainly due to geographical parameters of the Grand Duchy. At present only two agencies focus on interventions in recreational settings, namely the CePT (community project¹⁷) and the MSF Solidarity Youth (on site-interventions planned).

● SELECTIVE/INDICATED PREVENTION

○ Recreational settings

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

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

The main national institutions involved in the youth activities or programmes are:

¹⁷ In the beginning of 1995, a pilot project on **community-based drug prevention** has been launched by CePT (see EDDRA). The main idea was to focus prevention activities on the very environment and daily life experiences of young people. Various demand reduction activities have been undertaken, either developed by CePT, SNJ and several youth centres, or initiated by the respective District Councils. *13 district councils and 150 volunteers are currently involved in the project.* The funding of this community project is jointly ensured by the involved district councils, the EU (Drug Prevention Programme DG-V) and CePT.

The primary aim of the project is to improve communication skills on drugs, to increase participants' abilities in handling conflicts, stress and frustration (age range: 12 to 65 years) and to set up autonomous groups to continue implementing local prevention measures. In each participating municipality, prevention groups were composed of local volunteers who were asked to organise local drug-prevention activities related to their specific needs. Cornerstone concepts of the project are as follows:

- Multidisciplinary drug prevention
- Tailor-made community solutions
- Health promotion with regard to risk and protective factors
- Holistic and systemic approach
- Target groups oriented
- Routine evaluation

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

- The Service National de Jeunesse (SNJ)
- CePT
- The programme 'Support of initiatives of young people'
- The National Agency for the Community programme for the exchange of young people
- Centre Information Jeunes (CIJ) .
- Centre d'Animation Pédagogique et de Loisir (CAPEL)
- The Mondorf Group

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

In this respect, the demand reduction activities organised by the "Mondorf Group" (joint initiatives of border regions of France, Germany, Belgium and Luxembourg) jointly with the CePT and SNJ combine a **non drug-centred approach** with **intercultural components** in organising corporate leisure activities for youngsters from border countries based on the concept of '**adventure pedagogy**'. The annual "**adventure weeks**"¹⁸ do fit in a broader programme named "Adventure pedagogy and primary addiction prevention". Those activities primarily aim to provide the opportunity to youngsters to experience group dynamics, conflict management, limit and risk assessment as well as the feeling of solidarity within a group of socially and culturally different people. The program further aims at the reduction of risk factors and the enhancement of protection factors, by focussing on youngsters and their environment, rather than on drugs and

¹⁸ In 2003 youngsters from four youth centres of Luxembourg and Germany participated in the so called "adventure week". The project which aim is "adventure pedagogy as a method of addiction prevention" resulted from a larger program named "Nature- Movement- Creativity" set up by the Mondorf Group. The National Drug Prevention Centre" (CePT) was responsible for the project and its evaluation was ensured by the "Centre of empirical and pedagogical research" of the University of Koblenz-Landau.

The project consisted of two main parts: a continuing education for the education professionals and the "adventure week".

By means of structured interviews three months after the "adventure week", attitudes, opinions, social and personal skills of the youngsters were evaluated.

The results showed that the youngsters positively evaluated the interactions, the unity of the group and certain sport activities. Social and individual aspects, such as reduction of conflicts, mutual support and growing sense of responsibility were often cited. In addition answers stressed a greater self-confidence and the positive aspect of new friendships. The majority of the youngsters gained new physical and emotional experiences, recognized own limits, experienced common interests and group dynamic. The fact that only half of the youngsters had been reached for the interviews three months after the adventure week constituted a restriction to the evaluation.

By means of structured interviews and pre-post surveys, a week before and two months after the educational measure (adventure week), the educators evaluated the continuing education, the measure, the attitudes and general and personal changes in all day life in the youth centres.

The training and the concept of the adventure pedagogy were evaluated as very positive. Also the aspects of the sensory perception, body consciousness and creativity were positively judged. The educators observed improvements in conflict management and relationships between all actors. The results of the survey two months after the measure showed that generally the educators were still satisfied with the continuing education. The transferability of the contents into daily relationship with the youngsters was estimated very differently. Some opinions were that the measure doesn't provoke long-term effects. No greater changes in the personal life skills of the educators were noted.

The conclusions of the project underline that youth centres constitute a special social environment and confirm the importance of an internal structure helping youngsters to maintain the personal and social skills acquired during the measure in all day life of the centre.

The complexity of the adventure pedagogy illustrates the difficulty of evaluation of the measure and its effects. More data and results are needed to explain the relevant factors and to guarantee the development of this method. Further scientific research is recommended.

addiction. Currently regional teams specialised in drug prevention meet in autonomous working and training groups and report activities to the Mondorf Group.

The CePT closely collaborates with the National School for Physical Education and Sports (ENEPS) in the framework of a project called ' Give strength to children'. Information and training sessions in presence of a top professional sportsman have been organised. A working group has been set up in order to elaborate a concept for future activities. A programme called '**Sport and drug prevention**' started in the course of 2002.

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

Major organisers of techno or rave events do contact the national drug coordinator's office and law enforcement agencies in order to seek advice and to inform on planed events. However, there is no legal obligation to do so. Moreover, nightlife venues are recommended to apply common **saver nightlife guidelines** by prevention agencies, but once again, there is no legally binding framework.

The **law of 29 June 1989** on taverns (inns)¹⁹ management regulates the functioning of establishments licensed to serve alcoholic beverages in terms of control measures and security standards to meet (laid down by subsequent grand-ducal decrees). No reference is explicitly made to illegal drug use. The Ministry of Finances controls the application of the law at the national level. As far as nightlife venues are concerned, organisers have to fulfil security and hygiene standards defined and controlled by special departments of the ministry of Labour²⁰ and the ministry of Health.

An exploratory study on the current situation and needs with regard of prevention in night life settings has been included in the drugs action plan 2005 – 2009.

○ At-risk groups

Special attention is currently given to **Youngsters** and to the **local Portuguese community**. In the framework of the EU PIC-Equal programme, a project on ethno-specific prevention measures is about to be set-up. The latter focuses on linguistic and socio-cultural specificities of ethnic minorities and in particular Portuguese natives. Moreover, the 2004-2009 governmental programme underlines the necessity to further develop prevention programme for Youngster with regard to polydrug use and in particular the increasing use of alcoholic mix-drinks also called Alcopops.

¹⁹ Loi du 29 juin 1989 portant réforme du régime des cabarets. Entry in force 29/06/1989

²⁰ A special department of the ministry of Labour called ITM is in charge of issuing and controlling security standards for workplaces and places with public access. The ITM standard ITM-CL54.1 addresses night and festivity venues. These standards are legally binding. The ITM has to provide a formal authorisation before the opening of a given venue.

4. Problem Drug Use

Overview

At the national level 'problem drug use' (PDU) or 'harmful use' is defined according to the WHO Lexicon of Alcohol and Drug terms (Geneva, 1994):' *A pattern of psychoactive substance use that is causing damage to health, physical or mental. Harmful use commonly, but not invariably, has adverse social consequences [...].*

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

According to recent indicators **prevalence figures** applied to the national population aged 15-64 situate between 2,500 and 2,800 PDUs. **Intravenous heroin use** associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. More recently **low quality cocaine use** in combination with heroin has become more prevalent. **Ecstasy-like** substances and **ATS** show an increasing demand even though seizure figures do suggest an inverse and currently stable trend. The use of most 'new synthetic substances'²¹ recently detected in other EU Member States have not been reported at the national level.

All indicators on **cannabis use** (problematic and recreational) have been on the increase for several years. Cannabis showing **high THC concentrations** is increasingly found on the national market.

The ratio of **intravenous opiates consume** to the **inhalation mode** has stabilised at 2:1. Specialised drug agencies have recently started to provide '**blowing paraphernalia**' (e.g. aluminium foils) in order to encourage non-iv use of heroin and reduce risks associated to intravenous use, which may have influenced consume patterns.

The **average age of first consume of cannabis, ecstasy and i.v. heroin** tends to decrease. Also, the **average age**, applied to the total PDU population has markedly increased over the last 5 years. The proportion of **PDUs aged 35 and more and those younger than 19 years** has constantly increased as well as the **standard deviation** of the observed age distribution meaning that the gap between the youngest and oldest problem drug users tends to increase. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders, in the total PDU population and to the percentage of students in problem drug users.

The average ages of native and non-native problem drug users tend to balance. The **average ages** at the moment of **first consume** of the current main drug and illicit drugs in general have shown a slow but constant downward trend for the last 5 years. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2003.

● PREVALENCE AND INCIDENCE ESTIMATES

Data presented in the present chapter have been provided by the most recent drug prevalence study on PDUs aged between 15 and 64 years (hereinafter referred to "2001 study") conducted by the focal point between 1999 and 2001 (Origer 2001)²² and refers to the years 1999 and 2000.

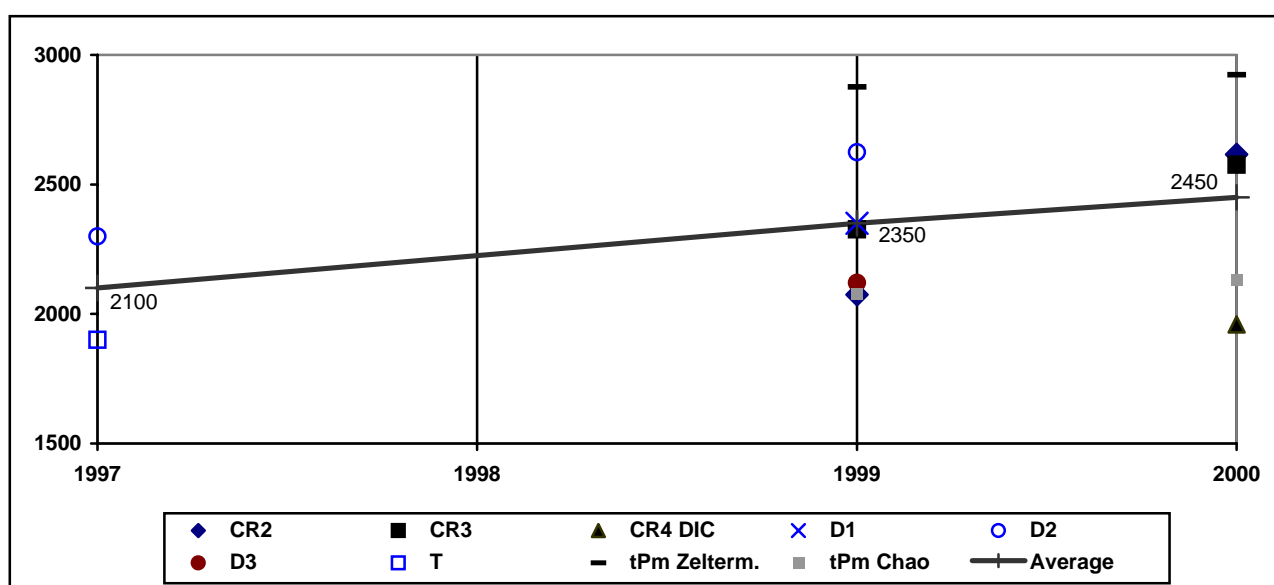
²¹ substances such as MBDB, 4-MTA, Ketamin, PMMA 2C-I, 2C-T-2, 2C-T-7, 2C-D, 2C-E, TMA-2, BZP, TFMP, 5-MeO-DIPT, 5-MeO-DMT, AMT, ALEPH 7, DXM, DPT

²² Downloadable at <http://www.relis.lu>

Since there have been no national prevalence study since 2000, indirect indicators have been further observed and produced in order to assess the general evolution of PDU prevalence.

Data from 1999 and 2000 have been considered in comparison with first national drug prevalence figures from 1997. The following methods have been applied: Case finding (CF), capture-recapture on 2,3 and 4 sources (CR 2,3,4), truncated Poisson model associated to Zelterman's and Chao's estimators (tPm), and four different multiplier methods using data from law enforcement sources, drug mortality registers (D1, 2, 3) and treatment agencies (T).

Fig4.1. Prevalence estimation of problem HRC drug use (1997 – 2000)



Source: Origer 2001

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

	1997	1999	2000
GENERAL POPULATION			
National population on 1 st July	421,000	432,450	438,500
National population aged between 15 and 54 years on 1 st July	239,818	245,308	248,440
HRC USERS IN CONTACT WITH THE NATIONAL INSTITUTIONAL NETWORK (low threshold agencies not included)			
Total number of indexed users (multiple counts excluded)	/	1,198	1,024
Number of drug treatment demanders in specialised institutions		757	637
Outpatient	/	624	557
Inpatient	/	218	178
Number of drug law offenders (ad minima consume of HRC drug(s))	/	551	510
PROBLEM USE: HRC DRUGS			
Average prevalence	2,100	2,350	2,450
Total prevalence rate	5 / ¹⁰⁰⁰	5.43 / ¹⁰⁰⁰	5.59 / ¹⁰⁰⁰
Total prevalence rate – age: 15-54	8.8 / ¹⁰⁰⁰	9.58 / ¹⁰⁰⁰	9.86 / ¹⁰⁰⁰
PROBLEM USE: MAIN DRUG – HEROIN			
Prevalence heroin	1,680	1,975	2,010
Total prevalence rate – heroin	4 / ¹⁰⁰⁰	4.57 / ¹⁰⁰⁰	4.58 / ¹⁰⁰⁰
Total prevalence rate – heroin – age: 15-54	7 / ¹⁰⁰⁰	8.05 / ¹⁰⁰⁰	8.09 / ¹⁰⁰⁰
INTRAVENOUS DRUG USE (IDU)			
Prevalence IDU	1,370	1,780	1,715
Total prevalence rate – IDU	3.25 / ¹⁰⁰⁰	4.12 / ¹⁰⁰⁰	3.91 / ¹⁰⁰⁰
Total prevalence rate – IDU – age: 15-54	5.71 / ¹⁰⁰⁰	7.26 / ¹⁰⁰⁰	6.90 / ¹⁰⁰⁰

Source: Origer 2001

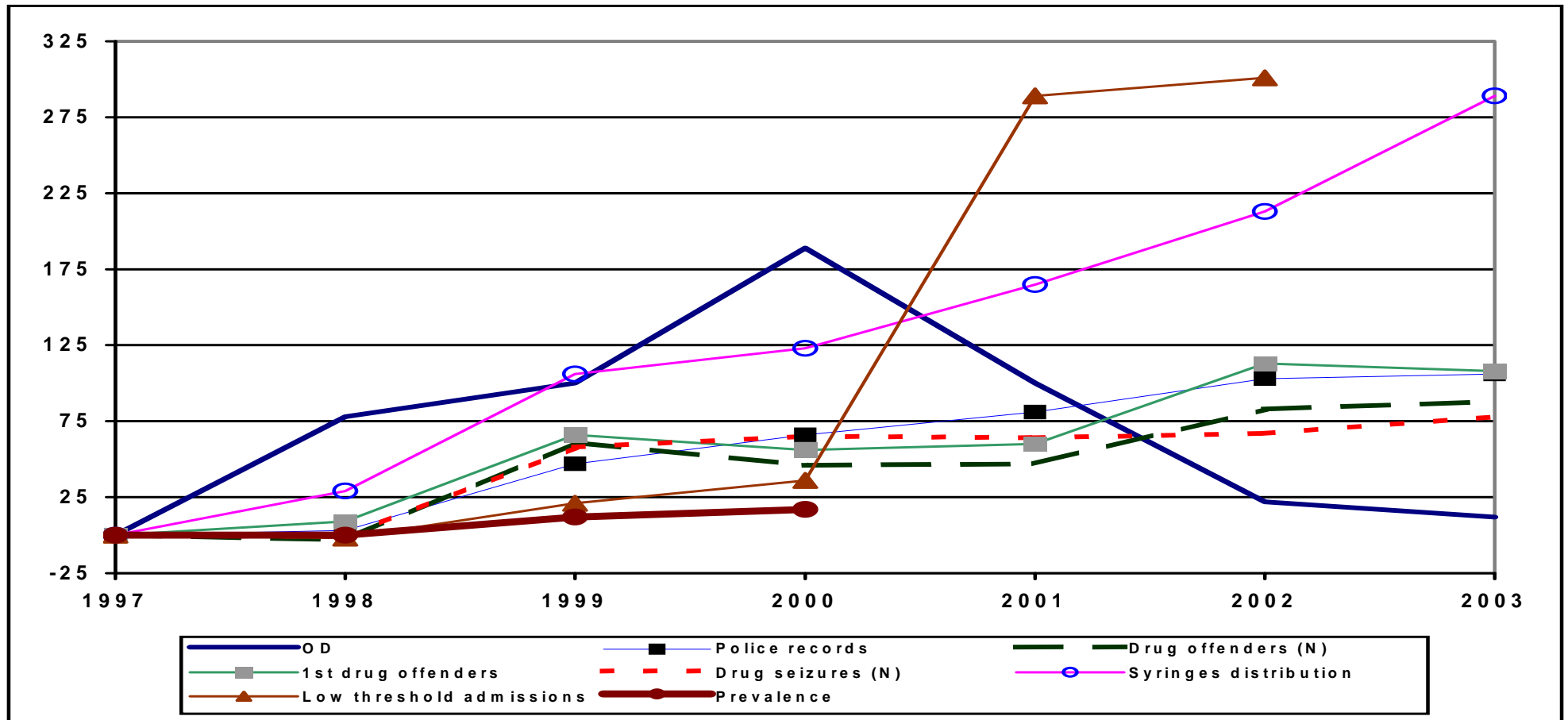
Absolute prevalence and prevalence rates of **problem HRC drug use** have shown a growing tendency over the past four years. The increase curve observed between 1999 and 2000 is less

pronounced than the one observed during the period 1997 to 1999. The observed figures comply with the stability of **heroin use** and **intravenous drug use** prevalence between 1999 and 2000. Although the overall drug use prevalence shows an upward tendency, heroin use did not contribute significantly to the referred progression. Intravenous drug use prevalence has even shown a slight decrease in 2000.

In order to validate estimated prevalence rates, data from different sources had to be considered. As can be seen in chart 2.3.a.1, prevalence estimates from 1997 to 2000 indicate a moderate upward trend in compliance with the observed evolution of **indirect drug use indicators** (1997: reference year, all values set to zero).

As can be seen in graph. 4.2 all indirect indicators, except number of overdose cases (which have shown to be a fairly unreliable predictor as far as drug prevalence estimates are concerned) have been showing an increasing trend since 2000, the year of the last national prevalence study. Summarily one may state that drug prevalence is still increasing at the national level, although the progression rate observed from 2000 onwards is obviously weaker than the one observed between 1997 and 2000. A second national drug prevalence study, which is foreseen for year 2005 will provide a clearer picture of the current situation

Fig. 4.2. Prevalence estimates (problem use of high risk drugs) and evolution of selected indirect indicators



Source: Origer 2003

LOCAL PREVALENCE STUDIES

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

NATIONAL 'DRUG SCENES'

Summarily five different problem drug user groups are to be distinguished at the national level:

- a sub-group of **cannabis consumers**, mainly minors, located in one of the central bus stations of Luxembourg-City. The referred group is a rather closed one showing poor contact with other drug scenes. Male and female users are represented equally. Cannabis use is also significantly associated to ecstasy consume in youngsters.
- A second group, the so-called '**disco scene**', is often event-related and limited to rave or other dancing or party locations. This group is composed of youngsters between 15 and 20 years mainly attracted by ecstasy like substances and cannabis.
- The '**hard scene**' is characterised by a fair heterogeneity regarding age of users and consumed substances. However, composed by a majority of male users, the social-economic situation of this specific group is precarious. Female users who join this scene mostly do so for prostitution purposes and constitute a high risk group as regards overdosing (e.g. shorter drug carriers than males).
- The exclusive '**cocaine scene**' is described as a very dispersed one and difficult to access since cocaine consume mainly takes place in privacy. Typical cocaine users/abusers are middle age men of upper classes. Recently, however, cocaine use has largely spread within the street PDU population.

The '**regional scenes**' are mainly situated in the South of the country but more recently also in major cities of the Northern district.

CHARACTERISTICS OF INDEXED PDUS

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

The **number of problem PDUs** indexed by national institutions in 2003 figures 3,847 (1994: 2,213) (double counting included). 873 users have been indexed by national specialised drug demand reduction agencies and 1,340 persons by supply reduction agencies in **1994**. Referred to **2003** the same agencies have indexed 1,440 and 2,470 respectively, which equals to a total **progress rate of 74%**.

30% (32%) of PDUs (62% of non-natives) reported their first institutional contact (intra-institution) in 2003. Solely applied to specialised drug treatment agencies, this rate, decreasing since 1997, subsequently ran up to 22% (27%). On average, a given user has 1.8 (2.14) contacts/year with a specialised agency. 8% of PDUs did report there are **first lifetime drug treatment** in 2003. 74% (69%) of respondents have had at least one **substitution treatment** before being indexed in 2003.

The male/female ratio of the PDU population is 4:1. The proportion of indexed non-native PDUs has been decreasing over the last 4 years ranging between 48% and 35%. The **population of non-natives** drug users largely consists of Portuguese nationals (45%), a proportion which is consistently higher than the one observed in the general population. A sensitive increase of PDUs coming from eastern countries and particularly from the Soviet Union is observed.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 29 years and 7 months in 2003. The gap between the youngest and the oldest PDUs continues to grow. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to “new” PDUs. Worth mentioning is the significant increase of the average age of overdose victims and an increase of the proportion of minors and total population of PDUs among drug law offenders STUP (14%).

The mean age of native and non-native problem drug users tend to balance. The **difference in age in proportion to gender** has increased until 2000 mainly due to the low but currently increasing age of female drug users. Generally speaking, the **profile of female users** has known most significant changes during recent years. In comparison with male users, one should mention a lower age at first consume of cigarettes, at first use of illicit drugs and an earlier start of a physical addiction state reported by female users. **Average age at first use of illicit HRC drugs** has decreased approximately 3 years from 1995 to 2002. The **average ages** at the moment of **first consume** of the current main drug and illicit drugs in general have shown a slow but constant downward trend resulting in a decrease of more than 1 year from 1994 to 2003.

The **residential status** of indexed PDUs has improved over the last years. **The geographical distribution** suggests that the southern region (43%) and the centre region (36%) are the most representative. As in previous years, the northern region confirms its progression (14%).

All indicators included, the **employment status** of respondents has known no significant improvement during the last years. Also the **unemployment rate** has stabilised at a high level (46- 50%) since 1998. The decrease of financial autonomy of PDUs is associated to an **increasing social dependency**. Although a continuous decline at the level of revenues of illegal origin and a moderate decrease of the proportion of PDUs presenting **major depths** have to be underlined.

Intravenous heroin use associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. The switch to **intravenous drug use** occurs earlier compared to year 1995. More recently **low quality cocaine use** in combination with heroin seems to become more prevalent. The ratio of **intravenous opiates consume** to the **inhalation** mode has stabilised at 2:1 The recent provision of ‘**blowing paraphernalia**’ (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns.

Ecstasy-like substances and **STA** show an increasing demand even though seizure figures do suggest an inverse and currently stable trend.

All indicators on cannabis use (problematic and recreational) have been on the increase for several years. Cannabis showing high THC concentrations is increasingly found on the national market.

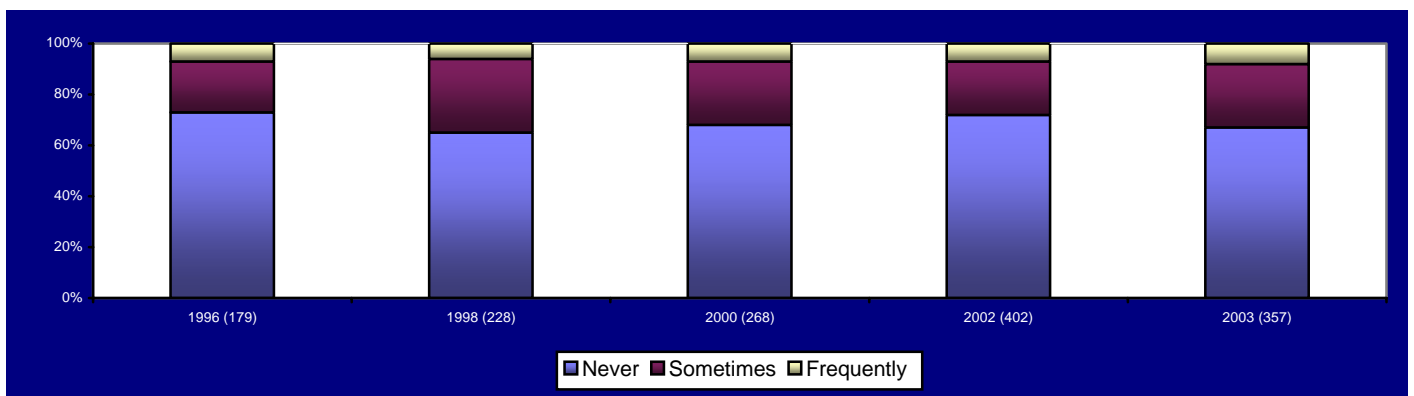
The **average age of first use of cannabis, ecstasy and i.v. heroin** tends to decrease. Also, the **average age**, applied to the total PDU population has markedly increased over the last 5 years. The proportion of **PDUs aged 35 and more and those younger than 19 years** has constantly increased as well as the **standard deviation** of the observed age distribution meaning that the gap between the youngest and oldest problem drug users tends to increase. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders, in the total PDU population and to the percentage of students in problem drug users.

A majority of drug injectors procure their injection material in pharmacies (32% ↘) followed by specialised agencies and automatic dispensers. The growing tendency in syringe distribution on recollection is partly explained by the fact that new agencies, addressing socially marginalized populations (prostitutes, homeless, etc.) have joined the needle exchange programme and that infectious disease prevention activities have been intensified.

RELIS allows for further monitoring of risk behaviours:

Needle exchange: The needle exchange rate in indexed problem drug users has been showing a slightly increasing trend over the last 6 years. In 2003, 67% of RELIS respondents reported not to exchange used needles.

Fig. 4.3 Needle sharing by i.v. PDUs during the last month. (Valid %) (1996-2003)



Source: RELIS 2004

Saver sex: Since 1997, 44 to 49% of RELIS respondents have reported condom use. No notable trend has emerged since the set up of RELIS. Male respondents report on whether they usually use condoms and women report on whether they ask partners to use them during sexual intercourse.

The RELIS protocol includes specific annually collected items on **risk factors**. Low educational levels, unemployment, foreign nationality (especially recent immigrants and Portuguese nationals), low professional profiles of parents, drug abuse within the family of origin, peer pressure (identification, etc.), and early start of drug consume have shown to be closely related to drug abuse behaviour (Origer 1998).

Risks factors with regard to drug-related fatalities are addressed in a recent comparative study on drug related deaths (Origer & Dellucci 2002) (<http://www.relis.lu>).

● PROFILE OF CLIENTS IN TREATMENT (CHARACTERISTICS, PATTERNS OF USE)

○ By substance used

The main substance involved in drug treatment demands is **heroin**. Prevalence rates fluctuate around 60 and 65% (50% iv / 15% non iv). The increasing preference for heroin by **inhalation** registered several years ago is not observed anymore. The i.v. heroin sub-population shows the highest mean age (30Y11M) of all treatment groups. 7% of the latter are **first treatment** demanders compared to 9 % of non-iv heroin users.

Cocaine use as main reason of treatment demand shows an increased prevalence (11%) that is consistent with current supply indicators. Mean age of cocaine using treatment demanders is 30 years. With 15% of first treatment demanders, cocaine users show the highest lifetime first treatment rate. Cocaine prevalence as secondary drug has stabilised around 30%. **Crack** is newer reported as main problem drug and very rarely (1%) as secondary or occasional drug.

A recent trend has also to be seen in the increasing number of treatment demands related to **cannabis use**. The percentage of the latter has passed from 4% in 1997 to 11% in 2002 showing no increase in 2003. Treatment demands related to **ecstasy use** are rare (1-3%) and have shown a fair stability over the last years. The same comments apply to **STA use**.

○ By centre types

The present section is based on RELIS data and on in-house statistics of all specialised drug treatment agencies at the national level. The overall number of clients and **number of admissions** in specialised drug treatment agencies have constantly increased over the last ten years. The proportion of **first treatment demanders** observed in 2003 was 8% (1998: 4%). For the sake of a comprehensive presentation of main observed trends, the following typology of treatment settings is applied:

➤ Outpatient, adults

After several years of stabilisation national drug counselling and therapy centres show **decreasing admission rates and first treatment rates** in 2003. Gender distribution shows **stability following a three-year upward trend in female treatment demanders** (2003: 43% / 1997: 34%). **Age distributions** have to be analysed according to the geographical situation of treatment centres. The proportion of treatment demanders in the centre region of the Grand Duchy, aged 30 years and beyond (55.9%) has sensibly increased, during recent years as did the same age group for three years in the South of the country, although the observed proportion is sensibly higher. The proportion of **underage treatment demanders** has been increasing in recent years. **Treatment demands for problem i.v. opiate use** or for multiple-use, including opiates, is still the main demand pattern although one observes a clear decrease for several years (2003: 44% / 1997: 72%). **Cannabis-related demands** show a clear upward trend (2003: 15% / 1997: 1%). **Problem cocaine use** also tend to become more prevalent.

➤ Outpatient, underage

Specialised drug care agencies for minors only exist in the centre of the country. The **rate of new treatment demanders** has constantly increased since the implementation of the referred agencies. Likewise adult outpatient agencies, gender distribution in minor treatment demanders has been showing a **rising proportion of female users** (2002: 34% / 1997: 26%) which is currently stabilised. The **mean age of clients** has been slowly decreasing since 1997. In 1997, the proportion of clients aged below 15 has raised from 7% in 1997 to 28.8% in 2003. Cannabis use is increasingly the main reason of treatment demands (83.1%), followed by heroin and ecstasy.

➤ Inpatient, drug therapy

Likewise the situation observed in outpatient counselling centres, the proportion of **new clients** has markedly increased in inpatient therapy settings in 2003. The proportion of **female treatment demanders** has stabilised at 22-25% and the observed mean age still is on the increase (2003: 29Y10M / 1998: 27Y). The referred age distribution reflects an **overall trend** observed in most adult drug treatment demanders, that is, a decrease of patients under 25 and an increase of patients **older than 25 years**. An increase is observed as to the **proportion of natives** within the inpatient treatment demanders. All treatment demands are related to **opiate abuse**, mainly i.v..

➤ Inpatient, detoxification

Drug detoxification units throughout the country show a stable trend regarding number of admissions and patients. **First treatment demands also tend to stabilise**. **Gender distribution** has remained fairly unchanged and the mean age of clients has been on the decrease for the last six years. **Multiple drug addiction** including heroin is the main reason for detoxification demand.

➤ Substitution treatment

The **number of patients** admitted to the national substitution programme has been decreasing (131) for the last 5 years, which is probably due to the increasing access to low threshold substitution by GPs. The proportion of female substitution treatment demanders (36.6% stable) is higher than the proportion of female PDUs in the overall drug treatment population. The **mean age** of clients (33Y, 9M) has significantly increased compared with 1997 data (28Y2M) and the proportion of **native substitution treatment demanders** has stabilised in recent years (70-75%). The **socio-economical** situation of substituted patients is consistently more beneficial than the one observed in other treatment demanders, which has been confirmed by the latest external evaluation (Dellucci, 2003). The number of patients who did receive substitution treatment by prescription **from independent general practitioners** is still increasing (2003: 913 /1999: 745 – multiple counts excluded), with the consequence that the **overall number of medically substituted problem users** at the national level is rising. 1,554 patients (multiple counts included) have been provided substitution treatment by the national GP network meaning that the ratio of treatment demander to prescribing GP is 1:1.7.

➤ Low threshold services

The **number of contacts** indexed by low threshold agencies has increased dramatically over the last seven years (2003: 30,407 / 1996: 6,456), and so has the number of syringes distributed by the same agencies. The proportion of **new clients** within low threshold settings is on the increase. The number of **female clients** has been showing a weak but constant decrease. Approximately 72% of clients are aged between 18 and 35 years. 35% of clients (increasing) are non-natives.

● MAIN CHARACTERISTICS AND PATTERNS OF USE FROM NON-TREATMENT SOURCES

No information available

5. Drug-Related Treatment

Overview

Drug treatment is the use of specific medical and/or psychosocial techniques with the goal of reducing or abstaining from illegal drug use thereby improving the general health of the client¹.

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

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

For the purpose of the present chapter, drug treatment, that **may or may not be associated to the medical prescription of drugs**, is divided in the following categories:

- **Outpatient treatment:** the patient receives drug treatment without staying overnight ;
- **Inpatient treatment:** the patient who receives drug treatment is staying overnight, including detoxification;
- **Substitution treatment:** a type of medical treatment provided to opiate addicts primarily based on the delivery of a similar or identical substance to the drug normally used. Substitution treatment may be accompanied by psycho-social care;

- **Low threshold measures**²³: refer to measures aimed at reducing the harm associated with drug use without necessarily requiring a reduction in consumption

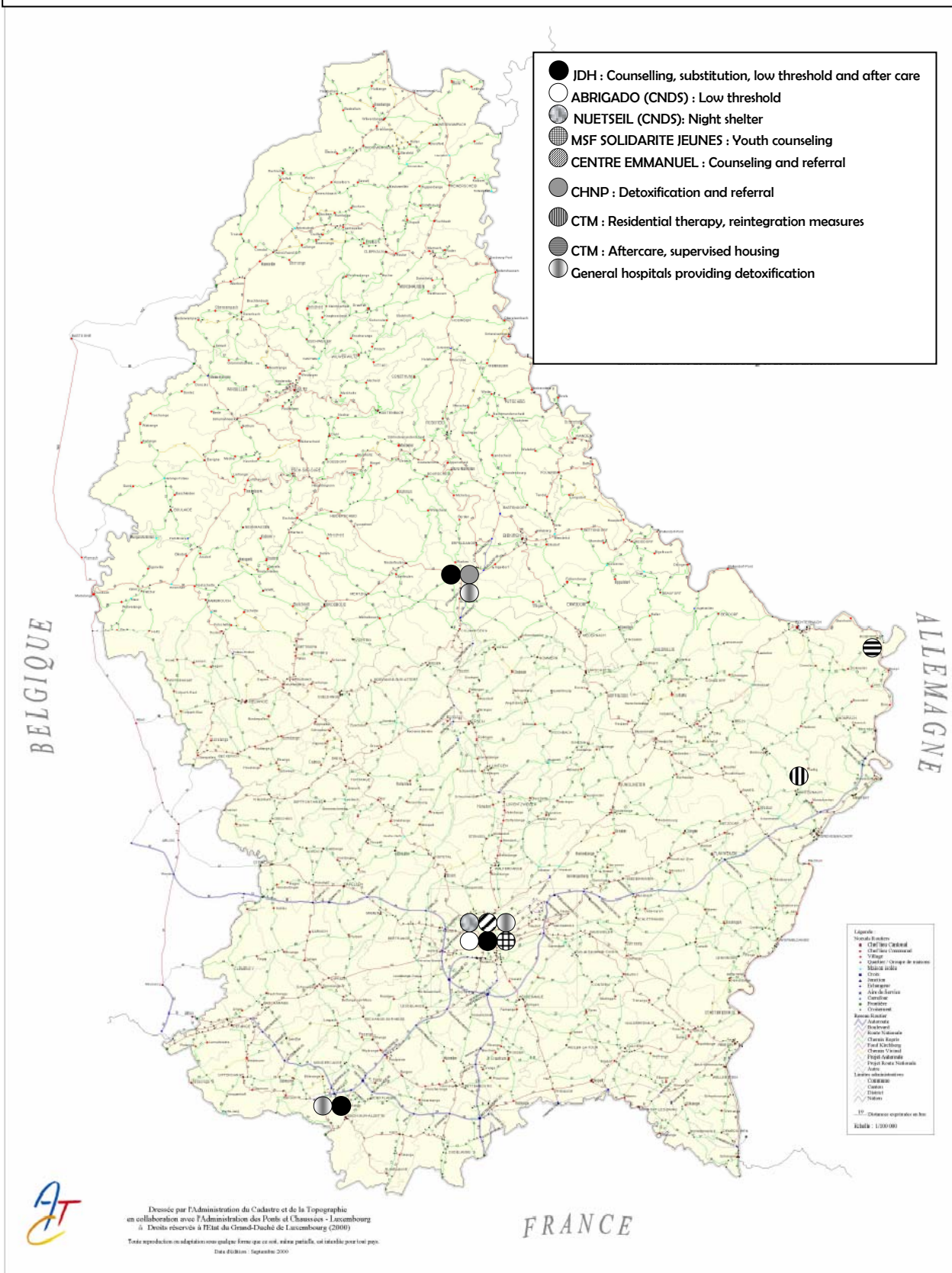
In recent years inpatient drug treatment demand has been fairly stable while outpatient treatment has been showing a weak decrease. A clearly observable increase has been reported in substitution treatment and low threshold care demanders.

The national drugs action plan 2000 – 2004 has largely contributed to fill a series of gaps in the drug treatment network. Increased admission figures related to harm reduction offers may be linked to the implementation of new low threshold services under the former action plan. The current situation analysis is therefore taken account of in the elaboration of the 2005 – 2009 drugs action plan.

²³ Although harm reduction measures are specifically addressed under chapters 6 to 9, low threshold services are to be seen as a possible alternative to treatment and thus need to be included in the analysis of treatment demand patterns.

● Treatment systems

Map 5.1 Geographical coverage of specialised drug agencies in the Grand Duchy of Luxembourg (status 2004)



As can be seen in graph. 5.1 drug treatment facilities are regionalised showing however a high concentration and diversity within the area of Luxembourg-City. All listed services are specialised with the exception of regional general hospitals providing detoxification treatment. Compared with the

situation observed in 2002, a new service has been created by the end of 2003, namely the 'Nuetseil' providing night shelter and low threshold services to drug addicts.

All drug treatment infrastructures, general hospitals excluded, are relying on governmental support and control. Most of specialised agencies have signed a **convention** with the ministry of Health, which guarantees their annual funding. NGOs involved in drug treatment fall under the obligation of the so-called '**ASFT**' law (8 /09 /98)²⁴ and the subsequent grand ducal decree of 10 December 1998²⁵, both regulating the relation (duties and rights) between State and NGOs or organisation providing psycho-medico-social and therapeutic care. The overall management of the referred agencies is ensured by a 'co-ordination platform' that includes 3 members of the concerned institution and at least one representative from the competent ministry. All major decisions have to be approved by the **co-ordination platform**.

All referred institutions work in close collaboration and have to be viewed as an **interdependent therapeutic chain** even though there are no formal agreements between them. With the exception of detoxification departments, that mainly deal with opiate users, all treatment units or agencies accept any drug using patient independently of the type of substance(s) that are involved.

The **governmental quality standard certification**, as foreseen by the law '**ASFT**' of 8 October 1998, **represents** the main tool towards a standardised quality control. However, funding is not directly related to clearly defined evaluation requirements. The quality standard certification commits respective NGOs to undertake necessary evaluation measures of their activities by means, however, they deem adequate.

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

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

Table 5.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 2003. **Intra-institutional multiple counts** are excluded meaning that all treatment demanders indexed by a given agency is only indexed once by the referred agency during a reporting year. **Inter-institutional multiple counts** are not excluded since a given treatment demander may have contacted several national agencies during a given year. More detailed admission data, including low threshold agencies are produced in respective sub-chapters.

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

²⁵ Règlement grand-ducal du 10 décembre 1998 concernant l'agrément à accorder aux gestionnaires de services dans les domaines médico-social et thérapeutique. (entry in force 18/12/1998)

Table 5.1 Clients admission statistics of drug treatment institutions (Inter-institutional multiple counting included)

INSTITUTION	NUMBER OF ADMISSIONS (A) AND/ OR CONSULTATIONS (C) AND/OR CONTACTS (CO)						NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)					
	94	96	98	2000	2002	2003	94	96	98	2000	2002	2003
SPECIALISED OUTPATIENT TREATMENT												
SPECIALISED OUTPATIENT TREATMENT	1,664	1,093	1,104	1,444	1,936	2,227	467	618	764	884	1,052	982
SPECIALISED INPATIENT TREATMENT	48	58	39	43	57	44	48	55	56	56	52	56
INPATIENT - DETOXIFICATION							≈ 308	≈ 277	≈ 251	316	289	282
LOW THRESHOLD AGENCIES		6,456	9,499	13,083	29,536	31,336						
DRUG TREATMENT ABROAD							≈ 50	55	71	102	101	120
TOTAL Number of drug treatment demanders (Multiple counts not excluded) (Multiple counts excluded)							713 n.a.	885 n.a.	1,006 n.a.	1,113 637	1,448 n.a.	1,440 n.a.

Table 5.1 summarises in-treatment statistics of PDUs excluding inter- and intra-institutional multiple counts as determined for the first time by the RELIS database in the framework of the national drug prevalence study 1997 - 2000 (Origer 2001). Although, **inter-institutional multiple counting** controlled data on drug-related institutional contacts are only available since 1999, a **current stabilisation** seems to occur following a steep increase observed between 1998 and 2000.

● DRUG FREE TREATMENT

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

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

For the purpose of the present report low threshold, harm reduction services and withdrawal treatment have been excluded from the present sub-chapter. Distinction will be made between outpatient treatment and inpatient treatment.

Outpatient treatment

RELEVANT TREND: Decrease of **admission rates and first treatment rates**. Stable gender **distribution**. Increasing proportion of **clients over 30 but also increasing number of underage treatment demanders**.

The most relevant national outpatient treatment facility is the ‘JDH Foundation’. Regional antennas of JDH are respectively implemented in Luxembourg City, in the South and in the North of the Grand Duchy and are entirely financed by the Ministry of Health. MSF Solidarité–Jeunes is addressing youngsters who have run into conflict with law enforcement for drug related offences. The Emmanuel Centre is primarily a referral agency of the Communita Emmanuel situated in Italy.

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.

Jugend- and Drogenh llef Foundation. (JDH) (nation wide)

Team: 13 staff members	Prevention, counselling and orientation
Therapeutic interventions	Street work / Outreach
Methadone programme	Preparation to residential care
Needle exchange	and post cure facilities
Social assistance	Interventions in prison
On-site counselling (Hospitals and prison)	Open Door

M decins Sans Fronti res (MSF)-Solidarit  Jeunes

Counselling, orientation and networking
 Therapeutic interventions (individual and family)
 Social assistance and legal advice
 Team: 3 psychologists

The 'Centre Emmanuel association' is subsidised by the Ministry of Health. The team, composed of former drug addicts, one psychologist and one educator offers former drug addicts and addicts' parents the opportunity to meet on a regular basis. The centre also is the national interface for the Italian treatment communities 'Comunita Emmanuel'.

Inpatient treatment

RELEVANT TREND: Stable situation

The only therapeutic community called 'Syrdallschlass' (CTM-CHNP), is situated in the East of the G. D. of Luxembourg. The therapeutic programme of the CTM is divided into three progressive phases that have been revised during 1997. The duration of a therapeutic journey varies from 3 months to 1 year.

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

The **national drug action plan** had foreseen the extension of CTM offers by creating a network of **modular therapeutic annexes** for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone, etc. These annexes are operational since September 2002 and are situated in the vicinity of the main centre (see chart 11.1) in order to take advantage of training and social reintegration facilities offered by the CTM.

Therapeutic offer:

- individual therapies
- family-oriented therapies
- thematic talking groups
- gender specific groups
- work based therapy

sport therapy
 professional training
 post-cure facilities
 body therapy and relaxation
 leisure activities

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

Table 5.2 Drug treatment abroad covered by health insurance scheme (1996-2003)

AGE GROUP	1996	1997	1998	1999	2000	2001	2002	2003	Males (2003)		Females (2003)	
	N	N	N	N	N	N	N	N	N	%	N	%
< 20 years					3	3	5	1	1	1,1	0	0
20 à 25 years					33	26	33	35	24	27	11	35,5
> 25 years					66	68	63	84	64	71,9	20	64,5
TOTAL	55	57	71	91	102	97	101	120	89	74,2	31	25,8
Mean age					27Y9M	29Y5M	28Y	30Y7M	31Y		30Y	

Source : Administration du Contrôle Médical : Cures de désintoxication (drogues dures et polytoxicomanie) à l'étranger - Exercices 1996-2003

● MEDICALLY ASSISTED TREATMENT

○ Withdrawal treatment

RELEVANT TRENDS: Number of admissions, first admissions and number of clients stable - Increasing mean age – Increased proportion of clients aged 15 to 24 years.

Physical drug detoxification is provided by five different hospitals via their respective psychiatric units. The most important detoxification unit is implemented within a specialised department of the CHNP (15 detoxification beds). Medical interventions and psychosocial support are provided to control and reduce withdrawal symptoms in the framework of a 1-2 week detoxification programme. Ideally, detoxified patients are referred to more therapeutic oriented institutions.

The other four detoxification services are provided by non specialised psychiatric units within four general hospitals:

- Clinique St. Louis – Ettelbrück (North) – 15 psychiatric beds
- Hôpital de la Ville d'Esch-sur-Alzette - HVEA (South) – 33 psychiatric beds
- Centre Hospitalier de Luxembourg – CHL (Centre) – 45 psychiatric beds
- Clinique Ste. Thérèse (Centre) – 12 psychiatric beds.

The interventions of the latter are basically limited to physical detoxification (admission figures see table 5) whereas the BU-5 unit of the CHNP provides the following:

- Short term detoxification,
- Counselling and orientation / individual and familial approach;
- Methadone distribution in the framework of the national substitution programme;
- Average duration of treatment 2-3 weeks;
- Team: multidisciplinary.

○ Substitution treatment

RELEVANT TRENDS: Decrease in number of patients in structured programme. Increase in low threshold substitution demands – Increase of female clients- Increase of mean age of

substitution treatment demanders - Increase in proportion of Portuguese nationals in substituted patients.

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

Substitution treatment is provided at the national level since 1989 (JDH). Until the beginning of 2001, however, there has been no **legal framework** regulating drug substitution treatment. The law of 27 April 2001 modifying the basic drug law of 19 February 1973 introduces a legal framework for substitution and maintenance treatment. The grand ducal decree of 30 January 2002²⁶ regulates the practical modalities of substitution. The new law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of **substitution treatment licenses** granted to MDs and specialised agencies, the application of training requirements for prescribers and adequate control mechanisms of **multiple prescriptions** (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a **structured substitution treatment programme** (JDH - mainly liquid oral methadone – 131 patients in 2003) provided by specialised agencies (JDH) and a **lower threshold substitution treatment** offer provided by freelance state licensed MDs (MEPHENON ® METHADICT ® and SUBUTEX ®).

*A **central substitution register** is about to be implemented jointly by the newly created 'Surveillance Commission on Substitution Treatment'²⁷, the national drug coordinator and involved specialised treatment centres.*

General admission criteria to substitution treatment as defined by the decree of 30 January 2002 are as follows:

- treatment demander presents symptoms of drug addiction as documented by international diagnostic criteria and toxicological evidence, and is not likely to be adequately treated by other therapeutic techniques,
- treatment demander is native or is a resident of the Grand Duchy of Luxembourg. (Demanders who do not meet the latter requirement are nonetheless admitted if they follow a documented substitution treatment in another Member state of the EU).
- a written demand by the demander or his/her parental authority in case he/she is underage.

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 action. The grand-ducal decree of 30 January 2002 lists medicaments as well as preparations containing methadone (liquid oral form in programme and pill form in lower threshold prescription) and **buprenorphine** if the notice mentions substitution treatment as a possible therapeutic indication. Furthermore, **morphine-based (salts)** medications can be prescribed if the listed substances are deemed inadequate by medical authority. Finally, the decree allows for heroin prescription in the

²⁶ The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>

²⁷ 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, the AST, two pharmacists and two GPs affiliated to the programme, and is in charge of admissions, releases and exclusions of substitution treatment demanders or patients. The composition of the new commission is similar to the one of the former Methadone commission.

framework of a pilot project managed by the Directorate of Health. The list of substitution substances can be rapidly modified by amending the referred decree.

In addition to drug prescription and medical care, the grand ducal decree on drug substitution treatment (30/01/2002) defines a series of psychosocial counselling services to be provided by licensed specialised centres:

counselling and support,
 information and orientation,
 social assistance,
 regular contact with delivering pharmacies,
 accommodation and job finding interventions,
 periodic toxicological analysis.

Licensed MDs may refer substitution patients to licensed treatment centres for psycho-social counselling.

Diverted MEPHENON ® (methadone in pill form prescribed by accredited MDs) is largely available on the national black market. This situation is primarily due to uncontrollable **multiple prescription** of mephenon® and dealing between patients and other drug addicts. Given that no centralised substitution treatment register does currently exist, prescribing MDs have major difficulties in determining rapidly whether their patient is simultaneously be prescribed a substitution drug by one or more of his/her colleagues. In that respect, it has been decided to set up a **national substitution treatment register** within the Directorate of Health in order to reduce illicit diversion of substitution drugs. The register should become operational in the course of 2005.

The union of national sickness funds annually provides the number of patients receiving referred substitution drugs on prescription as well as the number of prescribing MDs. One observes a continuous increase of low threshold substitution patients and a stabilisation of the number of patients choosing the official substitution programme, more demanding in terms of therapeutic constraints.

Table 5.3 Ambulatory, low threshold prescription of substitution drugs by the national network of liberal MDs

	YEAR	1999	2000	2001	2002	2003
Number of indexed patients (double counting controlled)		745	844	849	820	913
Number of prescribing GPs (double counting controlled)		125	145	147	157	154

Source : Union des Caisses de Maladie 2004

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

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

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

The number of **drug-related deaths** is not correlated to the increase of methadone-substituted patients. This relationship is, however, purely descriptive since no scientific analysis on the latter has been performed thus far.

The adequate tool towards the assessment of the **impact of substitution treatment** would be a cohort study. This solution has not been envisaged since, in medium term, the RELIS database, including all indexed institutional contacts of drug addicts, will allow to follow up individual careers (health and law

enforcement institutions) and for instance enables the NFP to assess the impact of substitution treatment.

6. Health Correlates and Consequences

Overview

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

1. The Special Drug Unit of the Judicial Police (SPJ) maintains a register on acute drug deaths (RSPJ). The RSPJ indexes all direct overdose cases due to illicit drug use documented by forensic evidence. RSPJ applies the following definition of acute/direct drug-related death:

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

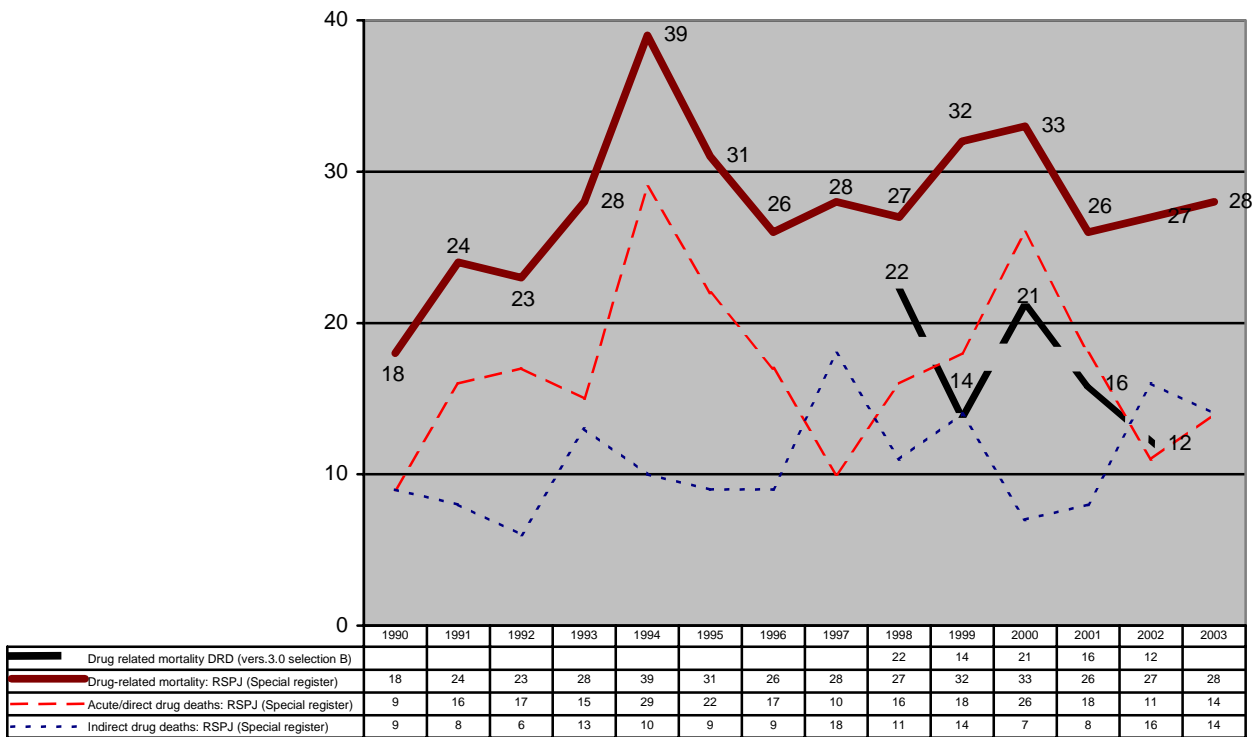
2. The statistical department of the Directorate of Health maintains the General Mortality Register (GMR) indexing all deaths that occurred on the national territory by means of death certificates provided by GPs. Since 1998 the GMR applies the 10th revision of the International Classification of Diseases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

● DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS

○ Direct overdoses and (differentiated) indirect drug related deaths (see ST 5 and 6)

Based on the outcome of the latest study: *'Epidemiological study on drug-related deaths and analysis of methodological aspects of indexing procedures applied in the Grand Duchy of Luxembourg from 1992 to 2000'* (Origer & Dellucci 2002), the NFP has decided to update annual figures by comparing SR (RSPJ) data with DRD version 3.0 data. As can be seen in figure 6.1 the DRD v. 3.0 standard appears to be a valid instrument to estimate direct/acute drug deaths as indexed nationally by the RSPJ. Overall drug related mortality, however, should not be assessed by the same standard as far as Luxembourg is concerned.

Figure 6.1 Evolution of drug-related death cases (direct - indirect - total mortality) from 1990 to 2003 (Origer 2004)



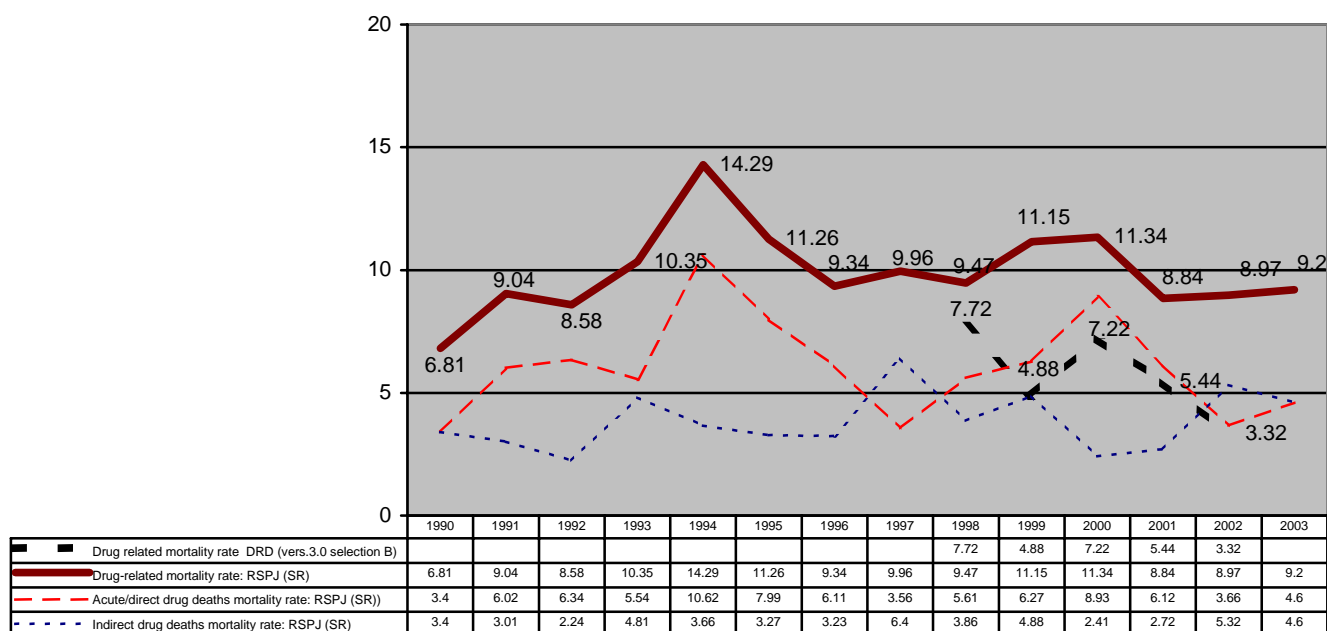
The number of **fatal acute overdoses** indexed at the national level has shown an increasing trend from 1985 to 1994 (29 cases), followed by a slow decrease until 1997 (10 cases). A similar evolution has been observed between 1997 and 2002, showing a peak in 2000 (26 cases) decreasing anew to 11 cases in 2002.

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

The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants²⁸ in 2000 (2.09 in 1997). An international comparison shows that the **overdose rate** of the G. D. of Luxembourg in 2000 was among the highest within EU Member states. 2001 and 2002 figures, however, show significant decreases. In 2002 an overdose rates of 2.45 and 4.10 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed.

²⁸ All age groups included

Figure 6.2 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2003 (Origer 2004)



The steep decrease of acute overdose cases between 1994 and 1997 has been associated to the regionalisation and extension of the methadone substitution programme as well as to the development of low threshold facilities. Whether the **upward trend in acute drug deaths from 1997** onwards was due to an increasing drug user prevalence, a changing drug market profile and use patterns, remains uncertain at present. One should stress, however, that recent figures (Origer 2001) confirm an increasing prevalence of problem drug users. On the other hand, an increase in non-iv heroin administration mode, observed for the last 3 years, should have reduced associated risk factors. The decreasing trend from 2000 onwards may be a medium term consequence of the higher proportion of non-i.v. opiate users. Also, availability and quality of drugs available on the national market, multiple-drug use, associate morbidity and contexts of drug-related deaths are some of the relevant topics that have been addressed by the latest study on drug-related deaths (Origer & Dellucci 2002).

In 2003, 14 **indirect drug death cases** have been indexed by the RSPJ. It is remarkable that the number of direct drug-related deaths have followed an **inversed evolution** as compared to indirect deaths from the beginning of the nineties until now.

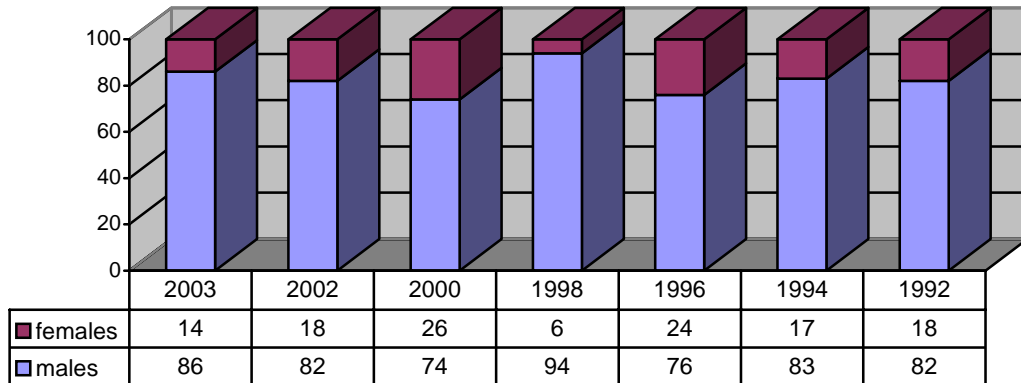
Since 1992, results of **toxicological analysis** performed on overdose victims refer to the presence of opiate traces in almost all direct drug death cases. **Heroin** has been detected in a vast majority of acute drug deaths, either exclusively (36 – 66.7%; average 46.5%), or as primary drug associated to other substances (21.5 – 62.5%; average 39.6%). In all reported cases heroin has been administrated intravenously.

Forensic data from 2000 suggested a **decrease of heroin-related deaths (72%)**, which, however, has not been confirmed by 2001 and 2003 data (94% / 88% of cases involved heroin use). Deaths exclusively due to **cocaine** use remain very rare. **Ecstasy**-related deaths have not been reported thus far. **Multiple substance use** has been increasingly reported during last years. In terms of associated drugs detected in blood samples of victims, cocaine and methadone are most represented. **Methadone** traces in blood samples have increasingly been detected for the last 4 years. **Buprenorphine** (SUBUTEX®) has been first detected in direct drug deaths in 1999.

Gender distribution of direct drug death cases reflects the sex ratio observed in the total number of drug-related deaths and in the overall drug population although there has been an increase of male o.d.

victims over the last 4 years. However, there appears to be no consistent evolution trend during the last 10 years.

Figure 6.3 Gender distribution of direct drug death cases (1992 - 2003) (%)



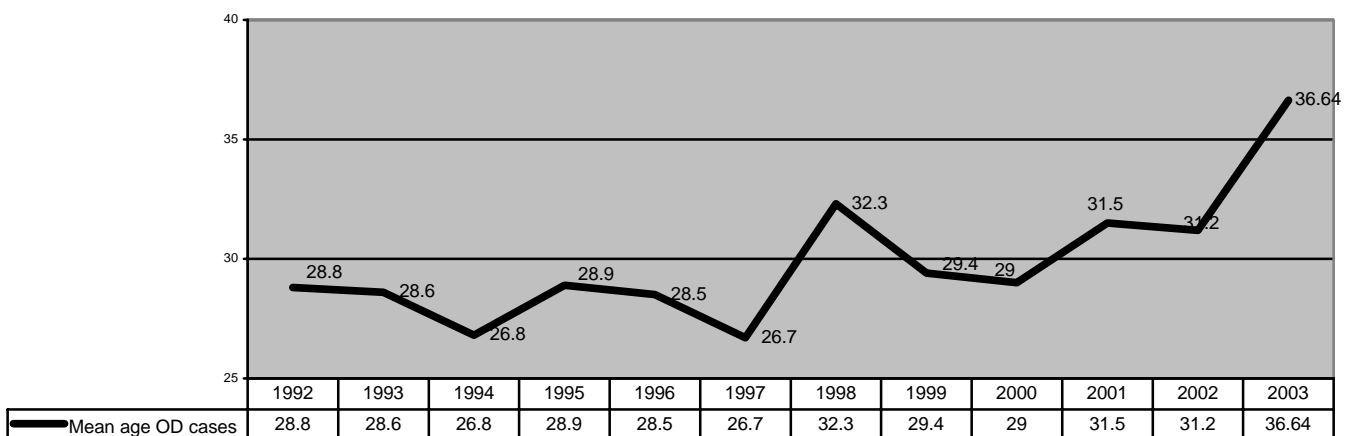
Source: RELIS 2004

The **mean age of direct drug-related death cases** shows quite important fluctuations over time (mean age from 1992: 28.4 to 2003: 36.64 years). However, over an observation period of 12 years, it appears that the mean age of acute drug deaths victims follows a long term increase. This increase has been fairly spectacular in 2003 even though it has to be confirmed by 2004 data. Age group 20 to 35 years is most represented. Overdose victims are significantly younger than **indirect drug deaths cases**.

Table 6.1. Age distribution of direct drug death cases indexed from 1992 to 2003

	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	Total
< 20			2	1	1			1		3	3		11
20-24		4	2	8	3	2	2	5	6	6	6	6	52
25-29	2	1	5	6	6	5	5	5	10	13	2	6	68
30-34	4	3	2	6	3	2	2	4	5	6	3	3	42
35-39	3	1	5	4	3	4		1	2	1	1		25
40-44	3		2	1	1	3			2			1	13
45-49	2	2		1					1			1	6
> 50								1					1
Mean Age	36.64	31.18	31.5	29	29.35	32.3	26.7	28.5	29.85	26.8	24.6	28.4	28.9

Figure 6.4 Mean age of acute drug deaths victims (1992-2003) (RELIS 2004)



A statistically significant **difference in age between male and female** overdose victims is observed. The same result applies to the overall number of drug-related death cases. Female PDUs often report relationships with older drug using partners, who have initiated them to drug use and accelerated their drug careers in terms of a rapid transition from non-i.v to i.v. use and an increased disposition towards risk behaviours such as needle sharing and prostitution. (Origer & Dellucci 2002)

A majority of drug-related deaths cases (direct & indirect) are **natives** (86% in 2003). The same applies to direct and indirect drug deaths analysed separately. The **non-native** subpopulation of victims is primarily composed of Portuguese citizens, which proportion is much higher than the one observed in the general population. Portuguese natives are followed by Italians and citizens from border countries, whose proportion have remained fairly stable during the last five years. A confirmed majority of od victims have been in **contact with law enforcement agencies** prior to their death.

○ Mortality and causes of deaths among drug users

In terms of **drug-related mortality** (direct and indirect deaths indexed by RSPJ), 18 cases have been indexed in 1990; prevalence has been showing small variations since 1996 figuring roughly 26 to 33 cases per year.

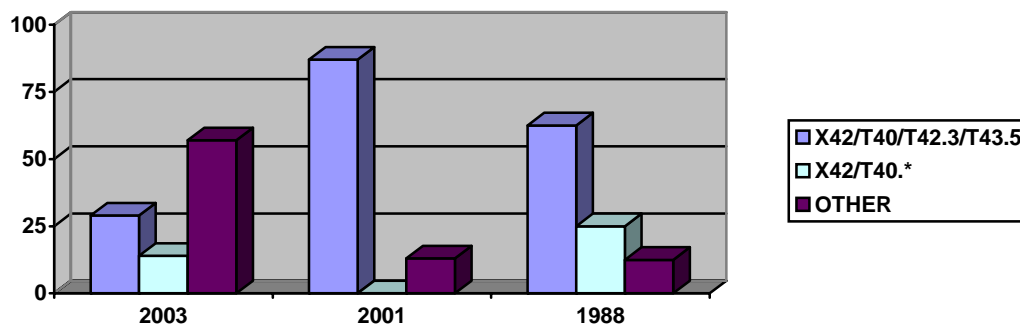
The above mentioned study (Origer & Dellucci 2002)²⁹, has revealed that, as far as the Grand-Duchy of Luxembourg is concerned, the mere application of the DRD standard does not allow for a valid computation of drug related death cases. Therefore, the authors did compute the total number of drug-related deaths by adding cases of the SR that were not indexed by the application of the DRD standard to the GMR. The figures resulting from corrected DRD v.3.0. data are referred to as '**national selection**' and provide the annual total number of controlled drug-related fatalities at the national level (28 in 2003 of which 14 direct/acute death cases).

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

Origer & Dellucci (2002) reported 38 drug-related death cases in 2000. Applied to the estimated number of problematic drug users in 2000 (2,450) (Origer 2001), one obtains a rough **mortality rate of 1.51%**. The difference might be explained by the fact that the cohort study only included IDUs whereas the prevalence estimation, on which the present calculation is based, refers to PDUs. Chart 6.5 present the exhaustive list of **indexed acute drug deaths** as indexed by the GMR by means of the ICD-10 standard from 1998 to 2003 (Origer 2004).

²⁹ A full text version of the study can be downloaded under: <http://www.relis.lu>

Figure 6.5 Distribution (%) of ICD-10 criteria sequences for overdose from 1998 to 2003³⁰



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. Since the implementation of ICD-10 coding by the GMR (1998), 67% overdose cases have indexed as follows: X42.-, T40.-, T42.- T43.- . At a more restricted level the code sequence: X42.-, T40.- includes 72% of all reported overdoses.

Main **causes of indirect deaths between** 1996 to 2003 are, in order of importance: Suicide (31%)³¹ traffic accidents (18%), undefined intoxication (12%), associated cardio-vascular or pulmonary complications (11%) pharmaco-dependance (8%), liver failure (7%), HIV/AIDS (5%) and other (3%).

● DRUG RELATED INFECTIOUS DISEASES

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

HIV and AIDS

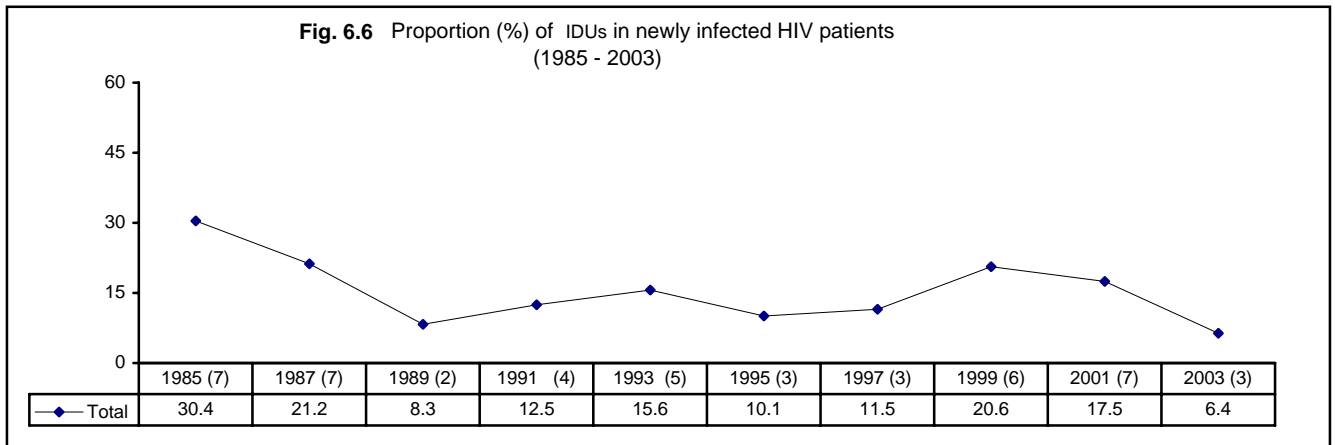
Official statistics from the national Retrovirology Laboratory of the CRP-Santé provide **the number and proportion of IDUs in HIV infected patients**. Between 1984 and 2003, 590 HIV infected persons have been registered at the national level; 91 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 15.4 per cent since the registration of the first HIV case in Luxembourg in 1984.

Intravenous drug use appears to be the third most reported transmission mode of HIV infection (new HIV infections (15.4%)) after homo/bisexual and heterosexual transmission. This sequence has remained fairly stable for the last three years. The proportion of intravenous drug use transmission has noticeably decreased between 1998 (23%) and 2003 (6.4%), although the **number of newly indexed HIV infection has increased** from 30 to 47 cases during the same period.

³⁰ The category 'OTHER' includes following sequences:

- 1998: K92.2/G40.3/G40.9
- 2001: X70.0/T71
B24
- 2003: I500
X49.0/T50.9 (2X)
B18.2/J45.9
F14.2/X14.2/T40.1
F19.2/T50.9
X56.4/T51.8
F190/X49.0/T50.9

³¹ Valid percentage



Source : Laboratoire de Retrovirologie – CRP-Santé. 2004

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2003, 73% of RELIS indexed PDUs reported a **test** during the last 5 months. Female PDUs tend to report higher testing rates than males.

In 1997, a significant decrease of **HIV rates in drug users**, mainly in IDUs, occurred. Subsequently, **HIV rates in current IDUs have been increasing to reach 4.17% in 2003**.

A study on **HIV and HCV prevalence in prison**, commissioned by the Ministry of Justice in 1998 (Schlink 1998), tends to confirm RELIS figures. The study included 90% of the total national prison population and applied saliva antibody testing. Calculated HIV prevalence rates are included in table 6.2.

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

YEAR	1997	1998	1999	2000	2001	2002	2003
HIV rate in problem drug users (RELIS)	3	2.9	2.9	4.3	4.07	4.49	3.88
HIV rate in drug treatment demanders	3.8	2.6	3.4	4.87	4.78	4.32	3.88
HIV rate in current IDUs (RELIS)	3.6	3.5	3.3	3.6	3.41	4.08	4.17
HIV rate in current IDUs treatment demanders	4.5	3.4	3.9	3.9	4.24	4.32	4.24
HIV rate in current IDUs prisoners (Schlink 1998)	/	4.4	/	/	/	/	/

Source: RELIS 2004

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

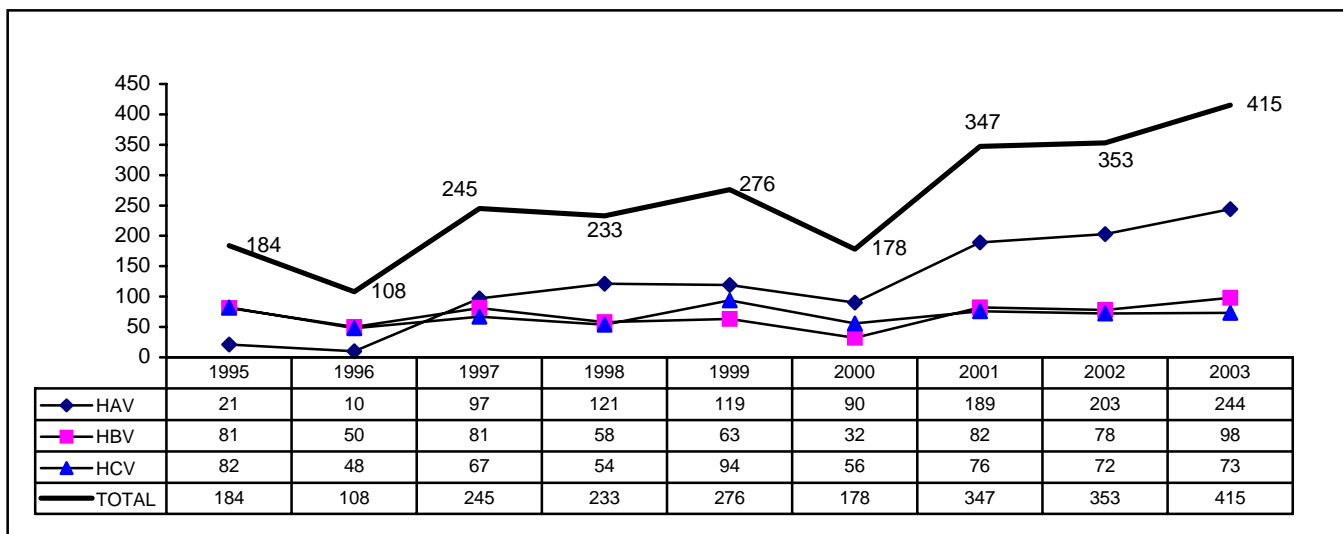
YEAR	1997	1998	1999	2000	2001	2002	2003
AIDS rate in drug users (RELIS)	2.5	2.5	1.25	1.35	2.03	1.72	1.07
AIDS rate in drug treatment demanders	/	/	1.66	1.76	2.43	1.60	1.28

Source: RELIS 2004

b) Hepatitis B and C

The Public Health notification system on infectious diseases provides the following data concerning HAV, HBV and HCV prevalence in general population:

Fig. 6.7 Notified hepatitis cases in general population (1995-2003)



Source: Division de l'Inspection Sanitaire. Direction de la Santé. 2004

The prevalence of **HBV** infection in problem drug users has decreased over the last six years in all PDU sub-groups. The **significant increase of the HCV infection rate** during the same period is particularly marked in drug treatment demanders, reaching 60.49% in 2003. The above referred **prison study** (Schlink, 1999), provides a 37% HCV infection rate in IDU prisoners (saliva sample test) in 1998.

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

YEAR	1997	1998	1999	2000	2001	2002	2003
HBV rate in drug users (RELIS)	29	30	30	28	25	22	12.78
HBV rate in drug treatment demanders	/	27	32	27	24	20	12.34
HBV rate in IVUDs (RELIS)	/	33	35	30	30	25	13.69

Source: RELIS 2003

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

YEAR	1997	1998	1999	2000	2001	2002	2003
Self-reported HCV rate in drug users (RELIS)	26	25	32	46	50	49	59.92
Self-reported HCV rate in drug treatment demanders	/	29	41	53	54	54	60.49
HCV rate in IVUDs prisoners (saliva tests)	/	37	/	/	/	/	/
Self reported HVC rate in IVUDs (RELIS)		45	50	53	56	53	67.97

Source: RELIS 2004 (Origer 2004)

Summarily, HBV infection prevalence in PDUs and in drug treatment demanders is decreasing while HCV prevalence in general population and in PDUs has significantly increased during the last 6 years. HIV infection rates follow a weak but continuous increasing trend.

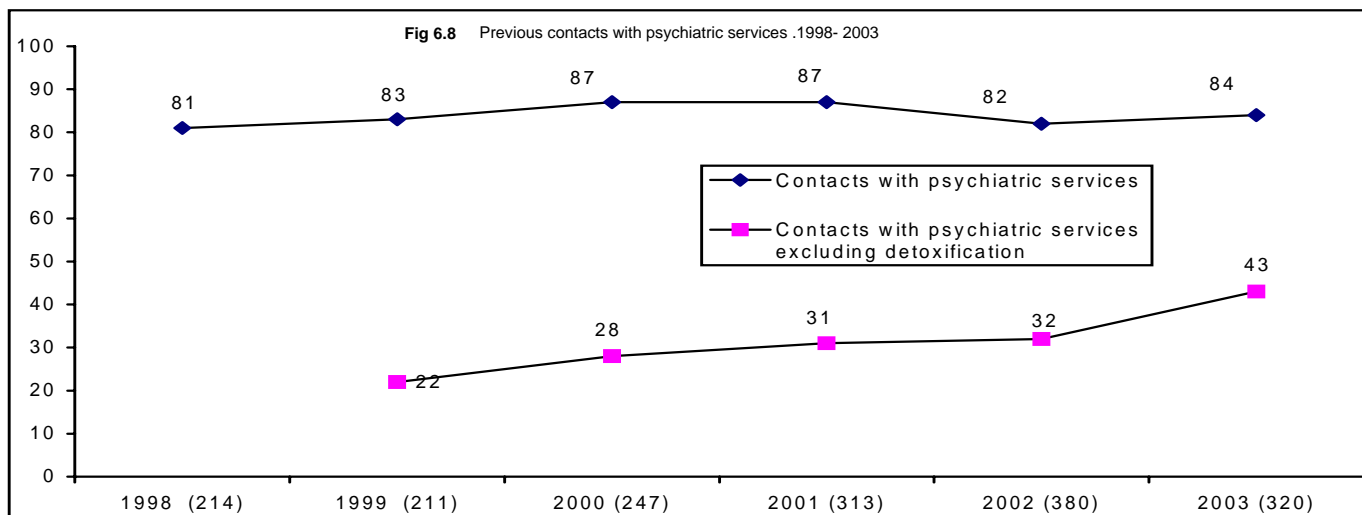
● PSYCHIATRIC CO-MORBIDITY (DUAL DIAGNOSIS)

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

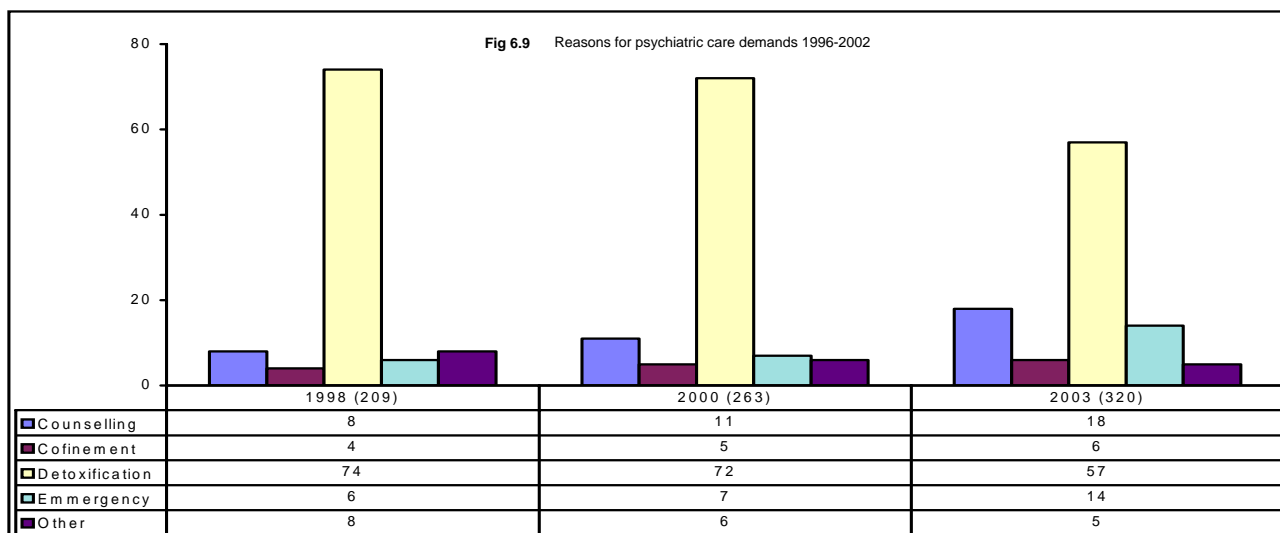
Most common mental disorders observed in clients seeking help in specialised drug agencies or in contact with other institutions are: anxiety, depression, neurosis, psychosis and borderline behaviour. Residential drug care settings estimate that 10% of their clients show psychotic symptoms.

Furthermore, Post Traumatic Stress Disorders (PTSD) are most common and show great similarities with border-line behavioural aspects as for instance rapidly changing mood and auto-destructive tendencies.

Referring to annual data provided by the national drug monitoring system RELIS one could draw the following picture:



SOURCE: RELIS 2004



SOURCE: RELIS 2004

Figure 6.8 differentiates between contacts with psychiatric services and psychiatric contacts excluding detoxification. This distinction is necessary since, at the national level, most of detoxification treatments are provided by psychiatric departments of general hospitals.

Data from 1996 to 2003 reveal a quite stable proportion of PDUs showing a psychiatric history, unlike the proportion of clients reporting contacts for mental problems excluding detoxification treatment, which has been following an increasing trend in recent years.

There seem to be no significant differences of psychiatric profiles in clients according to the type of institutional settings. Consume patterns of double diagnosis (DD) patients are most frequently chaotic

ranging from moments of absolute abstinence to life-threatening doses intakes. Multiple drug use is observed in almost every DD patient.

DD patients are considered as drug treatment demanders with specific and highly diversified needs that are difficult to encounter in traditional drug agencies. The concept of 'multiple vulnerabilities', that is, concomitant vulnerabilities to drug abuse and mental disorders, tends to be recognised by professionals. DD patients very often present a lack of behavioural structure or stability. Usually those patients are unable to function in a regulated environment. For instance, they show great difficulties to respect time frames (e.g. appointments, length of therapeutic sessions) or any other form of commitment. Moreover, the requirement of most therapeutic settings include that the patients submit to detoxification treatment prior to admission. This latter requirement is often impossible to meet with DD clients as drug intake often represent a kind of self-managed auto-medication, dangerous to change radically at the beginning of an therapeutic process. It is therefore most difficult to integrate DD patients in traditional drug care settings also in terms of consistency of rules to be respected by all drug treatment demanders. This specificity has led to the concept of 'dry, damp and wet house' in several countries, meaning that there should exist settings with modulated tolerance policies with regard to drug use during the treatment process. Several national treatment centres do try to implement similar concepts, although the legal situation does not facilitate such developments.

Moreover DD patients do require time and cost intensive care strategies as for instance individual case management and emergency interventions. This kind of additional service providing does often lead to conflicts in terms of human resources management and economical constraints.

The overall impression of specialised drug workers reflects a lack of qualification when it comes to the handling of DD patients. Training of drug workers did most commonly not include practice oriented intervention tools to be applied to DD patients. If required, drug agencies' staff is provided with on-the-spot training.

Since there exists no care facilities specialised in drug addiction co-morbidity at the national level, the Department of Medical Control of Social Security Administration, in collaboration with drug agencies, assesses whether a given patient should be referred to specialised institutions in foreign countries. There exist agreements between the latter administration and a series of specialised care agencies abroad. If the referral demand is approved, related costs are reimbursed by Social Security.

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

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

Compulsory treatment or confinement does only occur if there is a proved offence against the law by which the offender is declared irresponsible of his/her own behaviour. This only occurs following a legal psychiatric expertise. Due to the lack of specialised infrastructures, the NFP disposes of no data on DD treatment and outcomes.

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

The above quoted priority areas result from professional experience sharing. As the implementation of drug treatment and prevention strategies are traditionally planned and executed by the national drug coordinator's office in close collaboration with field agencies, emerging needs are effectively integrated in political debates and action planning. Since the current drug action plan covers the period 2000 to 2004, the development of new care facilities according to listed priorities will be considered in the forthcoming drug action plan 2005-2009.

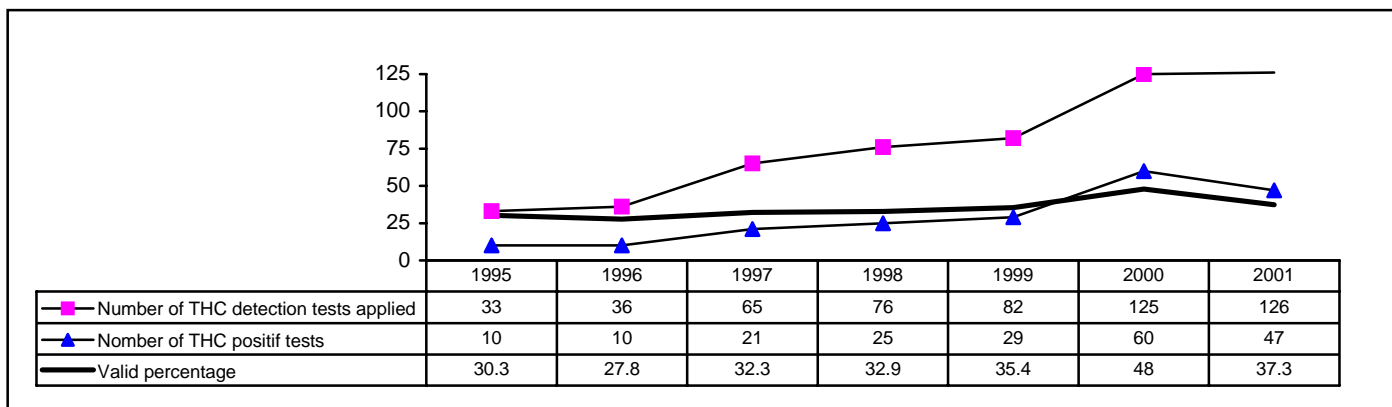
● OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES:

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDUs except for HCV prevalence. In 2003, 75 per cent of problem drug users reported a self-perceived satisfying general health condition against 53 per cent in 1997 (RELIS 2004).

One indexed PDU of two report single or multiple suicide attempt during lifetime. No significant changes have been observed during the last 3 years.

The toxicological unit of the National Health Laboratory performs THC detection test on blood samples. The evolution curve of THC detection in persons involved in traffic accidents clearly shows an upward trend. Almost 50% of analyses samples contained THC traces. Positive test results, however, are not a prove that THC use is to be considered as the cause of accident. Post 2001 data are currently not available.

Fig. 6.10 Detection of THC (cannabis) in persons involved in traffic accidents (1995-2001)



Source: LNS 2001

7. Responses to Health Correlates and Consequences

Overview

Responses to Health Correlates and Consequences of drug use aim at minimising the resulting damage on the drug users him/herself and on his/her environment and at increasing individual/collective resources. The concept of risk and harm reduction are directly linked to it, whereas nuisance reduction is seen as a correlate of the latter.

● PREVENTION OF DRUG RELATED DEATHS:

In 1999 the NFP has commissioned a study on epidemiological and methodological aspect referred to drug related deaths. Results were published in 2002: *'Epidemiological study on drug-related deaths and analysis of methodological aspects of indexing procedures applied in the Grand Duchy of Luxembourg from 1992 to 2000'* (Origer & Dellucci 2002). The epidemiological part of the study was designed to provide information on the process that leads a drug user to a drug induced fatality and to contribute to implement prevention measures.

Several risk factors or profiles have been stressed by the study:

- A statistically significant **difference in age between male and female** overdose victims has been observed (F: 25.65 years, M: 29.17 years). The same result applies to the overall number of drug-related death cases. Female PDUs often report relationships with older drug using partners, who have initiated them to drug use and accelerated their drug careers in terms of rapid transition from non-i.v to i.v. use and an increased disposition towards risk behaviours such as needle sharing and prostitution. (Origer & Dellucci 2002)

- The **release from an institutional setting** (e.g. prison, residential therapy, etc.) often creates a high-risk context for concerned persons in terms of social deprivation and substance tolerance levels. A significant number of drug-related death cases occur rapidly after institutional release (sometimes only a few hours).

- A majority of drug-related deaths cases (direct & indirect) are **natives** (64,6 to 90.9%). The same observation applies to direct and indirect drug deaths analysed separately. The **non-native** subpopulation of victims is primarily composed of Portuguese citizens, which proportion is much higher than the one observed in the general population. Italians follow Portuguese natives and citizens from border countries which proportion has remained fairly stable during the last four years.

The following measures have been recommended:

- opening of supervised injection rooms as foreseen by the national drugs action plan
- medical controlled heroin distribution programme (foreseen by the national drugs action plan)
- first aid training courses provided to users and their relatives and partners
- gender and ethnic specific interventions
- provision of morphine receptor antagonists to users and selected persons
- creation of 'transition centres' for ex or current drug addicts leaving an institutional setting,
- development of resocialisation programs for prisoners in the framework of the recent 'Global care programme for drug addicts in prison'

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 should contribute to reduce drug-related deaths occurring in consumer groups.

Finally, in the line of the recommendations of the Origer and Dellucci (2002) study, a low threshold service in collaboration with the Ministry of Health edited a documentation kit on overdose prevention and emergency intervention by peers. The information kit includes flyers on following issues:

- First aid in case of an overdose. Useless interventions (such as salt injections). Epileptic crisis. Potential added risks of substance mixtures. Vein care. Potential risk of specific injection points. Inhalation as administration mode. Risks of abscesses and endokarditis.

Provision of first aid and harm reduction training to drug users and peers will takes place in low threshold agencies.

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

At present no drug users or injection room does exist at the national level.

Articles 2 and 3 of the law of 27 April 2001 have set the legal framework for 'user rooms and other means duly licensed by State', which also includes controlled distribution of certain narcotics (e.g. heroin). The implementation of such facilities has been included in the national drugs action plan 2000-2004 of the Ministry of Health.

The implementation of a drug injection room has to be seen as a part of a broader harm and nuisance reduction oriented strategy. The national drug action plan refers to the creation of a low threshold emergency shelter facility for drug addicts that will be implemented in the vicinity of the city railway station. During the planning phase of this centre it has been decided to integrate a drug user room due to obvious advantages to combine both of them (in terms of logistics staff and situation). Architectural plans are finalised. Running cost of the centre are estimated at 142.000 EUR/year.

The emergency centre provides the whole range of harm reduction services, counselling facilities, accommodation, washing, laundering and storing facilities. It should be added that the night accommodations are not to be seen as a permanent housing facility; there were indeed daily admissions procedures. Target population for the consumption room are primarily IVDUs. Inhalers might be admitted in a second phase. The main objective of the project is the reduction of drug-related harm and nuisances. More precisely it aims at reducing the risks of infectious diseases, overdoses and public nuisance in the neighbourhood, contact making with difficult to reach addicts, provision of special designed night shelter facilities and avoiding unnecessary prison journeys over night. The project was designed with the support of law enforcement agencies. The public nuisance is an important factor in the public debate around the project. The site has its pro and cons although there is a general consensus that in terms of proximity to the hard drug scene and the reduction of nuisance, the site is adequate. One may add that the area in which the centre will be implemented has known major problems since a series of non-inhabited houses served drug addicts as 'self-elected' injection rooms to the distress of the immediate environment.

An expert group has been visiting similar projects in the EU in order to fine-tune the concept and implement quality control standards.

As most relevant drug scenes concentrate in the City of Luxembourg and in the main city in the South of the country, Esch-sur-Alzette. Intense discussions are currently hold with the community council of Esch/A in order to implement a similar facility. The aim is to open both centres (Centre and South) simultaneously in order to avoid potentially problematic migration towards and overload of one of the regional sites.

● PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES:

○ Prevention

Interventions aiming at the prevention of drug-related infectious diseases have been initiated and developed prior to the set up of a proper legal framework. At that time, services as needle exchange and substitution programmes have been tolerated and also financed by the state. The last drug law amendment did not only allow to maintain and to further develop existing harm reduction offers but also set the first stone for the implementation of new services such as shooting galleries and medically assisted heroin distribution as foreseen by the national drugs action plan 2000 – 2004.

Objectives of these interventions are straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Traditionally harm reduction (HR) measures have been focusing on IVDUs since most exposed to a variety of health risks. Nevertheless, initiatives such as the provision of aluminium foils to heroin users and the current discussion on the future distribution of 'strawbags'³² for sniffing purposes witness a progressive switch from IVDUs users to PDUs being considered as target groups. Furthermore infectious diseases prevention does not focus specifically on IVDUs as shows a new action-research project on HIV and hepatitis infection among PDUs starting in August 2003.

³² A 'straw bag' contains one-way straws especially designed not to hurt the nasal cavities, thus avoiding wounds and bleeding, a special liquid to smooth tissues, a professional condom and lubricants.

The most relevant measure in the field of prevention of infectious diseases in drug users is the **national needle exchange programme** established in 1993 and co-ordinated by JDH. In addition to free of charge needle provision by specialised drug and AIDS agencies, automatic syringes dispensers/collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy. Regarding the quantity of distributed syringes, table 10.1.b.1 shows an **increase of 337 per cent during the period 1996 to 2003**. 2003 figures witness a steady upward trend with regard to the number of distributed syringes and so do the return rates, however, reaching up to 94% in 2003. Obviously automatic dispensers show the lowest return rates.

	Distributed syringes					Collected used syringes				
	1996	1998	2000	2002	2003	1996	1998	2000	2002	2003
TOTAL	76,259	109,743	189,413	254,596	333,213	28,646 (38%)	58,886 (46%)	112,625 (59%)	202,581 (80%)	271,091 (94%)

Source: RELIS 2004

Condoms and syringes are provided by the **Division of Preventive Medicine** (Directorate of Health) to field actors in the framework of the national programme on prevention of infectious diseases. Vaccination for HAV and HBV is free of charge for persons under 18.

Several local outreach prevention activities have to be mentioned as for instance contact making with prostitutes within their daily work environment for HIV and hepatitis testing and subsequent health care, if needed. These specific activities are currently further developed by the **'Drop In'** centre for drug users and prostitutes (RED CROSS).

Moreover, outreach interventions targeted at (drug using) prostitutes aiming to establish contact and to prevent dissemination of infectious diseases have taken place.

According to EMCDDA's key indicators and with a view to improve quality of national data on infectious diseases, the NFP has set up an **action-research plan** (2002-2004) with the objective to estimate HCV and HIV prevalence in recent drug injectors based on medical diagnosis data (blood sample testing) and to implement required health care infrastructures. The provisional budget of the project is estimated at 25.000. - EUR. The NFP has been granted a full financing of the project by the FLTS. Duration of the project :August 2003 - 2005.

○ **Counselling and testing**

AIDSBERODUNG (RED CROSS), is the main national counselling and prevention centre for HIV and AIDS. Prevention campaigns are conceptualised by the AIDSBERODUNG team in collaboration with an important network of volunteers. Facing an increasing rate of drug users within its clients, AIDSBERODUNG has joined the RELIS network in 2001. Testing is provided by the CHL and the LNS and is free of charge for drug addicts. The above mentioned action-research aims at increasing the testing coverage of PDUs since it includes anonymous on-site testing and diagnosis transmission facilities. Furthermore, HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison.

○ **Infectious disease treatment**

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

● INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY

Double diagnosis patients (DD) are considered as drug treatment demanders with specific and highly diversified needs that are difficult to encounter in traditional drug agencies. The concept of 'multiple vulnerabilities', that is, concomitant vulnerabilities to drug abuse and mental disorders, tends to be recognised by professionals. DD patients very often present a lack of behavioural structure or stability. Usually those patients are unable to function in a regulated environment. For instance, they show great difficulties to respect time frames (e.g. appointments, length of therapeutic sessions) or any other form of commitment. Moreover, the requirement of most therapeutic settings include that the patients submit to detoxification treatment prior to admission. This latter requirement is often impossible to meet with DD clients as drug intake often represent a kind of self-managed auto-medication, dangerous to change radically at the beginning of an therapeutic process. It is therefore most difficult to integrate DD patients in traditional drug care settings also in terms of consistency of rules to be respected by all drug treatment demanders. This specificity has led to the concept of 'dry, damp and wet house' in several countries, meaning that there should exist settings with modulated tolerance policies with regard to drug use during the treatment process. Several national treatment centres do try to implement similar concepts, although the legal situation does not facilitate such developments.

Moreover DD patients do require time and cost intensive care strategies as for instance individual case management and emergency interventions. This kind of additional service providing does often lead to conflicts in terms of human resources management and economical constraints. A majority of DD patients are currently referred to specialised treatment centre abroad.

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 activities of mentally disturbed 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.

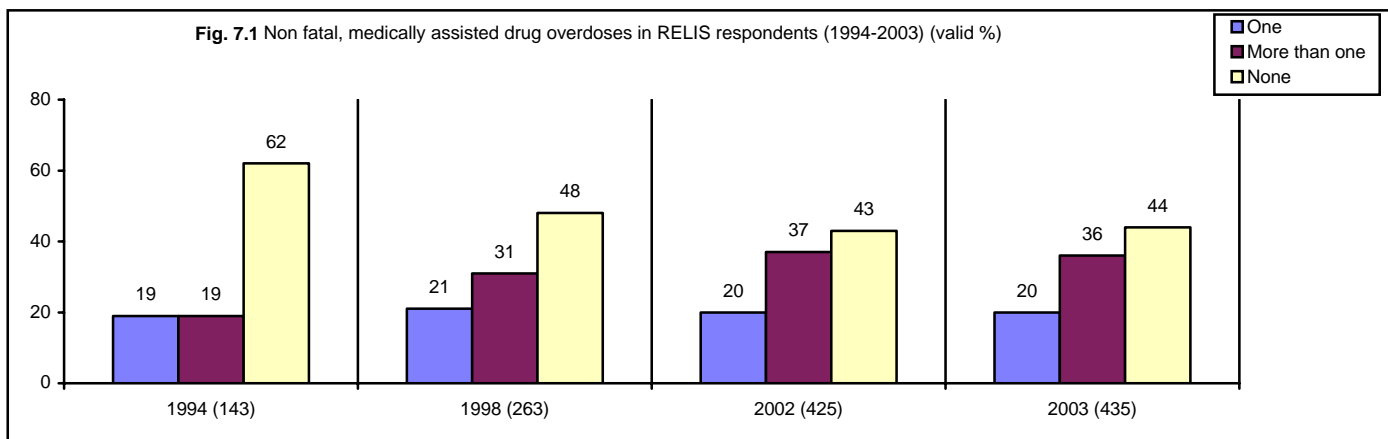
● INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

○ Somatic co-morbidity

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

○ Non-fatal emergencies and general health-related treatment

Non-fatal drug emergencies currently situate between 30 and 50 cases per year. Figure 7.1 refers to RELIS data on previous non-fatal and medically assisted drug overdose self reported by respondents. The proportion of indexed drug users reporting at least one overdose (as defined) (56%) during lifetime has slowly increased during the last five years. This trend is partly due to an aging IVDU population. However the temporary stabilisation observed during the last three years might be related to an increased proportion of PDUs who prefer inhalation as administration mode of heroin.



Source: RELIS 2003

○ Prevention and reduction of driving accidents related to drug use

A liberal MP introduced a proposition of law (N°5164) modifying the national traffic code and introducing illicit drug testing in vehicle drivers. The homologation of respective saliva and sweat tests has already been approved by the Council. The related grand ducal decree should enter in force by the end of 2004. The application of these tests will provide a more accurate insight as far as the relationship between illicit drugs intake and traffic accidents are concerned.

○ Other health consequences reduction activities

The future implementation of injection rooms and medically controlled heroine distribution, as foreseen by the national drugs action plan 2005-2009 will further contribute to reduce drug related health damage.

8. Social Correlates and Consequences

Overview

Social correlates of drug use typically involve Justice, Health and Educational competences. The Ministry of Health and the Ministry of Family both intervene to reduce social consequences by measures ranging from early detection of drug use to social-professional rehabilitation measures. The reduction of drug related crime involves the Ministry of Justice, that focus on supply reduction activities and the Ministry of Health coordinating measures (e.g. heroine distribution) aiming at reducing daily expenses of drug addicts and thus the prevalence of acquisition crimes.

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

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

Intervention of law enforcement agents based on reasonable suspicion. The *'interpellated'* person is heard and a police officer's record occurs. In practice the number of police records fits more or less the number of convictions (usually slightly inferior). At this level, however, there is no notification to the Public Prosecutor and no mention in the judicial record.

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

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

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

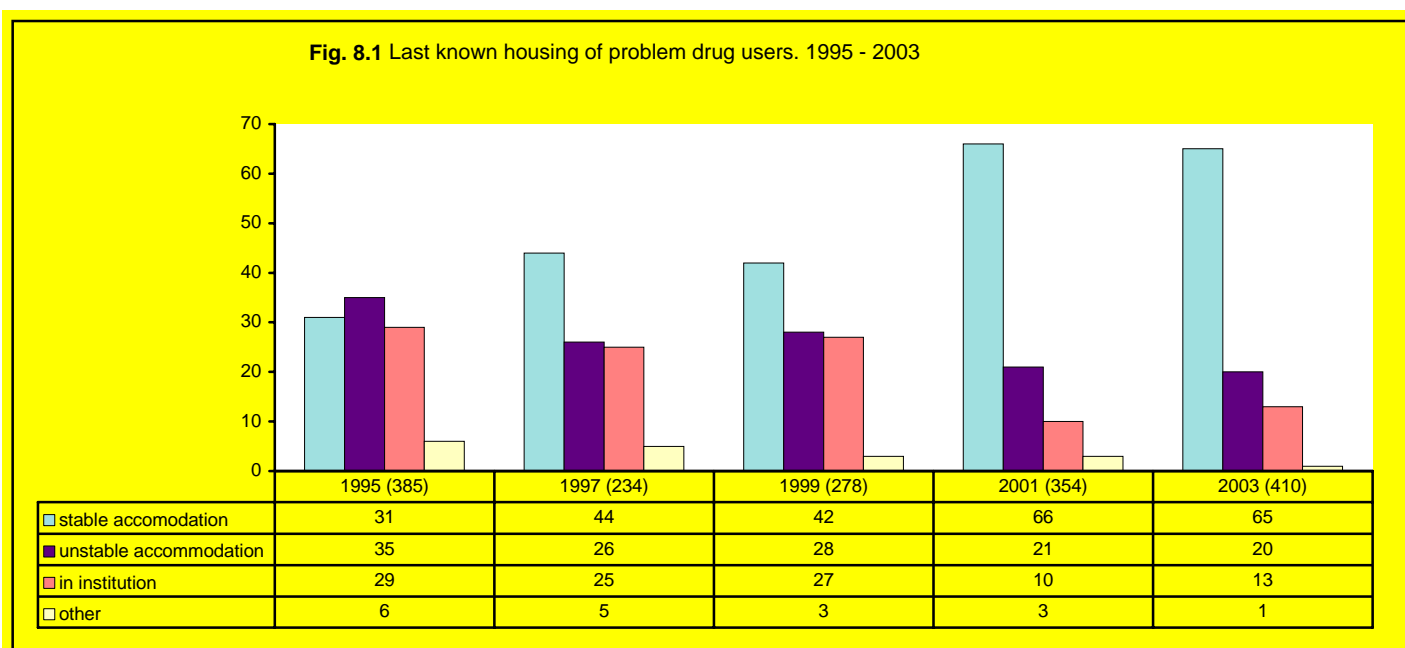
- 'Condamnation' (Eng. Conviction) :
Judgement by which the accused person is found guilty.

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

• **Social Exclusion**

- Homelessness

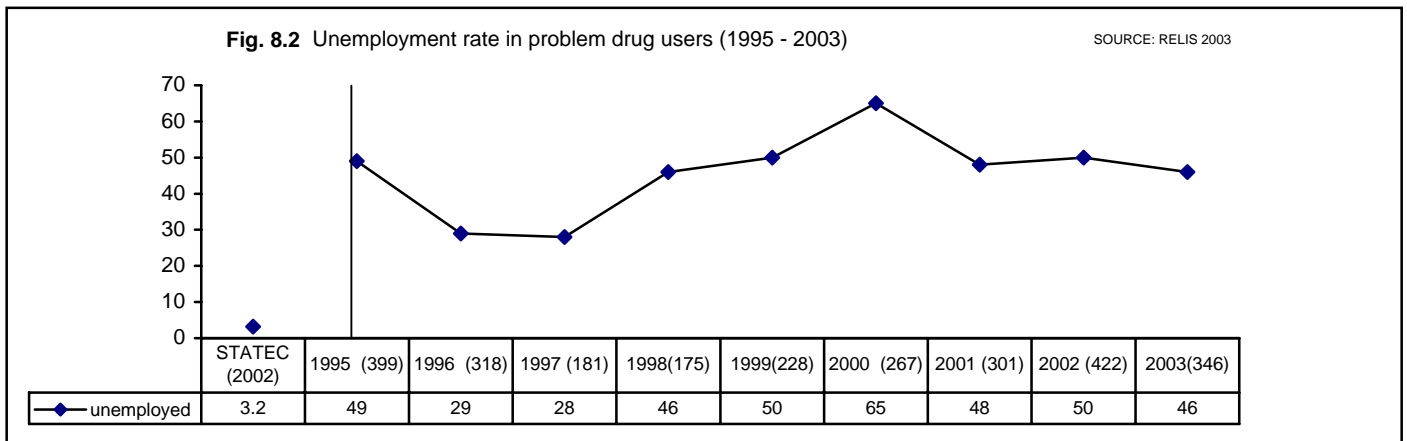
Housing status of registered drug users has markedly improved during recent years and tends to stabilise. Currently 65 percent of PDUs report a stable housing situation. This positive evolution may be linked to an increased awareness of the housing problem and the set up of new housing networks for socially deprived people by the Ministry of Health and specialised agencies referred to under chapter 9.



Source: RELIS 2004

- Unemployment and financial situation

All indicators included, the **employment status** of problem users has been showing a fair stabilisation over the last four years. The unemployment rate in problem drug users has grown in significance since 1997 and has stabilised around 50 % and so does the proportion of PDUs reporting stable employment.

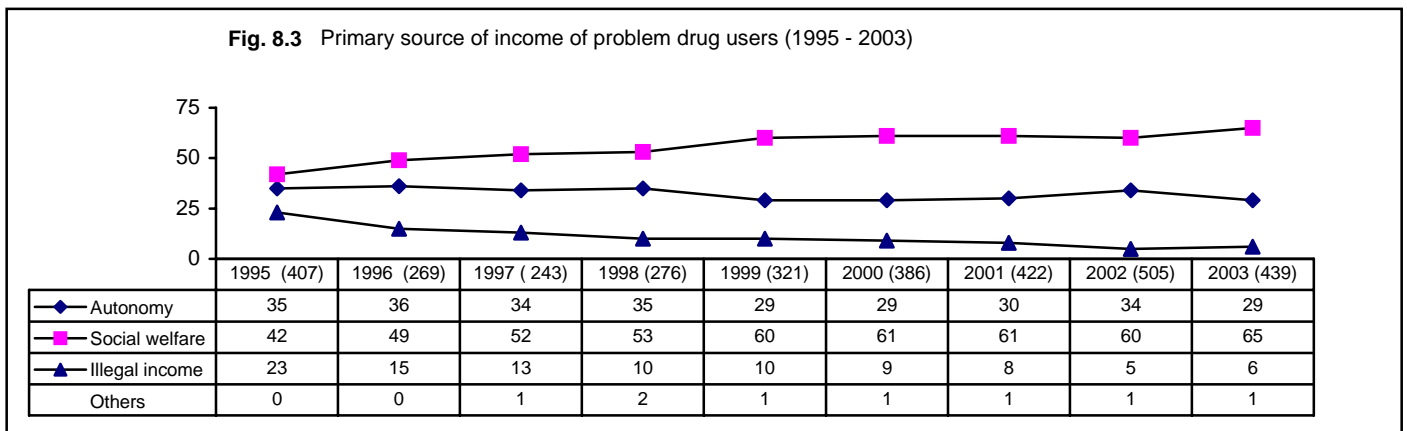


Source: RELIS 2004 (Origer 2004)

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

Data on revenues confirm observed trends in occupational status:

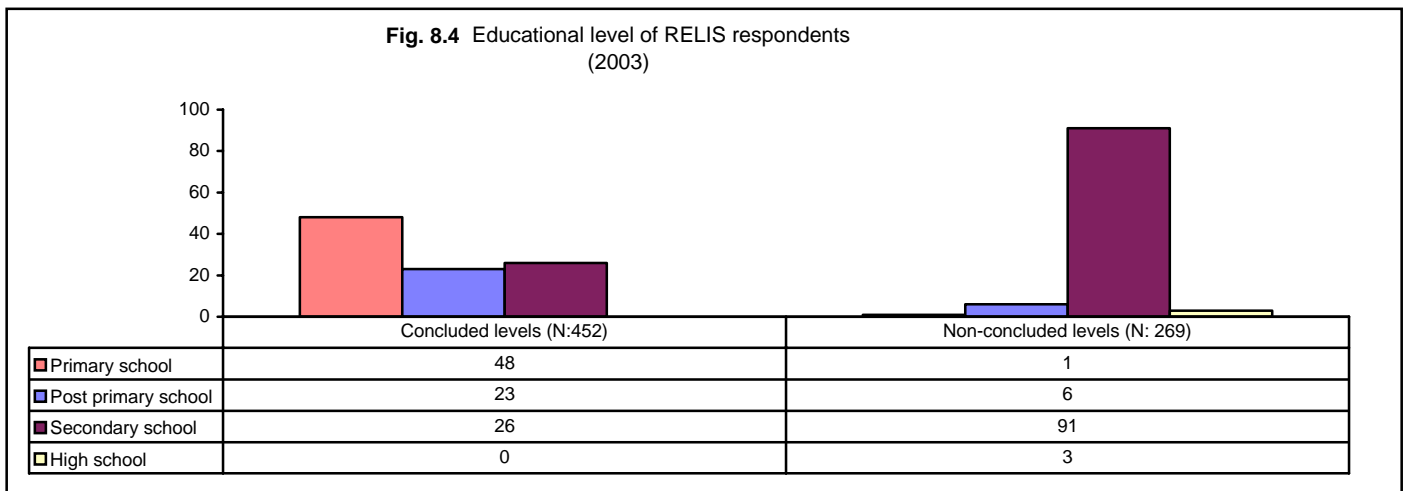
- increase of social dependence (e.g. Guaranteed Minimum Income) associated to a stable **financial autonomy**;
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 1995
- the proportion of respondents reporting **major depths** ($\geq 2,500$ EURO) (40%) has stabilised at a high level.



Source: RELIS 2004

- o School drop out

The **educational level** of PDUs shows a slow but constant deterioration over time, even though the average age at the end of studies remains stable. Lower levels are particularly observed as regards acquired secondary and high school diploma. Post primary school is a special educational setting for primary school pupils with learning difficulties.



Source: RELIS 2003

- Drug related crime**

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

a. Drug related arrests data

As can be seen in tables 4.2.a.1-2, the total number of arrests (77) has decreased compared with previous years. The observed decrease, however, is subtle and might rather be interpreted as a stabilisation. Heroin is the main substance involved in drug-related arrests, followed by cocaine and cannabis. Simultaneous use and traffic appears to be the most frequent charge.

Table 8.1 Arrests broken down by type reporting institution (1995-2003)

Year	ARRESTS				
	1995	1997	1999	2001	2003
S.P.J.	27	25	27	7	25
Gendarmerie	8	15	15		
Police	32	32	32	45	82
Customs	61	82	34	40	28
Total	128	154	108	92	135

Table 8.2 Arrests broken down by type of offence and substances involved (1995-2003)

Substance	Offence	1995	1997	1999	2001	2003
Heroin	Use & Traffic	68	57	48	41	21
	Traffic/Deal	21	53	18	8	22
	Use	24	7	27	8	4
	Total	113	117	93	57	47
Cocaine	Use & Traffic	20	27	21	27	19
	Traffic/Deal	7	23	9	9	30
	Use	10	6	12	4	3
	Total	37	56	42	40	52
Cannabis	Use & Traffic	25	18	32	23	52
	Traffic/Deal	1	11	8	1	17
	Use	4	4	3	15	9
	Total	30	33	43	39	79
Amphetamines	Use & Traffic		2	1	2	2
	Traffic/Deal				0	0

	Use	2						0		0
	Total	2		2		1		2		2
Ecstasy (MDMA, etc.)	Use & Traffic	3		3		3		1		1
	Traffic/Deal	1		3				0		0
	Use	1						0		1
	Total	5		6		3		1		2
LSD	Use & Traffic			1		1		0		0
	Traffic/Deal							0		0
	Use							0		0
	Total			1		1		0		0
Total number of arrest motives independently of involved substances	Use & Traffic							59		57
	Traffic/Deal							13		61
	Use							20		15
	Total	128		154		108		92		133

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2003

b. Prosecution data

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP), stable between 1996 and 1998, shows an important increase from 1998 onwards (2003:1,660). The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 1998 followed by a subsequent increase clearly confirmed by 2003 data (2,270). The number of arrests on the same charge has decreased from 154 in 1997 to 133 in 2003 (see table 8.2).

Table 8.3 records the total number of law enforcement interventions and number of 'prévenus' at the national level ensured by respective law enforcement actors that are the Specialised Drug Department of the Judicial Police (SPJ), Police and Board of Customs from 1995 to 2003. One should emphasise that the Gendarmerie and the Police have merged into a single force in 2000, namely the Grand Ducal Police.

Table 8.3 Number of national law enforcement interventions (1995-2003)

Year	DRUG LAW ENFORCEMENT RECORDS							PREVENUS						
	95	97	99	2000	2001	2002	2003	95	97	99	2000	2001	2002	2003
S.P.J.	123	137	343	231	216	288	239	152	182	434	278	321	469	369
Gendarmerie	198	255	782	965	1,126	1,261	1,326	319	335	916	1200	1272	1,605	1,753
Police³³	199	177	189					371	280	283				
Customs³⁴	244	236	173	144	113	89	95	421	408	306	280	182	143	148
Total	764	805	1,187	1,340	1,455	1,632	1,660	1,263	1,205	1,939	1,758	1,776	2,217	2,270

Source: Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 87% **males**; a proportion that has been varying between 79 and 89% during the past decade. Since 1997, **non-natives** have been representing the majority of drug law offenders (52-63%). The proportion of **first drug law offenders** has known a quite spectacular increase in 2002-3 (808) compared with 2001 (621). The **percentage of minors** (< 18 years) among drug law offenders has increased since 1994 (4.9%) (2003: 13.8%).

Table 8.4 Socio demographic data on 'prévenus' (1986-2003)

YEAR	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003
AGE												
0-14	9		7	6	1	3	7	27	21	11	15	41
15-19	121	212	179	320	169	270	249	415	413	399	647	602

³³ The general activity report of the Grand-Duchy of Luxembourg can be downloaded from: <http://www.gouvernement.lu/gouv/fr/doss/rapact2003/index.html>

³⁴ A summary of the general activity report of the "Anti-Drugs and Sensible Products" division of Customs can be found in annex H. The original report can be downloaded from : <http://www.gouvernement.lu/gouv/fr/doss/rapact2003/index.html>

20-24	264	569	383	527	403	447	321	519	497	566	650	557
25-29	119	220	278	371	309	304	220	448	354	299	388	375
30-34	49	67	124	159	186	191	187	269	208	194	219	254
35-39	17	29	27	52	65	80	76	131	113	139	177	162
≥40	17	19	43	46	21	42	78	84	108	113	82	174
unknown	27	21	30	50	20	31	32	46	44	55	40	106
TOTAL	623	1,137	1,071	1,531	1,174	1,368	1,170	1,939	1,758	1,776	2,218	2,271
Male	503	970	851	1,248	938	1,138	958	1,658	1,415	1,546	1,905	1,935
Female	120	166	220	256	209	173	193	248	241	215	292	288
gender unknown	0	1	0	27	27	57	19	33	44	15	21	48

Source: Specialised Drug Department of the Judicial Police 2003.

Table 8.5 Distribution of 'prévenus' according to first offence and underage status (1992-2003)

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
First offenders	697	331	382	498	508	389	422	645	608	621	828	808
Nb. of offenders underage	96	48	57	92	102	84	79	155	154	100	145	189
TOTAL ('Prévenus')	1,531	890	1,174	1,263	1,368	1,205	1,170	1,939	1,758	1,776	2,217	2,271

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2003.

Table 8.6 Distribution of first offenders (use and use/traffic) and substance involved ad minima (1992-2003)

	1992	1993	1994	1995	1996	1997	1998	1999	2000	01	02	03
High risk substance involved ad minima												
Heroin	162	91	154	170	121	104	109	157	133	91	114	97
Cocaine	64	15	39	46	34	20	30	60	37	47	64	112
Amphetamines	5	0	15	11	11	12	18	14	9	14	12	10
Type 'Ecstasy'	1	3	9	47	20	26	26	6	11	16	34	23
Illicitly acquired medicaments	1	0	3	0	0	0	1	0	7	1	0	3
Illicitly acquired substitution substances	0	0	1	0	0	0	0	0	0	0	1	1
TOTAL (substances HRC)	233	109	221	274	186	162	184	237	197	169	225	266

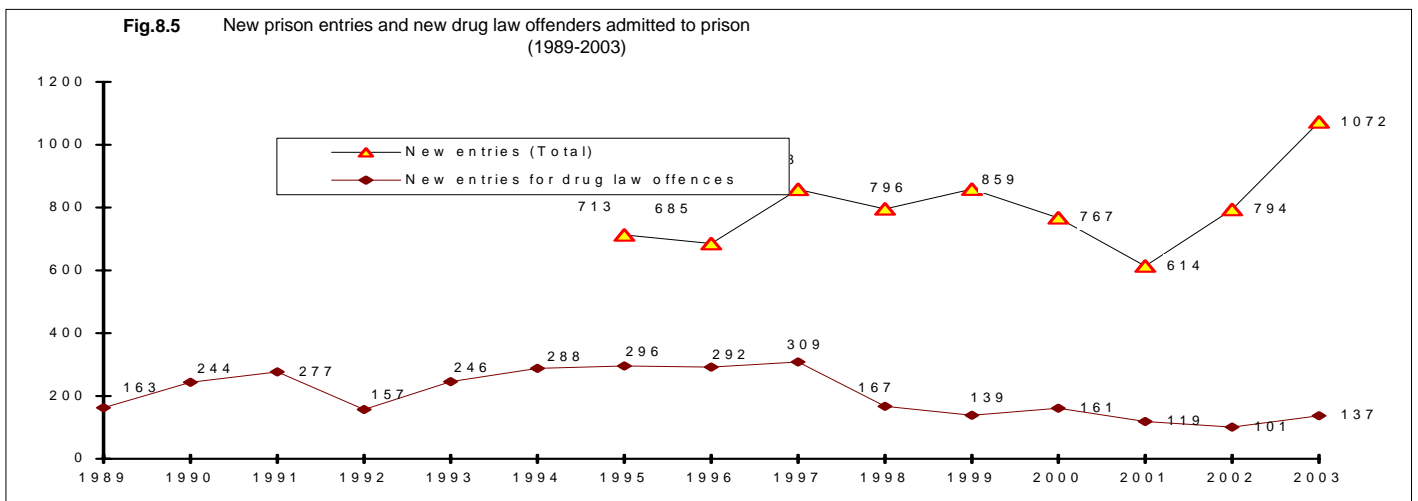
Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2003

c. Convictions data and court sentences for drug offences

No data available.

d. Imprisonment for drug-related crime

The Grand Duchy of Luxembourg counts two state prisons; one situated in the vicinity of Luxembourg-City (CPL) and the other in the North of the country (CPG). The proportion of **prison sentences for drug law offences has been decreasing since 1998**. In 2003, 137 new entries (13 %) (1997: 36%) in national penal institutions referred to the ' DELIT- STUP ' (Drug law offence) codes have been reported. The referred trend reflects the decreasing number of drug-related arrests previously reported.



Source: Central Prison Administration 2003

e. Drug-related crime

The data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results are worth to be retained for 2003:

- 93% of drug users indexed³⁵ by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime. 78% (↗) of the total PDU population show multiple law enforcement contacts.
- The proportion of 'interpellations' for other reasons than presumed offences against the dug law (e.g. **petty crime**) has been decreasing since 1997 (38%), and has stabilised (2002:26%). The extension of substitution treatment and the intensification of socio-economic reintegration measures appear to have contributed to the currently observed situation.
- 76% of indexed PDUs have already served at least one **prison sentence** during lifetime. The proportion of PDUs having served more than one prison sentence at the time of reporting (31%) is still on the increase. Compared with previous years, a significant deterioration of the penal situation of indexed drug users must be stressed; associated, however, to a decrease of the duration of served prison sentences.

• Drug Use in Prison

In 1998, the Ministry of Justice commissioned the medical department of the state prison (CPL) to perform an epidemiological study on HIV and HCV prevalence in prison population (Schlinck 1999). Both national prisons (CPL and CPG) have been included in the study. The research protocol relied on a self-administrated anonymous questionnaire on health behaviour and injecting drug use prior and during prison sentence. HIV and HCV status were determined by serological analysis of on-site collected saliva samples. Data has been collected during two days on the current stock of prisoners (convicted and in custody) in all national prisons. The following synopsis sheet provides an overview of methodological aspects of the study that currently represent the most representative study on infectious diseases in the national prison population.

Dr. Schlinck J. (1999), Etude épidémiologique des infections à l'HIV et à l'hépatite virale C dans les prisons luxembourgeoises, CPL, Luxembourg.

EN: Epidemiological study on HIV and HCV prevalence in prisoners

Year

1998

³⁵ Persons who have been indexed by the RELIS network during a reporting year.

Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence in prison
Area covered	All national prisons
Type sample	Stock of prison population on 4 September 1998
Age range	> 17
Data coll. procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES
Sample size	362
Sampling frame	Exhaustive
Response rate (M, F, T)	90%

MAIN RESULTS:

Drug use in prison

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

Risk behaviour

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

Miscellaneous

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

Source: Scilnick, 1999

● **Social Costs:**

A recent study (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). Furthermore, the budget allocated by the Ministry of Health to drug related services and programmes, as foreseen by the national drug action plan, has known an increase rate of 283 % between 1999 and 2003.

9. Responses to Social correlates and Consequences

● **Social Reintegration:**

Social reintegration measures and in particular improvement and diversification of housing offers for drug addicts have to be seen as one of the priorities of the 2000 – 2004 national drugs action plan.

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. A more detailed description of the projet is found under chapter 13.

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

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

The yet to be endorsed 2005-2009 national drugs action plan foresees to further develop capacities of the above mentioned services and includes new projects such as an **occupational centre for drug addicts** that provides the opportunity of a series of paid day jobs for the target population. The centre is supposed to open in 2006 and will provide to approximately 30 addicts daily job opportunities adapted to their respective skills and physical and mental resources without imposing restrictive contractual requirements on them.

● **Prevention of drug related crime**

- Assistance to drug users in prisons

There exist two state prisons at the national level; the CPL situated in the vicinity of Luxembourg City and the CPG implemented in the east of the country. Figure 8.5 provides general admission) and number of admissions according to drug-related convictions in both prisons from 1989 to 2003.

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.

In addition, an external expert has worked out a proposal for a pilot project (2000 – 2005) providing a global framework for specialised drug care associated to an in-house drug prevention programme on drugs and infectious diseases (hereinafter referred to as '**global drug care programme in prison**'). The first phase of the project is currently implemented and focuses on the diversification of treatment supply, prevention and harm reduction intervention as well as quality improvement of training activities for prison staff. Joint financing by the Ministry of Justice, the FLTS and the EU (regarding evaluation) is ensured.

Currently three different types of treatments are provided to drug users in prison:

- Detoxification
- Substitution treatment
- Harm reduction measures

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

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

Although the psychosocial care strategy is similar in both national prisons, the CPG currently disposes of a more structured intervention programme. The CPL runs a proper psychosocial and educational department (SPSE). Jointly with the SCAS and the prison guards' association, it has set up a project called 'DEFI' (Challenge) that aims at the development of therapeutic means, training facilities, socio-professional reinsertion measures and ineptness management, during prison journey and during the prison release phase..

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

Regarding **substitution treatment in prison**, no formal or binding guidelines do currently exist. Three scenarios may occur:

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

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

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

- o Alternatives to prison and punishment for drug users

See chapter 12.

10. Drug Markets

OVERVIEW

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

2003 data confirms that **cannabis is widely and increasingly available** on the national market. New distribution networks have developed in recent years and operate in an obviously professional way and by doing so have significantly increased drug availability and in particular the supply of **low quality cocaine**. In general, most drugs show stable or decreasing quality while prices tend to go down with the exception of cannabis.

● AVAILABILITY AND SUPPLY

Several reliable information sources indicate that the majority of illicit drugs consumed in the G. D. of Luxembourg originate from the Netherlands. Till the beginning of the nineties, most of the persons involved in illicit drug distribution were consumers who supplied themselves in the Netherlands or acquired limited extra quantities of drugs in order to sell them within restricted local networks. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market.

The **expansion of micro-networks**, relying on similar distribution techniques than international networks, involving however, a smaller number of local dealers, mostly of foreign origin, represents another observable trend. Specialised law enforcement agencies report a recent disproportional increase of west-African asylum demanders involved in drug trafficking. Since last reporting the situation has significantly worsened. Currently law enforcement actors estimate that approximately 300 persons (presumably underage) are involved in this new drug traffic and distribution network. Typically, involved dealers carry small quantities of drug hidden in their mouth. Initially they sold drug of good quality to low prices. Progressively however the quality and diversity of sold drugs has been decreasing. Currently, the national **drug market is flooded with low quality cocaine** which has induced major changes in consume patterns and behaviour of national drug users, especially in Luxembourg-City where an open drug scene has clearly established.

Little, however, is known on the provision sources of the referred dealer network. It seems to rely on important stocks of cocaine. It is highly organised and has managed to significantly increase the supply and availability of drugs at the national level. It is estimated that **0.5 kg of cocaine are daily sold** to drug users within the Luxembourg City drugs scene.

In the beginning of 2003 a **clandestine laboratory** manufacturing amphetamines has been discovered at the national level. The local production of cannabis and magic mushrooms is rather insignificant in terms of quantity.

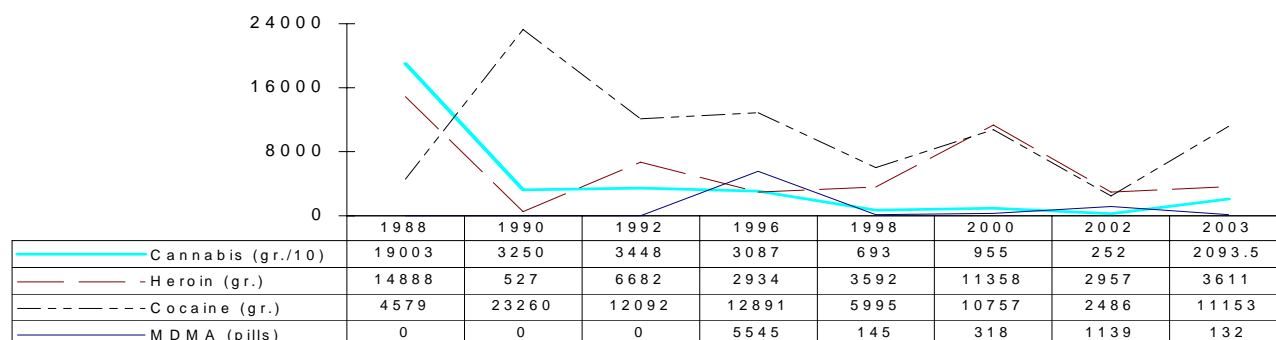
● SEIZURES

Striking variations have been observed as to the **quantity of illicit substances seized** since 1984. The general trend of decrease in heroine and cocaine quantities seized since the beginning of the nineties has been confirmed by 2003 data, with the exception of cannabis (leaves and resin) showing an obvious increase for the last four years.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. The number of cocaine and heroine seizures has stabilised whereas the **number of cannabis seizures** has markedly increased. For instance, the number of cannabis seizures has risen from 167 to 788 between 1994 and 2003. The total **number of persons** involved in traffic has followed a constant upward trend. A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

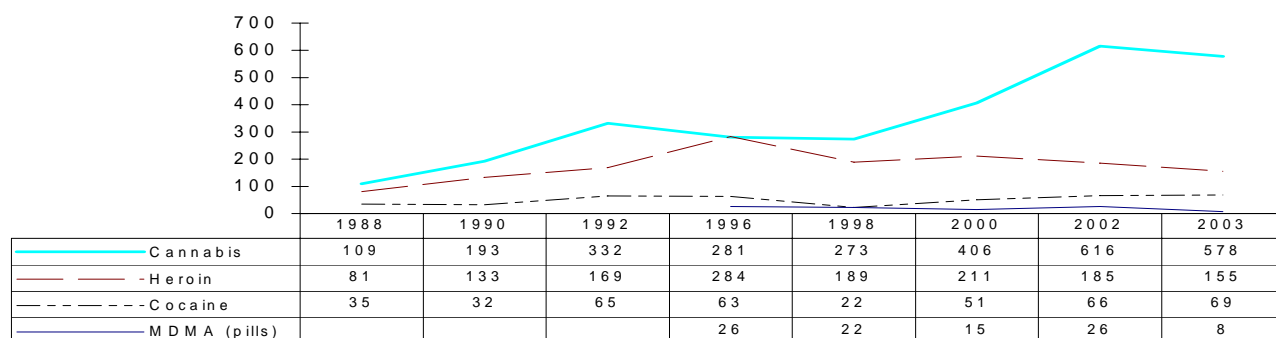
Crack (cocaine-base) seizures have not been reported to date by national authorities. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. The availability of ecstasy appeared to soar between 1994 and 1996. Most recent data indicate however a stabilization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

Fig. 10.1 Total quantity of seizures: heroin, cocaine, ecstasy type (1988 - 2003)



Source: Specialised Drug Department of the Judicial Police 2003

Fig. 10.2 Total number of seizures: Cannabis, Héroïne, Cocaine, MDMA (1988 - 2003)

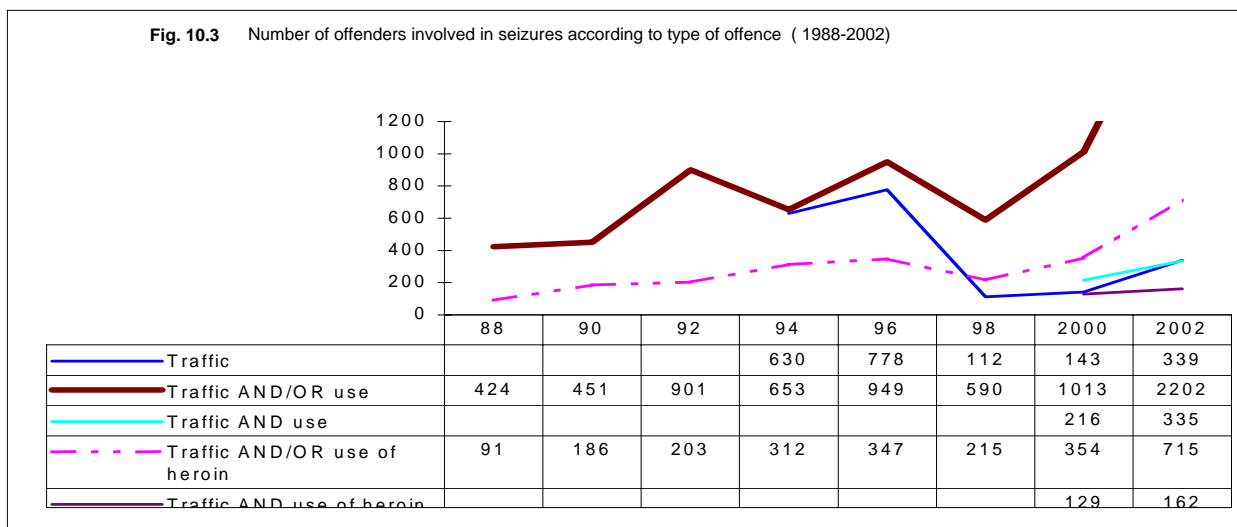


Source: Specialised Drug Department of the Judicial Police 2003

Table 10.1 Number and quantities of drug seizures – TOTAL (Police & Customs) 1997-2003

Substance		1997		1999		2001		2003	
		N	Q	N	Q	N	Q	N	Q
Cannabis (total)	kg	191	35.655	375	5.202	490	16.156	578	20.935
Hashish	kg	57	0.868	115	1.270	382	12.779	494	15.561
Marihuana	kg	133	34.787	255	3.932	106	3.377	84	5.374
Plants	units	1	5	5	93	2	11	12	34
Heroin	kg	237	2.525	306	1.914	211	1.351	155	3.611
Cocaine	kg	54	8.983	56	0.327	58	7.620	69	11.153
Of which crack	kg	0	0	0	0	0	0	0	0
Amphetamines	gr	0	0	5	16	7	11	8	28
	pills	3	9 gr						
Ecstasy type	pills	12	367	10	357	16	272	8	132
	gr								
LSD	doses	3	4	1	1	1	0.001	0	0
Psilocybin	gr	1	57.6	4	24.76	0	0	7	0.124
Methodone	ml	4	940	2	180	1	n.a	0	0
		1	840						
MEPHENON	pills	8	115	5	169	0	0	0	0
Number of offenders involved in heroin seizures		362		570		400		357	
Total number of offenders involved in seizures		802		1,168		1,065		1,386	

Source: Specialised Drug Department of the Judicial Police 2003



● PRICE/PURITY (see ST 14)

Average **street retail prices** of cannabis have been remaining fairly stable over the last ten years showing, however a more significant increase as far as marijuana is concerned. Heroin and cocaine prices have been falling during the same period of time. Heroin is frequently sold as 'boulette (meat ball)' containing 0.4 grams for 25. - euros. Typical street retail cannabis is sold in pieces of 2.5 to 3 grams for 25. - euros. Ecstasy retail prices tend to decrease.

Table 10.2 Price per unit evolution at the street level (1994-2003)

	1994	1998	2000	2002	2003
CANNABIS					
Haschisch	5-6	5 - 6	7,4	7	8.3
Marijuana		2,5 - 3	6,2		8.1
Cocaine	100-150	120 -170	90	50	30-85
Heroin (brown)	65-150	90 -150	74,4	50	40
STA		25-30	?	25	n.a.
Ecstasy		9 - 13	10,7	7	10
LSD	11-13	11 -13	?	n.a.	n.a.

Source: Specialised Drug Department of the Judicial Police 2003.

Price: expressed in EURO at street level.

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

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

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

As far as **purity** is concerned, the maximum quality of cannabis rates (% of THC) has been improving but the average quality has remained stable. MDMA purity in ecstasy-type drugs has improved. Heroin tends to show poorer quality and purity of cocaine has been remaining fairly stable in recent years.

Table 10.3 Purity of drugs at street level (1994-2003)

	1996	1998	2000			2001			2002			2003		
	Pur. (%)	Pur. (%)	Pur. (%)			Pur. (%)			Pur. (%)			Pur. (%)		
	AVERAG E	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.
CANNABIS (THC)			2.65	11,7	8,03	2,3	12,8	7,2	0.7	19.3	7.96	0.6	16.4	7.8
Cocaine	60-90	60-90	28,3	92,2	60,25	24,95	92,9	56,09	14.6	90.4	62.99	0.3	91.3	62.5
Heroine (brown)	15-23	20-25	2,8	54,9	17,59	24,95	92,9	13.62	2.0	22.9	9.97	0.9	47.75	12.15
STA									3.5	55.5	15.09	6.8	30.75	15.8
Ecstasy³⁶ (MDMA) (MDEA) (MDA)			18,7	52,3	35,5 6,8	35,61	109,7 5	67,25	11	120	71.11 - 24.6	33.7	101.6	77.8
Psylocine											0.15	0.1	0.1	0.1

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2003.

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

For cannabis, purity refers to percentage of THC.

For ecstasy-type substances, purity refers to percentage of MDMA-HCL in relation to total mass in 2000 and to mg of active substance per pill from 2000 onwards.

Part B – Selected Issues

11. Buprenorphine, treatment, misuse, and prescription practices

- **Treatment with buprenorphine**

³⁶ Ecstasy : dose in mg/pill

Until the beginning of 2001, there has been no **legal framework** regulating drug substitution treatment. However, the law of 27 April 2001 modifying the basic drug law of 19 February 1973 introduces a legal framework for substitution and maintenance treatment. The grand ducal decree of 30 January 2002³⁷ regulates the practical modalities of substitution. The new law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of **substitution treatment accreditations** granted to MDs and specialised agencies by the Minister of Health, the application of training requirements for prescribers and adequate control mechanisms of **multiple prescriptions** (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a **structured substitution treatment programme** provided by specialised agencies (JDH) and a **lower threshold substitution treatment offer** provided by freelance and accredited MDs.

Substances legally admitted for substitution treatment provided to drug addicts are listed in **article 13 of the grand-ducal decree of 30 January 2002**. Buprenorphine has been prescribed by MDs for substitution purposes since 1997 and included in the list of substitution substances under article 13 (g.d.d. 30/01/2002) in 2002. Medications containing buprenorphine can only be used for substitution therapy if the prescription notice explicitly mentions substitution treatment as a therapeutic indication.

SUBUTEX ® is considered to be a useful substitution treatment alternative rather than a new treatment option replacing methadone. It tends to be prescribed if medical incompatibility of methadone is reported by the patient. Moreover as a partial agonist its potential for abuse is limited because it produces less stimulation and physical dependence than full agonist medications, such as methadone, its euphoric effect peaks at a moderate level no matter how much is taken and there is a comfortable margin between the therapeutic dosage and the fatal dosage.

General admission criteria to substitution treatment are defined by the decree of 30 January 2002 as follows:

- treatment demander presents symptoms of drug addiction as documented by international diagnostic criteria and toxicological evidence, and is not likely to be adequately treated by other therapeutic techniques,
- treatment demander is native or is a resident of the Grand Duchy of Luxembourg. (Demanders who do not meet the latter requirement are nonetheless admitted if they follow a documented substitution treatment in another Member state of the EU).
- a written demand by the demander or his/her parental authority in case he/she is underage.

There are no specific admission criteria or guidelines for buprenorphine substitution treatment (other than the general admission criteria). Individual diagnosis and case management are key words when it comes to the decision of which substitution drug is most appropriate for a given patient.

Buprenorphine (sublingual SUBUTEX ® as far as drug substitution treatment is concerned) is more commonly prescribed by accredited GPs than by the national substitution programme run by specialised agencies. In 2003, 62 patients have been receiving SUBUTEX ® treatment of whom 8 were admitted in the specialised substitution programme. Referred to **913 patients having received substitution treatment in 2003**, the proportion of **SUBUTEX ® patients represents 6.8 %**.

Tab. 11.1 Comparative figures on buprenorphine (SUBUTEX®) prescription 2000/2003

Year Dosage	2000			2003		
	N. packages	N. pills	mg	N. packages	N. pills	mg
SUBUTEX 0.4 mg 1 pill	5	5	2	0	0	0
SUBUTEX 0.4 mg 7 pills	115	805	322	32	224	89.6

³⁷ The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: <http://www.eldd.emcdda.org>

SUBUTEX 2 mg 1 pill	76	76	152	125	125	250
SUBUTEX 2 mg 7 pills	366	2,562	5,124	490	3,430	6,860
SUBUTEX 8 mg 1 pill	113	113	904	19	19	152
SUBUTEX 8 mg 7 pills	250	1,750	14,000	198	1,386	11,088
TOTAL PACKAGES	925			864		
TOTAL PILLS		5,311			5,184	
TOTAL mg			20,504			18,439.6

Source: Union des Caisses de Maladie, 2004

SUBUTEX comes in 6 different packages according to buprenorphine dosage and number of pills included. As can be seen in table 11.1, there has been a slight **decrease in SUBUTEX® prescription** referred to year 2000. The respective number of patients is only known for 2003.

According to the grand-ducal decree of 30 January 2002, a substitution treatment accredited MD has to commit to participate in **continuous training programmes** and multidisciplinary exchanges on substitution treatment. Even though there are training and information session on substitution treatment organised by GP associations, the overall training offer in that specific field is fairly limited at the national level.

- **Misuse of buprenorphine:**

The prescription of SUBUTEX® in substitution treatment is fairly recent. No studies have been conducted at the national level in order to assess its misuse or diversion patterns. Temgesic®, another buprenorphine containing medication, is more likely to be used by drug addicts to reduce withdrawal effects in case heroin is not available than for substitution or maintenance purposes.

According to RELIS, approximately 5 % of PDUs in contact with specialised institutions report **misuse of substitution drugs** without distinction of substance types. According to specialised drug agencies, injection of buprenorphine is not common practice. Given the current situation, no harm reduction measures specifically focusing on buprenorphine misuse have been undertaken.

According to Origer & Dellucci (2002) and toxicological analysis results of overdose cases provided by the national Laboratory of Health (LNS, 2004) **direct or associated deaths** involving methadone are far more frequent than those involving buprenorphine. Between 1992 and 2003, the LNS has reported 11 direct methadone overdose deaths and 2 direct buprenorphine deaths. In 26 cases methadone has been found in blood samples of heroin overdose victims during the same reporting period against 0 cases for buprenorphine. The same picture emerges with regard to **non fatal intoxication cases**.

Methadone is known to be sold on the **black market**, especially MEPHENON® prescribed by GPs. The national substitution register is supposed to reduce this kind of diversion as it will allow to decrease the number of **multiple prescriptions** from different GPs to the same patient. Illegal diversion of buprenorphine is very rarely reported and unlike methadone no seizures of buprenorphine have been reported in recent years.

Luxembourg currently participates in a **regional prospective evaluation study** on the quality and impact of substitution treatment provided in non specialised settings in Belgium, France and Luxembourg. The study will be concluded in 2005 and is financed by the EU. Results of the referred study will be presented in the 2005 national report.

12. Alternatives to prison targeting to drug using offenders

- **Political, organisational and structural information**

Alternatives to prison targeting offending drug users do exist and are anchored in national legislations. Alternative measures to prison sentences are part of the national drug policy, they are not, however, explicitly referred to in drug strategy papers.

The Ministry of Justice and Prosecution authorities are in charge of implementing referred measures at the national level.

Article 30 of the law of 19/02/1973³⁸ establishes the 'Multidisciplinary Committee' in charge of treatment measures provided as alternative to drug related offences' sentencing. The grand ducal decrees of 28/12/1973³⁹ and 31/01/1980⁴⁰ regulate the composition and the functioning of the Multidisciplinary Committee, hereinafter referred to as '*Committee*'. Members of the Committee are designated by the Minister of Health who does also nominate its director.

The Committee takes in charge persons who according to article 23 of the 19/02/1973 law volunteer for drug treatment, and those who accept an alternative treatment proposition of the State Prosecutor and finally those persons who have been ordered drug treatment by the prosecution authority according to articles 24 and 26. The referred articles will be addressed more in detail below.

Following medical and social enquiries, the Committee, composed of three MDs, a psychologist, a pharmacist, a jurist an educator or teacher and a social assistant, chooses the adequate treatment setting and follows up treatment progress to be reported to the prosecution authority having proposed or ordered drug treatment.

• Legislation

General legislation regarding alternatives to prison relies on a series of codes as the criminal instruction code⁴¹, the penal code⁴² and laws on penalties regime⁴³. Legally possible alternative measures to sentencing or prison sentences rely on the nature of the offence and the type of sentence or penalties that are: criminal penalties, correctional penalties (minor offences) and police penalties.

As far as legislation on alternatives to prison targeting explicitly drug using offenders is concerned the modified basic drug law of 1973 (last modified by the law of 27/04/2001) provides the national legal framework .

Alternative measures to criminal proceedings by the Prosecuting authority (art. 23/law 1973 modified by law 27/04/2001)

In case of a recorded drug use offence, the Public Prosecutor ('Parquet') may decide:

- **not to prosecute** the case if the drug use offender (under certain circumstances defined by article 7, 8c and 8h of the modified 1973 law) submitted to detoxification treatment prior to the drug use offence record
- **to propose** to a drug user for whom a record for use of drugs defined under article 7 of the modified 1973 law has been established to undergo detoxification treatment on a voluntary basis. This also applies to drug distribution offenders if the underlying cause of the referred activity is personal drug use (as defined under art. 8a and 8b of the modified 1973 law.
- **to close** the case without proceedings (evtl. with a caution) if treatment proposed by the State Prosecutor is successfully completed (cf. Multidisciplinary Committee).

³⁸ Loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie. (Mém. 173, 319) (cf. ELDD)

³⁹ Règlement grand-ducal du 28 décembre 1973 déterminant la composition et le fonctionnement du service multidisciplinaire chargé de la lutte contre la toxicomanie et établissant les modalités de la cure de désintoxication (Mém. 1973, 1967) (cf. ELDD)

⁴⁰ Règlement grand-ducal du 31 janvier 1980 modifiant le règlement grand-ducal du 28 décembre 1973 déterminant la composition et le fonctionnement du service multidisciplinaire chargé de la lutte contre la toxicomanie et établissant les modalités de la cure de désintoxication (Mém. 1980, 81) (cf. ELDD)

⁴¹ Code d'instruction criminelle, art 621 ss.

⁴² Code pénal, art. 22

⁴³ Loi du 13 juin 1994 relative au régime des peines (Mém. 1994, 59)

Alternatives to sentence by Court (art. 24 and 26 / law 1973)

Once criminal proceedings for illicit drug use have started, the instructing judge, may:

- **instruct detoxification** treatment for adult illicit drug users. If the treatment is successfully completed (report by the MD in charge of treatment), the case can be closed without proceedings if related to offences defined under art. 7,8c and 8h (if not completed, the offender is prosecuted). The demand for detoxification treatment (instructed by the Instruction Judge) has to be addressed by the Public Prosecutor or the offender him/herself.
- **decide to postpone the sentencing** (suspension of sentence pronouncement in case the actual sentence is not higher than 2 years imprisonment) for a determinate length of time, but the instructing judge has to decide on the culpability. When the case goes back to the court, the judge may decide not to give a sentence. There are 2 types of postponements: simple postponement, postponement accompanied by probation (which may be associated to drug therapy).

The 'suspension sentence pronouncement' may be applied once a person has been found guilty but before he/she serves a sentence. The suspension of sentence may be applied once the person is in prison. It has to be seen as a measure that fits between the legal concepts of "prolonged leave" and conditional liberty.

In case of postponement with probation a custodial sentence may be suspended (totally or partially), under the monitoring of the Prison Probation Service (SCAS). The offender is released but is subject to measures intended to monitor his/her liberty of movement and is obliged to fulfil certain judicial orders such as undergoing therapeutic treatment in the case of drug addiction.

The sentence suspension may be accompanied or the sentence itself may be replaced by a requirement to perform community work, which can also be prescribed as main penalty. The legal term for community work is **Work of General Interest** (TIG). The TIG sentence, according to article 22 of the penal code is given by the Court whereas its modalities are decided upon by the State Prosecutor and commonly apply to 2 different scenarios:

1. Main sentence;
2. If sentence is less than 6 months imprisonment

The types of applicable TIG are regulated by the grand ducal decree of 20/09/1994⁴⁴ and are managed by the Prison's Central Probation Service (SCAS). In 2003, 121 TIG sentences have been given of which 8 were related to drug offences. As far as underage offenders are concerned the so called ' educational and philanthropic activities' (EPA) apply. In 2003, 6 of 95 EPA were related to drug use offences (Ministry of Justice, 2004).

Alternatives to sentence by Youth Court (art. 25 / 1973)

Youth Court may instruct detoxification treatment or counselling sessions (MSF) for underage drug law offenders (drug use). The referred measures can be delayed or modified according to the national law on childhood protection.

• **Implementation structure**

As can be deduced from information provided above, the implementation of alternative measures to sentencing and prison sentences applied to drug use offenders involves a series of authorities and actors namely the Ministry of Justice, the Ministry of Health, Prosecution authorities, the Multidisciplinary Committee, specialised treatment agencies and licensed MDs. The prosecution authority plays the

⁴⁴ Règlement grand-ducal du 20 septembre 1994 relatif au travail d'intérêt général (Mém. 1994, 1710)

central role in the decision process. There are no regional or local coordination mechanisms. Both, the multidisciplinary committee and the MD responsible for the ordered or proposed drug treatment may report to the Prosecution authority.

According to article 29 of the 1973 modified drug law implementation costs of specialised treatment infrastructures for drugs users within the regime of therapeutic injunction are to be taken in charge by the State. Treatment and medical surveillance costs are totally or partially taken in charge by the State if not covered by the Social Security insurance scheme of the beneficiary, and/or if the latter has no sufficient financial means. (art.8 of g. d. decree of 28/12/1973).

• Interventions

National legislation on treatment modalities for drug use offenders as an alternative to judicial measures explicitly refers to detoxification treatment. Article 30 of the 1973 modified drug law, however, allows the Multidisciplinary Committee to define adequate treatment options. According to article 29 of the same law, treatment may be provided by specialised drug treatment agencies or other therapeutical settings if medical surveillance is ensured. In practice, treatment interventions include, in- and outpatient detoxification, therapy and counselling and substitution treatment.

The modified grand ducal decree of 28/12/1973 regulates treatment modalities for drug users who present voluntary for treatment to the Multidisciplinary Committee and for those who have been proposed or ordered drug treatment by the Prosecution authority.

The Committee following a medical and social enquiry chooses the adequate treatment setting. Alternative drug treatment may be provided by all state licensed/accredited national drug care facilities and if deemed necessary also by treatment institutions abroad. Most involved drug treatment facilities or non profit organisations or foundations having signed a financing convention with and are accredited by the Ministry of Health. These specialised agencies provide drug treatment to a broad target population since they have not been set up specifically for drug users under the therapeutical injunction regime. Treatment in state accredited drug agencies are free of charge and physical detoxification falls under the health insurance scheme.

If the medical diagnosis reveals a minor addiction problem, treatment may be provided within an outpatient setting under the responsibility of an accredited MD. For this purpose MDs have to address a accreditation demand to be granted by the Minister of Health (art. 9 of modif. G. d. decree of 28/12/1973). The Multidisciplinary Committee follows up treatment progress of the concerned person and report to the prosecution authority having proposed or ordered drug treatment.

Annual admission statistics show that between 1995 and 1999 the number of drug users referred to the Multidisciplinary Committee by the Prosecution Authority varied between 20 and 60 cases per year. From 2000 onwards it became more and more common practice to refer concerned drug users directly to specialised drug agencies, which currently ensure medico-social enquiries and treatment itself. There are no data on referral schemes from 1999 onwards. The Committee is currently to be seen as the official link between treatment providers and the competent prosecution authority more than a diagnosis and orientation setting.

In 1996 a separate mechanism has been put in place with regard to underage and juvenile drug use offenders. The **MSF Youth Solidarity** (Doctors Without Frontiers) project is financed by the Ministry of Health and intervenes in case a minor of age has been running in conflict with law enforcement forces with respect to a drug-related offence. In this respect the MSF Youth Solidarity team may be considered as a crisis situation manager, offering their services to drug offenders referred by judicial and penal institutions. Proposed services are free of charge.

The MSF intervention team, in direct collaboration with Youth magistrates and competent law enforcement actors, offers a large variety of services with the primary aim to prevent minor aged drug offenders to enter in the criminal justice system. Interventions are based on a holistic approach of the

problem, including the involved person him/herself and his/her family. MSF directly reports on intervention progress to the demanding authority. Client statistics show an increasing demand for this kind of intervention from both the criminal justice system and the social oriented institution.

	1997	1998	1999	2000	2001	2002	2003	
Number of clients	27	46	99	132	195	208	231 ↗	
Referral from the criminal Justice system		26.1%	26.3%	41.4%	44.1%	44.2%	37.2%	
Gender distribution	Female	26%	28%	26.3%	34.1%	32,3%	34.1%	31.6%
	Male	74%	72%	73.7%	65.9%	67,7%	65.9%	68.4%
Age distribution	< 15	7%	11%	16.1%	12.6%	13,8%	17.8%	23.8% ↗
	15-17	82%	81%	73.8%	74.2%	80,9%	71.6%	63.6%
	≥ 18	11%	8%	10.1%	12.9%	11,3%	10.6%	12.6%
Main substance involved	Cannabis	45%	49%	65.7%	78%	72.3%	82.2%	83.1% ↗
	Heroin	33%	22%	21.2%	12.9%	7.2%	2.4%	3.5 ↘
	Solvents	7%	11%	5.1%	1.5%	0.5%	0.5%	0.0
	Ecstasy	4%	12%	3%	3.8%	3.6%	1%	0.9 ↘
	Cocaine		3%	1%		2.6%	1%	0.4
	Other	11%	3%	4%	3.1%	13.8%	12.9%	12.2

Source: Solidarité Jeunes (MSF). 2004

- **Monitoring**

Article 27 of the modified 1973 drug law stipulates that the prosecution authority having proposed or ordered alternative treatment options has to be informed on the start, process and outcome of the referred treatment by the Multidisciplinary Committee in charge. In case the concerned drug use offender does not undergo or interrupt the proposed or ordered treatment, the initial sentence will be given by the prosecution authority.

Cases referred to the Youth Court are processed according to the final outcome of MSF interventions.

- **Quality insurance**

The procedures applying to alternative sanctions to prison for adult drug use offenders are laid down by law. Measures for underage or juvenile drug use offenders rely on a series of agreements between the prosecution authority, the Youth Court and involved NGOs.

To date, evaluation strategies as well as treatment impact assessment with regard to prison alternatives are inexistent. The global drug care programme in prison set up in accordance to the law of 27 July 1997 foresees a clearly defined evaluation strategy in terms of process and output assessment. Furthermore, the recent routine application of the RELIS protocol to new prison admissions will allow in the medium-term to assess future careers of drug law offenders under the therapeutic injunction or the TIG regime in terms of subsequent law enforcement and treatment contacts, drug-related morbidity and mortality.

Training activities will be further developed in the framework of the global drug care project.

13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies

- **Definition**

At the national level the concept of "Public nuisance" is not approached as specifically related to drug use. PDUs are part of the population perceived as potentially nuisance generating, alongside with

homeless people, asylum demanders, prostitutes, ravers, late night bar clients, etc. It is neither population specific nor substance specific if referred to PDUs.

Even though there is no officially recognised national definition, public nuisance refers to behaviours and situations that are perceived as undesirable, unpleasant, annoying, threatening or harmful by a person or a community which consider not to be involved in its generation process. Hence, there are two crucial factors to be considered: “perception” (and all the subjectivity that goes with it) and non-responsibility (or victim position).

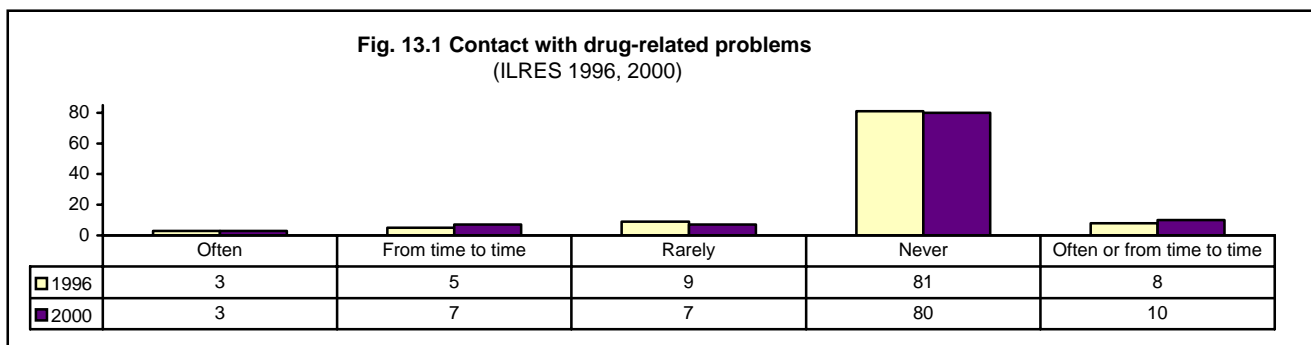
The following situations are commonly associated to the perception of public nuisance:

- Disturbance of public order
- Antisocial and objectionable behaviour
- Verbal or physical violence and intimidation
- Delinquency and Criminality
- Annexation of public space (squat)
- “Ghettosisation” (gathering of problematic populations in certain areas)
- Vandalism and damaging/destruction of public or private propriety
- Visibility of decay of standards and degeneration (public drunkenness and drug use included)
- Littering and encumbering public space

The only national opinion poll indirectly related to drug nuisance has been performed by ILRES in 1996 and 2000 in the framework of EUROBAROMETER wave surveys n°44.3 (1996) and 54.4 (2000) (EC 2001).

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

Figure 13.1 presents the distribution of answers to the question: 'Over the last 12 months, how often were you personally in contact with drug-related problems in the area where you live? (e.g. seeing people dealing in drugs, taking or using drugs, finding used syringes, etc.)'



Although the observed percentages are low compared with most of the other EU Member States, a slight increase of the number of respondents reporting contact with drug-related problems has been observed in 2000.

- **Genesis**

The historical link between drug use and public nuisance is best defined if referred to the complementary and gradual influence of **public health**, **public security** and **social/economical factors**.

Drug-related harm reduction measures may be considered as the first national response to a growing concern on the alarming health condition of PDUs and the spread of infectious diseases. The set up of needle exchange programmes and the spread of substitution treatment during the end of the eighties and the beginning of the nineties have been one of the first measures that originated partly from the need to reduce drug-related harm (esp. HIV infections) and nuisance factors. The fact that in 2002 and 2003 those measures have been given a legal framework and that other measures as shooting galleries and heroine distribution programmes are retained as priorities by the government, clearly shows that health prevention and nuisance prevention/reduction continue to be strongly linked.

Public security is another crucial factor when it comes to public nuisance analysis. Basically all situations listed under the definition heading induce fear and feelings of potential insecurity. As problematic drug use became a more studied and mediatised phenomenon in the beginning of the nineties, public awareness and concern has also been increasing. Reports on increasing PDU prevalence and drug-related petty crime by officially recognised authorities have contributed to this evolution. Research, information and media have played a major role in public nuisance management.

Public nuisance phenomena are geographically spread and are often limited to certain specific areas especially in urban regions. Typically, drug-related nuisance is most felt in surroundings where drug use and drug traffic occur simultaneously, such as central railway station or isolated lots near the dealers' scenes. Understandably, a series of treatment and harm reduction facilities are to be implemented in the vicinity of those "hot spots". The implementation of new infrastructures such as drop-ins, consumption rooms or night shelters for drug addicts is often perceived as a contribution cause to public nuisance, since they are said to attract PDUs and thus degrading local live quality.

In the mid eighties, the first association representing the interest of local store owners and residents has been created. The major concern of this association was, and still is, the degradation of life quality and economic losses caused by a presumed general feeling of insecurity keeping potential clients off their commercial area which is situated within the surroundings of the central railway station. However, it would be speculative to pretend that the perception of public drug-related nuisance has started with the activity of the referred association since, their views are not necessarily shared by other parties, especially with regard to the negative impact of harm reduction offers, secondly because the area they represent is limited and finally because they address a broader target population than PDUs.

- **Measures taken and outputs**

Drug-related public nuisance is not specifically addressed by **law**. Article 561 of the penal code addresses public nuisance related and to unacceptable noise levels. Civil law refers to neighbourhood trouble in art. 544 and to damage caused to others in art.1382. At the local or municipal level, public nuisance is regulated by Police decrees. The last amendment of the latter occurred on 26 March 2001. It regulates penalties for public order disturbance, night and noise disturbances, vandalism, and littering of public space. Drug addicts are not directly referred to but as far as the police decree for Luxembourg City is concerned, prostitution is clearly mentioned and areas where the latter is allowed to take place are listed.

The 2000 – 2004 national drugs action plan addressed harm reduction measures as a priority area, although public nuisance was not explicitly referred to. However, the creation of a **night shelter (called Nuetseil) for drug addicts** under the 2000-2004 action plan has proven that low threshold offers have to be carefully planned with regard to local socio-cultural realities. Originally the night shelter was to be

located in the vicinity of the central railway station in a non-resident area. Discussions were held between the Ministry of Health, local and judicial police, municipal authorities and local bar owners. All parties were aware that the chosen area was part of the “semi open” drug scene and that abandoned houses situated in the street of the future night shelter have progressively evolved to unofficial shooting galleries, meaning that drug-related nuisance was at its highest. By the end of the day, the municipal authorities expressed their opposition, arguing that the site was not appropriate.

In December 2003 the Ministry of Health opened a night shelter for drug addicts in a container structure built on an isolated plot near the railway station, as negotiations with municipal authorities were still ongoing. In doing so, police authorities were involved in the conceptualisation of the project, and information meetings with local residents were organised during which the benefits and potential risks were presented in an objective way. The latter received a phone number to call in case they witnessed drug-related nuisance. Staff members involve clients in nuisance prevention and periodically check the surroundings for thrown away used syringes. The Police is collaborating and is free to enter the night shelter although they try to keep a certain distance in order not to intimidate clients. Police authorities were highly in favour of project since they were in demand of a service that could admit and handle PDUs causing trouble during night time.

After 8 months of functioning, there have been no major problems in terms of public nuisance. On the contrary, the night shelter contributed to reduce rough sleeping in streets, squatting and late night disturbances caused by PDUs. The success of the project is believed to be primarily due to the following factors:

- consensual need analysis involving both service demanders and service providers
- early involvement and constructive collaboration of local police and municipal authorities
- early and reliable information to local residents and set up of a nuisance reporting line
- involvement of clients in the nuisance prevention process

A **national syringe distribution and exchange programme** has been set up in 1989 under the auspices of the Ministry of Health. One of the related concerns was to reduce the number of discarded syringes. Even though no specific study was conducted thus far, used syringe return rates may serve as performance indicators of such measures. At the beginning of the needle exchange project, the primary objective was to give the broadest possible access to free of charge sterile injection material to IVDUs. As the measure started to establish, the return of used syringes became a second priority. The 1:1 rule was becoming routine, meaning that clients only get a new syringe for a used one. This has led to a significant increase of the used syringe return rates over the last 7 years. Quite frequently clients even collect used syringes discarded by other IVDUs and return them to exchange agencies. As a result of the chosen strategy the return rate went up from 38% in 1996 (28,646) to 94% in 2003 (268,891).

The **national substitution treatment programme**, set up in 1992, indirectly targeted prevention of petty crime and other drug-related nuisance. As the number of patients grew rapidly, the programme was decentralised and ambulatory low threshold substitution, prescribed by the national accredited GP network, has been developed. RELIS⁴⁵ data has allowed to observe a significant decrease in drug-related criminal behaviour and an improvement of the financial situation of PDUs since the implementation of substitution treatment offers.

Measures such as **injection rooms** and **heroin distribution programmes** have been given a legal framework during the 2000-2004 action plan and their implementation is part of the 2005-2009 drugs action plan. These measures are believed to further contribute to reduce drug-related harm and nuisance.

⁴⁵ National drug monitoring system

**** END OF REPORT ****

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- Relevant data bases and information systems

- a. RELIS drug monitoring system

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

The main objectives of RELIS are the following:

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

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

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

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

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

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

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

In terms of data provision, RELIS further relies on following national registers:

- Register of drug law offenders - Special Drug Department of the Judicial Police,
- National Mortality Register – Ministry of Health,
- Special Overdose Register – Special Drug Department of the Judicial Police,
- AIDS and HIV Register - Laboratory of retrovirology – CRP-SANTE.
- Early warning system on new synthetic drugs

- b. Register on drug law offenders (SPJ)

The register on drug law offenders is paper-based and maintained by SPJ. Research and queries on drug law offenders are performed manually. Special authorisation has been reached by the NFP to access the referred register and to manually include non-nominative data on offenders into the RELIS database. The NFP thus has developed a standard data collection protocol relying on SPSS ® based data analysis. This procedure has enabled the NFP to dispose of detailed anonymous data on all drug law offenders indexed by SPJ and to operate breakdowns referring to use and traffic offences and to substances involved according to types of drug law offences.

- c. General Mortality Register (GMR)

GMR is run by the Health Statistics Department of the Directorate of Health. The main impediment towards refined data provision on drug-related deaths and the application of the EMCDDA promoted DRD standard has been the 3-digit ICD coding applied by GMR until 1997. In 1998, ICD-10 standard was first applied by GMR. Currently, drug-related death data are extracted from GMR by means of a separate extraction routine. Efforts are currently made to implement an integrated software based on the DRD ICD-10 standard and relying on the RELIS identification code, thus allowing for cross validation of drug-related death data.

- d. Special Overdose Register (SR) of SPJ

The SR is a paper-based register on acute and indirect drug-related deaths run by the SPJ. Over the past years, NFP has put major efforts in the development of a computer-based indexing procedure (SPSS ®) of drug-related deaths by means of a comprehensive data form. NFP is currently maintaining a standardised database on acute drug-related deaths from 1985 to 1999. Anonymous drug-related death data is encoded at the SPJ and transmitted to the NFP according approved standards. Data on indirect drug deaths that are still paper based is also provided to the NFP.

e. AIDS and HIV register (CRP-SANTE)

Official statistics from the national Retrovirology Laboratory of the CRP-Santé provide the number and proportion of IDUs in HIV infected patients. Breakdowns by limited core socio-demographic variables are available. Provided data has public status.

f. Early Warning System on Synthetic Drugs (NFP / SPJ)

In the framework of the Joint Action on Information Exchange, Risk Assessment and Control of New Synthetic Drugs, the NFP has developed a nation wide cross-sectional data exchange network

Decision has been made to adopt a centralised structure relying on a nation wide EWS partners' network (local contact persons) as well as centralised co-ordination of key data providers' activities. The national co-ordination unit of EWS is implemented within the NFP. The head of NFP has been appointed national EWS co-ordinator.

The new mandate of the **Inter-ministerial Group on Drugs** (November 2000), which represents the top decision level in the field of drug policies, expressly includes the follow-up of the national EWS system. Governmental delegates represented within the Inter-ministerial Group have disseminated information on EWS within their respective administration and have undertaken the required steps towards an effective inter-ministerial collaboration.

The implementation of EWS relies on a network of institutional **key-informants**. Currently all specialised drug agencies (low/high threshold) at the national are involved in the data providing process in terms of routine data transmission on new trends. Recently two new agencies have joined the EWS network, namely a counselling centre for drug users underage and a low threshold project. The first does provide relevant data on new consume patterns and trends within youngster population and the second focuses on opiate users. One has to stress that the key-informants network does mainly provide data on trends in drug use but not on toxicological characteristics of substances since the referred agencies do not propose substance related services.

Currently, drug seizures are still one of the most important and the most reliable data source as to substance profiling and detection of new drugs. Samples seized by Customs or Police are either analysed (rapid tests) by the SPJ, or sent, via the Prosecutors office, to the National Laboratory of the Department of Health (LNS) for toxicological profiling. Respective results are not systematically transmitted to the department of Health or the NFP. However, effective bilateral co-operation between the NFP and the **national Europol unit** (SPJ) allow for rapid data transmission in case a new trend or substances should be detected by the latter. The active involvement of law enforcement agencies in the national monitoring system highly facilitates the implementation of Joint Action-related activities.

Agreements have been made between the *National Fund Against Drug Trafficking*, the NFP and the **National Health Laboratory (LNS)** on the funding of new technical equipment allocated the toxicology unit of the latter. This achievement has largely contributed to the improvement of the quality of toxicological analysis provided by LNS.

General practitioners have recently been involved in the EWS in terms of data provision on new substances and new consume patterns. All GPs and psychiatrists registered in the Grand-Duchy of Luxembourg have received a standardised data form allowing them to provide relevant information to the NFP in case they were confronted with an unknown psychotropic substance or unusual consume patterns. The NFP, as a counter part, committed to provide GPs and psychiatrists with information on the detected trends or substances, as far as there is any information available.

Drug-related deaths have to be reported by **emergency services** to the Police and the SPJ. Non-fatal drug-related emergencies requiring medical intervention have not to be reported systematically. Moreover, emergency services do not index drug-related interventions separately, which means that no monitoring of those cases can be performed. The referred situation is not likely to change and thus, the inclusion of emergency services in the EWS appears to be unfeasible at the present stage.

National drug legislation does not foresee a legal framework for **testing or profiling illicit drugs** in nightclubs, public events or rave parties. No such activities have been planned or carried out under the authority of public administrations. Taking into account that the first official seizure of 'ecstasy' has only been recorded in 1994, harm reduction and close monitoring activities in this particular field were previously not viewed as a priority.

In October 1995, a **new drug help line** was created, under the responsibility of the CePT. Given its easy access and the anonymity it guarantees, phone help lines often represent the first step with regard to further orientation or treatment demand proceedings and as such are able to provide high quality data on recent trends in drug use. The national Drug Help Line has been included in the EWS system in the course of 1999.

The drug issue is largely covered by various **media supports**. Press, Music, fashion and leisure industries are often the mirror of life styles and current trends in substance use. Information could be collected by screening the media targeted at young people and sub cultural groups. Radio, television, newspaper, magazines, fanzines, books, comics, announcement of events, opening of new clubs, etc., are to be viewed as complementary indicators towards the global monitoring of new drug trends. Since the resources of the NFP do not allow for an overall monitoring of media supports, decision has been made to compile, in collaboration with the information and press department of the State's Ministry, a monthly national and international press review on drugs.

g. Documentation Centres (NFP / CePT)

The **Centre Logistique de Documentation sur les Drogues et les Toxicomanies (CLDDT)** is a logistic documentation service run by the NFP since 1995. CLDDT runs the only computer-based national documentation management base specifically focusing on licit and illicit drugs. The CLDDT indexes about 2,900 documents mainly in French, German and English language. Users of information services provided by the CDTL are mainly researchers, journalists, policy makers, drug treatment and prevention specialists, and general public. The majority of indexed documents are paper-based and abstracts are provided.

The following topics are covered by CLDDT:

- chemistry, pharmacology, etc.
- medical pathology & psycho pathology
- treatment
- prevention
- harm-reduction
- AIDS & HIV
- epidemiology
- drug trafficking & drug markets
- legislation & legal studies
- international co-operation
- training activities
- inventories of professionals, researchers etc.

In addition to its function of documentation base, CLDDT also ensure the conceptualisation and execution of drug documentation dissemination strategies as required by the NFP. Topic-specific mailing lists have been developed and maintained by active contact making and demand response.

CLDDT is linked to the **Centre de Documentation du Centre de Prévention des Toxicomanies** run by CePT since 1996. The CePT documentation centre mainly focuses on primary prevention, training and evaluation in the fields of licit and illicit drugs. The current stock approaches 1,000 documents or media supports. Queries are handled manually and no computer-based consultation facilities are provided.

- Alphabetic list of relevant Internet addresses

<http://www.ceps.lu/>

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

<http://www.crp-sante.lu/>

http://eldd.emcdda.org/databases/eld_search.cfm

<http://www.emcdda.eu.int/>

<http://www.etat.lu/>

<http://www.etat.lu/MS/>

<http://www.gouvernement.lu/>

<http://www.ilres.com/>

<http://www.jdh.lu/>

<http://www.legilux.public.lu/>

<http://www.msf.lu/>

<http://www.police.public.lu/PoliceGrandDucal>

<http://www.reitox.emcdda.org:8000/eddra/>

<http://www.reitox.emcdda.org:8000/eddra/>

<http://www.relis.lu/>

<http://www.statec.lu/>

<http://www.unodc.org/>

<http://www.who.int/>

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- List of Abbreviations

AST	Service d'Action Socio-Thérapeutique
CNDS	Comité National de Défense Sociale
CePT	Centre de Prévention des Toxicomanies
CPOS	Centre de Psychologie et d'Orientation Scolaire
CRP-HT	Centre de Recherche Public - Henri Tudor
CRP-Santé	Centre de Recherche Public - Santé
CTM	Centre Thérapeutique de Manternach
CHNP	Centre Hospitalier Neuro-Psychiatrique
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
GHD	Groupe Horizontal « Drogues »
GID	Groupe Interministériel « Drogues »
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMA	Agence Européenne pour l'Evaluation des Médicaments
EUROPOL	Office Européen de Police
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
JDH	Fondation Jugend- an Drogenhëllef
LNS	Laboratoire National de Santé
MSF	Médecins Sans Frontières
OEDT/EMCDDA	Observatoire Européen des Drogues et des Toxicomanies

OGD	Observatoire Géopolitique des Drogues
PFN	Point Focal National de l'OEDT
PNUCID	Programme des Nations Unis pour le Contrôle des Drogues
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
SEPT	Semaine Européenne de Prévention des Toxicomanies
SNJ	Service National de la Jeunesse
SPJ	Service des Stupéfiants de la Police Judiciaire
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
ZePF	Zentrum für Empirische Pädagogische Forschung – Universität Landau

- List of Standard tables and Structures questionnaires used in text

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