REPORT TO THE EMCDDA

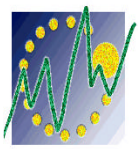
by the Reitox national focal point of Luxembourg,

Direction de la Santé

LUXEMBOURG

DRUG SITUATION 2000

REITOX REF/ 2000



POINT FOCAL
O.E.D.T.

GRAND-DUCHE
DE LUXEMBOURG

Annual National Report on the Drug Situation 2000

GRAND DUCHY OF LUXEMBOURG

October 2000

Alain Origer, PhD

Head of Focal Point

Commissioned by the

European Monitoring Centre for Drugs and Drug Addiction, Lisbon

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.

The national report has been produced in close collaboration with the following national actors. Andrée Clemang (Ministry of Justice), Robert Kirsch, Georges Neu (Special Drug Department of the Judicial Police), Sylvie Petry (State Prison CPL), Dr Romain Schneider (National Laboratory of Health LNS), Henri Goedertz (AIDS Berôdung asbl), Dr Robert Hemmer (Surveillance Committee on AIDS), Thérèse Michaelis (CePT), Henri Grün (JDH), Aloyse Moyse (National Methadone Programme JDH), Dietmar Dentzel (JDH), Romain Pauly (CTM), Dr Robert Kasel and Robert Hottua (CHNP-BU-V), Alain Massen (MSF), Helène Dellucci (PREEDS asbl), Daniel Schroeder (Consultant), Mady Rouleaux (Directorate of Health), J.-M. Schanck (Minsitry of Health).

Luxembourg, October 2000

Alain Origer, PhD.
National Drug Co-ordinator
Head of Focal Point
Directorate of Health

GLOSSARY

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-SANTE	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 ' Drogue '
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMEA	Agence Européenne pour l'Evaluation des Médicaments
EUROPOL	Office Européen de Police
JDH	Fondation Jugend- an Drogenhëllef
MSF	Médecins Sans Frontières
NFP	National EMCDDA Focal Point
OEDT/EMCDDA	Observatoire Européen des Drogues et des Toxicomanies
OGD	Observatoire Géopolitique des Drogues
PNUCID	Programme des Nations Unis pour le Contrôle des Drogues
RELIS/LINDDA	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 (Special Drug Unit of Judicial Police)
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
ZePF	Zentrum für Empirische Pädogogische Forschung – Universität Landau

Summary

Main Trends and Developments

Since its implementation in 1994, the Luxembourg National Focal Point (NFP) of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has aimed at maintaining and developing a national monitoring and information network on drugs and drug addiction, which is also known as the Luxembourgish Information Network on Drugs and Drug Addiction (RELIS-LINDDA).

Relying on a multi-sectorial data network including in- and outpatient specialised treatment centres, low threshold facilities, general hospitals as well as law enforcement agencies and national prisons, RELIS/LINDDA enables the rapid assessment of new trends and developments.

Its objective is to:

- 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.

Political, legal and budgetary orientations

Drug abuse is currently defined as a behaviour associated to health and social risks rather than a socially reprehensible criminal act (see Governmental Declaration 1999). In addition to the diversification of specialised health care facilities, a more pragmatic approach towards law enforcement is observed.

The parliamentary bill n°4349 of 25 August 1997, modifying the modified drug law of 1973 foresees the creation of a legal framework for a series of harm reduction and maintenance measures as for instance drug substitution treatment (including heroin prescription), needle exchange and shooting galleries as well as the revision of penalties according to the type of controlled substances involved.

The Ministry of Health, in charge of national drug co-ordination in the fields of demand and harm reduction, since the parliamentary elections of 1999, has recently presented a multi-annual action plan on drugs and drug addiction. The referred action plan relies on six intervention areas, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and low threshold services. In addition to the creation of new treatment facilities, synergies between the already existing network are enhanced. In order to optimise the implementation of the drugs action plan, the Minister of Health has appointed a national drug co-ordinator and the Directorate of Health is setting up a special division for social medicine and drug addiction.

The budget of the Ministry of Health directly allocated to actions against drugs and drug addiction shows an increase from 1.14 million € in 1999 to 2.13 million € in 2000, following the centralisation of demand and harm reduction activities by the Ministry of Health. The provisional budget of 2001 foresees a supplementary increase of 49 per cent, thus figuring 3.15 million €. In accordance to national needs and the upcoming workplan of the EMCCDA, a national study on the socio-economic costs of drug use is currently performed by the NFP.

Law enforcement indicators[1]

***S**eizures of illicit substances at the national level*

Striking variations have been observed as to the quantity of illicit substances seized since 1984. Since 1996, however, one observes a general downward trend as regards seized quantities of heroin, cocaine and ecstasy type substances. Heroin, cocaine, cannabis leaves and resin are the only substances that have been seized on an annual basis since 1980.

Notwithstanding the quantities seized, the number of seizures has grown steadily until 1996 (1999: 806), with the exception of cocaine, amphetamines and ecstasy. The number of persons involved in heroin traffic has followed a constant upward trend, which has remained remarkably homogeneous until 1999 (570) (except in 1998). The same trend, although proportionally less important, has been observed with respect to the total number of persons involved in drug seizures. Summarily, quantities of seizures have been decreasing since 1996, while the number of persons involved shows a significant increase, especially in 1999. The development of distribution micro networks may partly contribute to the current situation.

PCP or 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 from 1994 onwards whilst seizures, in terms of quantity, have significantly decreased in 1997 and have remained fairly stable over the last 3 years (1999: 357 pills). Nonetheless, it would not be wise to draw conclusions at this stage on the prevalence of ecstasy-type substances, in the light of divergent data resulting from other sources (e.g. recent school surveys). Further attention should also be paid to the increased number of magic mushrooms (psilocybin) seizures observed since 1997.

***D**rug law offenders and prison sentences*

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 in 1999 (1,187). The number of drug law offenders (' prévenus') has declined from 1,368 in 1996 to 1,170 in 1998. In 1999, however, an inverse trend has been observed peaking at 1,939 drug law offenders. The number of arrests on the same charge has decreased from 154 in 1997 to 108 in 1999.

The population of drug law offenders counts 87 per cent of males; a proportion that has been varying between 79 and 89 per cent during the past decade. Within the same period, non-natives have been representing the majority of drug law offenders (except in 1994). Regarding the proportion of first drug law offenders (33%), no trend-line can be observed. The percentage of minors (< 18 years) in drug law offenders has increased since 1993 (5%) (1999: 8%).

The proportion of prison sentences for drug law offences has decreased significantly compared with 1997 data. In 1999, 139 new entries (16 %) (1997: 36%) in national penal institutions referred to the ' DELIT- STUP ' code have been reported (of a total number of 859 entries in 1999).

RELIS/LINDDA provides the following figures for 1999:

- 83 per cent (↗) of problem drug users indexed[2] by specialised health care institutions have already been in conflict with law enforcement agencies during lifetime. 66 per cent (↗) of the latter show multiple law enforcement contacts.
- the number of '*interpellations*' for other reasons than presumed offences against the dug law (e.g. petty crime) has been decreasing since 1997, reaching for the first time (since reported) a lower figure than the number of drug law offences.
- 71 per cent of indexed problem drug users have already served at least one prison sentence during lifetime. 60 per cent of the latter have been in prison once and 40 per cent report more

[1] If not specified, data refer to 1999

[2] Persons who have been indexed by the RELIS/LINDDA network (see introduction) during a reporting year.

than one prison journey. Compared with previous years, a significant deterioration of the penal situation of indexed drug abusers must be stressed; associated, however to a decrease of the duration of served prison sentences. The steep increase of first prison sentences might contribute to the observed situation.

Profile of the national drug market

A series of reliable information sources indicate that 90 per cent 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 traffic were consumers who supplied themselves in the Netherlands or acquired limited quantities of drugs in order to sell them within a restricted local network. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market. Law enforcement agencies do stress the negative impact of the abolishment of border controls on the fight against drug trafficking measures.

The expansion of micro-networks, relying on similar distribution techniques than international networks, involving limited number of local dealers, mostly of foreign origin, as well as the increased availability of cocaine and cannabis on the national market represent further observable trends.

Furthermore, no production units (e.g. clandestine laboratories) have been discovered at the national level thus far. The local production of cannabis and magic mushrooms is rather insignificant in terms of quantity and quality.

Average street retail prices of illicit drugs have been remaining fairly stable during past years (brown heroin: 90 €/gram, ecstasy: 12.5 €/pill), with the exception of cannabis, on the increase (haschisch: 7.4 €/gram, marijuana: 6.2 €/gram) and cocaine on the decrease (90 € /gram).

In terms of purity, samples of 'suspect substances' analysed by the National Laboratory of Health (LNS) in 1999, revealed the following margins of purity of active substance: brown heroin: 7.2 to 27.7 per cent; cocaine: 45.8 to 88.76%; haschisch (THC): 2 to 5.13%). In 1999 and 1998, toxicological analysis of samples sold as ecstasy reported the presence of MDMA in 15 per cent and in 25 per cent of the samples respectively. Associated substances most frequently included in ecstasy pills were: amphetamine-sulphate, caffeine, codeine, benzodiazepines and ephedrine.

Epidemiological indicators

Drug use in population

Drug prevalence in school population

Comparable data from national school surveys, conduced between 1992 and 1999, show increasing lifetime prevalence in young people (16-20 years) for all common illicit substances. Special emphasise may be put on the disproportional increase of cannabis, magic mushrooms and ecstasy prevalence. In younger school populations (13-14 and 15-16 years), one observes the same trend, especially with regard to cannabis lifetime use. Prevalence of opiates use in youngsters is still showing a low prevalence, which has poorly increased during the referred period.

To date, a single national survey (Fisher 1999) provides last 30 days prevalence figures for 13 to 18 year old schoolchildren. Cannabis and ecstasy prevalence figure 13.8 per cent and 1.1 per cent respectively. Heroin, cocaine and LSD prevalence rates are close to last 12 months prevalence rates.

Problem drug use

Data on institutional contacts and drug treatment demands

The number of problem drug users indexed by national institutions (including double counting) reveals for the first time since the set up of the RELIS monitoring system in 1994, a marked upward tendency. In 1999, 3,186 persons have been indexed by RELIS. Compared with 1998 figures (2,250) this represents a relative increase of 42 per cent. Although the admission rate to specialised

treatment agencies has increased from 714 in 1997 to 985 in 1999, the total increase mainly relies on the disproportional increase of the number of drug law offenders (1999: 1,939). The number of drug law offenders admitted to prison is the only indicator on decrease over the last 3 years.

33 per cent (63% non-natives) of indexed drug users have been in contact for the first time in 1999 with a given RELIS institution (intra-institutional). Expressed in terms of drug treatment demands (health care institutions only), the same rate, on the increase since 1997, equals to 39 per cent. On average, a problem drug user addresses 1.7 drug treatment demands per year. For 15 per cent (↗) of registered cases it has been the first drug treatment demand during lifetime (inter-institutional).

***S**ocio-demographic and epidemiological characteristics of problem drug users*

Gender distribution has remained fairly balanced since 1994 (1999: 23 % females, 77 % males). In contrast to the reporting period (1996-1998), the proportion of non-natives (48%) among the overall national drug population has increased anew in 1999, reaching a progression rate unequalled since the set-up of RELIS. Since 1994, the duration of residence in the G. D. of Luxembourg of non-native drug abusers has constantly increased. The population of non-natives largely consists of Portuguese nationals (1998: 54% ↗).

Compared with 1998, the average age, applied to the total drug population (28 Y, 1M), has slightly increased, remaining, however, in the margins of 27Y, 6M to 28Y, 6M, observed since 1995. The average ages of native and non-native problem drug users tend to balance. The difference in age in proportion to gender tends to diminish in non-natives but increases with regard to natives.

The educational level of RELIS respondents shows a slow but constant improvement, even though the average age at the end of studies remains stable.

Residential status of RELIS respondents has improved for the last 4 years, especially referring to the homeless rate (1999: 6% / 1997: 10%). 63 per cent of respondents reported current or past drug abuse within their family of origin and 78 per cent have been living with their parents at the time of their first use of illicit drugs. Special attention should also be paid to the constant increase of respondents living with drug abusing partners. Geographic distribution, according to electoral districts, suggests that 36 per cent come from the centre region and 44.5 per cent (↗) from cities in the South of the country. Eastern cantons figure 11.5 per cent (↗) and Northern cantons have been showing a stable trend for 2 years following a significant increase until 1997.

All indicators included, the employment status of respondents has declined for the last three years. The unemployment rate among the drug population has grown in significance since 1997. Furthermore, the percentage of students (16%) within the national drug population tends to increase. Data on revenues confirm observed trends in occupational status:

- weakening of financial autonomy associated to an increasing social dependency (e.g. Guaranteed Minimum Income: 25%);
- increased financial contribution by parents related to the growing proportion of students within the drug population.

Illegal activities and revenues have seen a downward trend that has stabilised for the last 2 years. The proportion of respondents reporting major depths (41%) is still decreasing, however, proportionally less than in previous years.

***P**roblem drug use prevalence and consume trends*

The first national drug prevalence study, performed by the NFP in 1995 provided a figure of approximately 2,000 HRC (High Risk Consume) problem drug users, which represented at the time of the study 0.5 per cent in general population and 1.5 per cent of the nation population aged between 15 and 40 years. The observed prevalence rate, however, shows an upward trend, supported notably by the constant increase of drug treatment demands. The NFP is currently conducing a national multi-

indicator drug prevalence study. First, yet unpublished results, suggest a higher prevalence figure than the one observed in 1995. The final study report is due in the beginning of 2001.

Opiates are referred to as primary drug by 84 per cent (↗) of indexed respondents. Whilst the preference proportion has persisted over the past four years, significant changes have occurred as regards the route of administration. 1999 data confirm the decisive reduction in iv opiates consume associated to an amplification of the inhalation mode (also known as 'blowing' or 'chasing the dragon') to 33 per cent (36 % in 1998). Consume of cocaine and magic mushrooms as secondary drugs have also gained in popularity. Applied to problem drug users, cannabis use has stabilised over the past 3 years as well as the proportion of multiple-drug use (82 %). 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 3 years. For instance, 22 per cent of current problem drug users (1999) were younger than 14 years at the moment of first cannabis use and 43 per cent were still underage (< 18 years) as they first injected opiates.

Cannabis prevalence among drug treatment demanders appears to be fairly stable. However, applied to youngsters in general (school and youth surveys), one observes a upward trend, especially in association with synthetic drugs use. Between 1994 and 1999, the average age at the moment of first illicit drug use has shown a decrease of 1 year. The time span between the first illicit drug use and the first injecting of drugs also diminishes. Referring to the same indicators, one notices that differences according to gender tend to vanish.

***D**rug-related morbidity and mortality*

Indicators retained by RELIS stress a slight improvement of the general health state of indexed drug users except for HCV prevalence. In 1999, HBV and HCV prevalence rates[3] figured 24 per cent and 25 per cent respectively. The prevalence of HBV infection in problem drug users has remained stable over the last three years but has increased with regard to HCV. The increase of the HCV infection rate is particularly significant in drug treatment demanders, reaching 29 per cent in 1999. A study on HIV and HCV prevalence in prison population (Dr. Schlinck J., 1998), commissioned by the Ministry of Justice, reported a HCV prevalence in drug injecting prisoners of 37 per cent.

Since 1995, the proportion of AIDS diagnostics in problem drug users has been varying between 1 and 2 per cent. In terms of data validity, one may stress that the proportion of HIV tested respondents during the last 5 months has constantly increased, especially as referred to women. A vast majority of drug injectors report not to share used injection material. In 1997 a significant decrease of HIV rates in drug users and especially in IDUs occurred. In 1999, HIV rates have stabilised, varying between 2.9 and 3.9 per cent depending on the target group. HIV rate in IDU treatment demanders, although the highest among the referred target groups, has decreased in a most significant way. According to official figures published by the National Surveillance Committee on AIDS, the proportion of injecting drug users in HIV infected persons figured 20.6 per cent in 1999 (no observable trend). The NFP plans to participate in a European study scheduled for year 2001, aiming at the estimation of HCV prevalence in recent drug injectors.

As regards mental health and risk behaviour indicators, RELIS revealed a stabilisation in the prevalence of suicide attempts and non fatal overdoses since 1997 as well as a fairly invariable proportion of problem drug users (22.4%) showing psychiatric treatment demands for reasons other than drug detoxification.

The number of officially recorded overdose cases (acute/direct drug deaths) has increased steadily since 1985, peaking with 29 cases in 1994. Decrease was observed from 1995 and persisted throughout 1997 (9 cases). During 1998, the first growth tendency (16 cases) in four years has resumed reaching 18 cases in 1999. Results of toxicological analysis performed on overdose victims

[3] HIV and hepatitis figures refer to both, injecting on non-injecting drug users

refer to the presence of opiate traces in all cases. In 90 per cent of autopsy cases heroin consume was reported; a proportion which has remained stable for several years.

In 2000, a first cohort study on the mortality in the national drug population has been performed by the NFP. According to applied methodologies, results show mortality rates varying between 2.36 and 2.51 per cent.

Drug demand reduction activities

The multi-annual action plan on drugs and drug addiction outlines future priority areas in the field of drug demand reduction, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and low threshold services.

The current approach, as outlined in the drugs action plan, focus on prevention and treatment interventions best integrated in existing socio-cultural networks in order to take advantage of cross-sectorial synergies. Drug prevention messages increasingly enhance the role of other actors than the consumer him/herself in drug prevention as well as existing alternatives to drug use and peer education. A holistic approach addressing the general topic of addictive behaviours, not exclusively referred to substance abuse, has gained the attention of national drug demand reduction experts. Clear definition of expected outputs, time limited project funding rather than permanent service funding, scientific evaluation of defined objectives and project execution frameworks and the promotion of continuos training are some of the major elements defining the new approach towards a more effective national demand reduction strategy.

Special emphasis is put on first childhood interventions, school-based projects, mass media campaigns and, with respect to the important proportion of non-native residents, on socio-cultural integration projects. Furthermore, a broad offer of activities for youngsters integrating drug the prevention topic as one of the various components of Health education, has developed, especially in community-based settings.

Also, the development and diversification of the national drug treatment network is clearly regarded as a future priority. Treatment offers for specific target groups as for instance pregnant women, drug addicted couples and drug-substituted patients will be developed. Special attention is also paid to harm reduction interventions, post-therapeutic settings and socio-professional reintegration measures, as well as the creation of an adequate legal framework allowing their further development.

Research, training and evaluation activities in the field of drug demand reduction are still poorly developed at the national level. Further development of national expertise in these fields should be reached by increased funding, enhanced international collaboration and experience sharing.

Harm reduction activities

The number of sterilised syringes distributed (1999: 109,743 / 1996 : 76.259) has been rising right from the start of the needle exchange programme, which reunites institutions from all levels of specialised drug treatment. The number of used syringes collected (1999: 98.764 (57%) / 1996: 28.646) has increased accordingly. A majority of drug injectors (41%) procure their injection material from pharmacies, followed by automatic dispensers and low threshold services.

From 1984, the average proportion of injecting drug users in newly HIV infected persons has settled at 17 per cent of all (1999: 20.6 %). As already mentioned, RELIS 99 data provide the following prevalence figures: 3 per cent HIV positive (stable); 1 per cent AIDS (stable); 24 per cent HBV (stable) and 25 per cent HCV (increase). These results lie below the recorded average rates of other EU Member states (source: EMCDDA. (2000), Annual report on the state of the drugs problem in the EU-1999. EMCDDA, Lisbon).

Created in 1989, the national methadone substitution programme offered 30 places in 1993, 40 places in 1994, building up to 158 places in 1997 and 186 places in 1998. In 1999, the number of treated

patients stood at 164. A considerable number of general practitioners who do not necessarily participate in the official methadone programme also prescribe substitution substances, such as MEPHENON®, to a relevant, but hard to estimate (300 - 400), number of drug abusers.

The parliamentary bill n° 4349 of 25 August 1997, modifying the modified drug law of 19 February 1973, foresees among other amendments, the creation of a legal framework for drug substitution treatment, needle exchange programmes and the establishment for injection rooms. The referred bill has been advised by State Council and amended twice. The vote by the parliament, however, has not yet taken place (November 2000).

Drug research priorities

The main current priorities of the NFP in the field of drug research are as follows:

- drug prevalence in general population and in prison,
- prevalence of HIV and HCV infection in injecting drug users,
- prevalence of hidden populations and of treatment demands addressed to GPs,
- drug-related morbidity and mortality (particularly promoted recently),
- monitoring of trends in consume and chemical composition of synthetic drugs,
- prevalence of benzodiazepines use in drug population,
- socio-economic cost of drug addiction and the fight against illicit drugs.

Overview of main observed trends in problem drug using population. 1994 – 1999

Confirmed multi-annual trends (3-5 last years)

INCREASE ↗

- total number of drug seizures, except for cocaine, STA and ecstasy type substances
- number of magic mushroom seizures (psilocybin)
- total number of persons involved in drug seizures
- number of arrests of presumed drug law offenders
- proportion of underage presumed drug law offenders[4]
- frequency of served prison sentences by indexed drug users[5] ® [6].

- drug prevalence in general and in school population (especially cannabis, magic mushrooms and ecstasy)
- heroin as reported main drug ®
- cocaine as reported secondary drug ®.

®

- number of drug users indexed by national specialised treatment institutions
- proportion of drug users admitted for the first time in a given specialised treatment centre (intra-institutional)
  and the proportion of first treatment demanders in general (inter-institution)
- proportion of first treatment demands addressed to specialised care agencies on a par with a lower admission rate to general health services.

®

- proportion of Portuguese nationals within the non-native drug population
- duration of residence in the G. D. of Luxembourg of non-native drug addicts
- drug abuse in family of origin
- quality of residential status (notably, the proportion of homeless addicts)
- proportion of drug users originated from the Southern and Eastern regions associated to a decrease of the centre region of the G.D. of Luxembourg

- unemployment rate
- proportion of students within the national drug population.

- quality of general health state with the exception of HCV prevalence ®
- number of distributed and re-collected syringes through the national needle exchange programme ®
- number of fatal overdoses by illicit drugs.

DECREASE ↘

- quantities of heroin and cocaine seizures
- number and quantities of ' ecstasy' seizures
- proportion of presumed law offenders (e.g. petty crime) as opposed to drug law offenders
- proportion of drug law offenders sentenced to prison compared to the total number of new prison entries
- duration of served sentences by convicted drug law offenders. ®

®

- average difference in age between native and non-native drug users
- financial autonomy associated to an increasing social dependency
- proportion of problem drug users reporting major depths.

®

- average age at the moment of first use of the current main drug and any illicit drug, especially with regard to cannabis and intravenous heroin use
- time span between first illicit drug use and first intravenous drug use
- difference in average age of first illicit drug use according to gender (except cigarettes).

[4] The term 'Drug law offender' ('prévenu') exclusively refers to offenders of the amended 1973 national drug law.

[5] For the sake of consistent terminology, the term '*drug users*' refers to problem HRC drug users.

[6] The prefix ® notifies that respective data refer to problem drug users as indexed by RELIS/LINDDA.

STABLE

- average number of contacts per drug user and per year with a national specialised treatment agencies and with the national institutional network on the whole. ®

®
- gender distribution
- average age at the end of education
- residential situation at the moment of first illicit drug consume
- revenues associated to illegal activities .

®
- non-iv heroin use as preferential drug consume (following a significant increase in 1998)
- crack and volatile substances as main drug (confirmed by seizure data)
- rate of multiple-drug use.

®
- initiation to illicit drugs by an acquainted environment and within school
- proportion of drug users who acquire their main drug(s) in the G. D. of Luxembourg as opposed to foreign countries. The Netherlands as the reported main country of drug supply.

®
- pharmacies as the preferred supplier of injection material
- HIV infection and AIDS prevalence rates
- proportion of toxicological analysis which have revealed heroin consume in drug users who died from drug overdoses

Recent trends to be confirmed (1-2 last years)

INCREASE ↗

- number of police records for presumed offences against drug law
- number of drug law offenders
- proportion of indexed drug users with previous law enforcement contact(s) ®
- average age ®
- final level of education ®.

®
- consume of magic mushrooms as secondary drug
- average duration of intravenous drug use.

DECREASE ↘

- number of drug users admitted to the national substitution programme (methadone)
- average age at the moment of first drug treatment ®.

STABLE

- proportion of drug users originated from the Northern region of the G. D. of Luxembourg ®
- proportion (IDUs) in HIV infected population.

Inverse trends

INCREASE ↗

- number of problem drug users indexed by national institutions (multiple counts included)
- proportion of non-natives in drug population.

PART I

NATIONAL AND LOCAL POLICIES & LEGAL FRAMEWORK

I. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

The parliamentary elections of June 1999 have led to a governmental coalition composed by the Christian Social People's Party (CSV) and the Democratic Party (DP). After a 15 years coalition with the CSV, the Socialist Workers' Party (LSAP) had to join the opposition. The new Minister of Health, Mr. Carlo WAGNER is member of the Democratic Party.

Drug abuse is currently defined as a behaviour associated to health and social risks rather than a socially reprehensible criminal act. The governmental declaration of August 1999 [7], following the parliamentary elections, confirmed this approach putting further emphasis on the diversification of specialised health care, a more pragmatic approach towards law enforcement and the promotion of harm reduction.

The Ministry of Health, in charge of national drug co-ordination in the fields of demand and harm reduction, since the parliamentary elections of 1999, has recently presented ***a multi-annual action plan on drugs and drug addiction****. The referred action plan relies on six intervention areas, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and low threshold services. In addition to the creation of new treatment facilities, synergies between the already existing network are enhanced. In order to optimise the implementation of the drugs action plan, the Minister of Health has appointed a national drug co-ordinator and the Directorate of Health is setting up a special division for social medicine and drug addiction .A close link between the EMCDDA national focal point and the policy level is ensured by the fact the NFP will be implemented in the referred division and that head of focal point has been appointed National Drug Co-ordinator*.

1.2 Policy implementation, legal framework and prosecution

a. Law and regulations

The basic national drug law, namely: 'Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanies' regulates both, the selling of controlled medicaments and the fight against drug addiction and dates back to the 19 February 1973. *Furthermore, the current drug law establishes no distinction of penalties according to the type of controlled substances involved. In terms of penalties, the 1973 drug law currently distinguishes between following drug-related offences:*

Use
Detention/ transport *for personal use*
of drugs destined to the use by third parties
of drugs destined to the use by minors
of drugs having caused invalidity or death to the end consumer
if offender is part of a criminal organisation
Production of drugs

Traffic/Selling *of drugs destined to the use by third parties*
of drugs destined to the use by minors
of drugs having caused invalidity or death to the end consumer
if offender is part of a criminal organisation

[7] **ANNEX IV:** Déclaration gouvernementale du 12 août 1999, http://www.gouvernement.lu:80/gouv/fr/gouv/progg/declu.html

Import/Export
Promotion of drugs or drug use
Falsification of medical prescriptions
Maintenance of drug addiction (e.g. by GPs)
Traffic of drug-production equipment
Money laundering

N.B. (possession for personal use- only after the amendment of the modified 1973 drug law).

Up to 1999, the 1973 drug law has been amended by the law of 23 February 1977 (Mém. A 1977, p. 352), the law of 7 July 1989 (Mém. A 1989, p. 923) and the law of 17 March 1992 (Texte coordonné: Mém. A 1992, p. 2458).

As regards ***regulation mechanism on the control of substances,*** *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:*

- *Règlement grand-ducal du **4 mars 1974** concernant certaines substances toxiques*
- *Règlement grand-ducal du **20 mars 1974** concernant certaines substances psychotropes*
- *Règlement grand-ducal du **26 mars 1974** établissant la liste des stupéfiants*
- *Règlement grand-ducal du **8 mai 1993** relatif au commerce de stupéfiants et de substances psychotropes*
- *Règlement grand-ducal 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*
- *Règlement grand-ducal du **6 février 1997** relatif aux substances visées aux tableaux III et IV de la Convention sur les substances psychotropes, faite à Vienne, le 21 février 1971.*

In the course of 1999, the following substances have been placed under national control by Grand Ducal decree of:

***7 May 1999**: METHHYLPHENIDATUM (alpha-phényl-alpha-piperidyl-2acétate de méthyle)*
***6 December 1999**: 4- MTA (4-Méthylthioamphétamine)*
modifying the Grand Ducal decree of **4 March 1974**

6 December 1999:
DIHYDROETORPHINE (7,8-DIHYDRO-7-α-[1-(R)-hydroxy-1-méthylbutyl]-6,14-endo-éthanothétrahydrooripavine)
REMIFENTANIL (méthyl ester de l'acide carboxylique1-(2-méthoxycarbonyléthyl)-4-(phénylpropionylamino)-pipéridine-4)
modifying the Grand Ducal decree of **26 March 1974**

Other relevant laws *in the field of drugs and drug addiction are the following [8]:*

Loi du 3 juillet 1972 portant approbation de la Convention unique sur les stupéfiants, faite à New York, le 30 mars 1961 (Mém. A 1972, p. 1256).

Loi du 24 avril 1976 portant approbation du Protocole portant amendement de la Convention unique sur les stupéfiants de 1961, signé à Genève le 25 mars 1972 (Mém. A 1976. p. 394).

Loi du 4 décembre 1990 portant approbation de la Convention sur les substances psychotropes, faite à Vienne le 21 février 1971 (Mém. A 1990, p . 99) .

Loi du 17 mars 1992 portant
1. *approbation de la Convention des Nations Unies contre le trafic illicite de stupéfiants et de substances psychotropes, faite à Vienne, le 20 décembre 1988;*
2. *modifiant et complétant la loi du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie;*
3. *modifiant et complétant certaines dispositions du Code d'instruction criminelle.*

[8] **ANNEXE V**: Service Central de Législation, (2000) Relevé Général de la Législation 1999, Luxembourg http://www.etat.lu/SCL/RGL2000/215SANTE.PDF

Texte coordonné du 29 octobre 1992 de la loi du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie, telle qu'elle a été modifiée.

Loi du 26 avril 1996 portant approbation de la Convention contre le dopage, faite à Strasbourg, le 16 novembre 1989 (Mém. A n° 31 du 10 mai 1996, p. 1032) - Ratification et entrée en vigueur à l'égard du Luxembourg (Mém. A n° 48 du 29 juillet 1996, p. 1392).

Loi du 11 août 1998 portant introduction de l'incrimination des organisations criminelles et de l'infraction de blanchiment au code pénal (Mém. A – 73 du 10 septembre 1998, p.1455).

b. Prosecution policy

Legally speaking, police has no discretional power: every offence, once noticed, 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 supposes a case by case decision

Alternative measures to criminal proceedings by the Prosecuting authority (art. 23/1973)

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

- to close the case without proceedings with a caution (e.g. in case the recorded drug user has been admitted to detoxification treatment prior to the drug use offence record),
- to propose to a recorded drug user to undergo a detoxification treatment on a voluntary basis. If treatment is successfully completed (report from the Health Service), the case will be closed without proceedings (if not completed, the offender is prosecuted).

Alternatives to sentence by Court (art. 24 / 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 from the Multidisciplinary Committee), the case will be closed without proceedings (if not completed, the offender is prosecuted).
- *decide to postpone the sentencing (sentence suspension) for an determinate length of time, but he has to decide on the culpability. When the case goes back to the court, the judge may decide not to give a sentence. A custodial sentence may be suspended (totally or partially), under the monitoring of the Probation Service (SCAS).*

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.

c. Projects of law

The report of the Special Parliamentary Commission on Drugs published in March 1996, under the former government, took into account a series of reflections and motions on the revision of the 1973 drug law, introduced by members of the parliament. Based on the recommendations of the above-mentioned commission, the bill n°4349, that outlines the revision of the current drug legislation, has been introduced. Among other relevant amendments, the bill refers to:

- the creation of a legal framework for drug substitution treatment (including heroin prescription), needle exchange programmes as well as the creation of shelter and injection rooms;
- the decriminalisation of the possession of small quantities and the use of cannabis as well as the re-scaling of penalties according to the type of controlled substances involved.

To date the Council of State has advised the bill threefold, meaning that the amendment procedure is currently (October 2000) still in progress.

1.3 Developments in public attitudes and debates

a. Public perception of the drug issue and public debates

No national public opinion survey focusing on drugs and drug addiction has been conduced thus far. Generally speaking, drug addicts tend to be considered as people in need of help in the first place. In terms of public perceptions, reduction of nuisance caused by drug addicts is an important topic. For instance, the public opinion has received the national methadone programme as a necessary step towards the reduction of drug- related criminality.
The Governmental declaration and the subsequent coalition agreements as well as the drugs action plan of the Ministry of Health clearly stress the need to develop harm reduction activities as one of the future priorities. 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 referred to. General public, as well as NGOs working in the field of drugs and drug addiction have launched a common debate on new drug strategies, which has led to numerous discussion fori and public round tables in presence of political authorities.

Recently, there has been a series of controversial debates on drug use in prison. Both, prescription of pharmaceutics to drug users in prison and illicit drug use in prison are frequently on the agenda having led to a more general discussion on the need of general Health care and specialised drug treatment in prison.

The cannabis topic has also been in the front line of public interest, especially since the launch of a media campaign, following the publication of a rapid assessment study on cannabis prevalence by the CePT. The later referred to multi-annual drug prevention campaign, co-ordinated by the CePT and financed by the Ministry of Health, aims to provide objective information and to develop a so called ' discussion culture' on the topic.

Remarkably, the spread of Ecstasy use by a large range of young people has forced many parents to deal with the drug problem of their own children and hence to realise that drug consume is not only confined to opiates addiction of socially deprived people. The need and willingness to access information on drug consume behaviours by a larger public is seen as a direct consequence of this late evolution.

b. Media presentation and imaging of drug use

The NFP as well as national drug prevention actors increasingly consider national media as potential partners of a consistent information diffusion strategy. The NFP and the National Drug Co-ordinator have developed privileged contact with specialised journalists in order to guarantee a high quality level of objective information diffusion to the public.

A national and international press review on drugs, jointly compiled be the States' Press Service and the NFP since 1998, has allowed a close follow up of the media' approach towards the drug phenomenon. The written press and radio show a keen interest in the drugs topic especially since the governmental declaration, the bill n°4349 and the subsequent national drug action plan on drugs.

Most of national media fit to objective information although a few more socially orientated radio stations and newspapers put further emphasis on controversial, yet constructive, analysis of the current situation. The topics most currently covered by national media are prevention activities, cannabis and ecstasy use, national strategies against drug abuse and, recently, drug use in prison.

1.4 Budgets and funding arrangements

Funding of drug-related interventions is centralised at state level. There exist no specific regional or local funding mechanisms. 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 an agreement called ' *convention de collaboration'* with one or more 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 ' *collaboration platform'*.

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.

The structure of the national state budget does not allow for detailed 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. In accordance to national needs and the upcoming workplan of the EMCCDA, a national study on socio-economic costs of drug use and action against drugs is currently performed by the NFP. The study report is due for mid 2001. The following data are extracted from the first draft of the referred study.

The budget of the Ministry of Health *directly allocated to actions against drugs and drug addiction has shown an increase from 1.14 million € in 1999 to 2.13 million € in 2000, following the centralisation of drug demand and harm reduction activities by the Ministry of Health. The provisional budget of 2001 foresees a supplementary increase of 49 per cent, thus figuring 3.15 million €.*

Referring exclusively to ***public funding allocated to specialised drug treatment and prevention agencies****, the total budget of the main involved ministries, namely , the Ministry of Health, the Ministry of Family and the Ministry of Education figured 2.022 million € in 1999. Following the centralisation of the referred budgets within the Ministry of Health in 2000, the latter figured 2.2 million €. The provisional budget 2001 of the Ministry of Health foresees a total of 2.62 million € for the referred agencies.*

Part II
EPIDEMIOLOGICAL SITUATION

2. 1. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

From 1960 to the 70's

Significant development of drug use and addiction at the national level has started in the beginning of the 70's. Drug consume has been mainly focusing on cannabis, opiates and hallucinogens. LSD has shown a gradual increase during the 70's. Limited national epidemiological data on drug abuse have been available since 1975. By the end of the 70's, the national drug market has known the emergence and spread of cocaine based substances.

From 1980 to the mid 90's

The 80's are characterised by the decrease of hallucinogenic substances' use (mainly LSD), whilst cocaine, heroin and cannabis witnessed a slow but constant progression. The number and quantities of seizures have increased simultaneously.

Almost all specialised treatment facilities have been established during this very period. '*Soft drugs* ' (Low Risk Consume) such as cannabis and derivatives were the most consumed substances by mono-addicts till 1988. Multiple-drug users did mainly inject heroin, eventually mixed up with cocaine, in addition to cannabis consume. After 1988, consume patterns began to change. Multiple-drug use of opiates, alkaloids, pharmaceutical substances, amphetamines, etc., became more common.

During the early 90's, the use of LSD has decreased even more significantly. Towards the mid 90's, there has been a progressive increase of amphetamines' use and the first reporting of ecstasy-like substances on the national market. MDMA (172 units) seizures were first

registered in 1994 (1995 - 784 units) by the Specialised Drug Department of the Judicial Police (SPJ). The consumption of ecstasy-type substances have increased significantly especially in younger population involved in the then recent rave movement.

Hitherto, there has been no officially registered seizure of PCP or Crack (freebase) in Luxembourg. The latter substances can, however, be occasionally found on the national market.

From 1996 until today

During this late period, an increase of heroin and cocaine use has been observed. Cannabis and ecstasy-like substances show an increasing demand even though seizure figures do suggest an inverse and currently stable trend. Whilst preference patterns have persisted over the past four years, significant changes have occurred in the route of administration. The 1999 data confirm the decisive reduction in iv opiates consume associated to an amplification of the inhalation mode (also known as 'blowing' or 'chasing the dragon') to 33 per cent (36 % in 1998). Cannabis use is still developing in youngsters especially in association with ecstasy consume and the average age of first consume of cannabis, ecstasy and iv heroin tends to decrease.

Attention should be paid to the low national prevalence or absence of synthetic drugs which have gained in popularity in other Member states, namely: MBDM (N-metyl-1-(1,3-bezodioxol-5-yl)-2-butanamine), GHB (gamma-hydroxybutyrate), 4-MTA (4-Methylthio-amphetamine) and Ketamin (2-(2-chlorophenyl)-2-(methylamino)-cyclohexanone).

Both, seizure data and unofficial sources seem to support a meaningful but yet to be confirmed increase in hallucinogenic substances, notably magic mushrooms, nutmeg and other easily available ' bio drugs'.

Geographically speaking, the major part of drug supply is situated in metropolitan and urban areas. Initially, two major 'hard' drug scenes were observed. One in the centre of Luxembourg City and the other in the main town of the South of the country (Esch/Alzette). Drug consume is spread all over the country showing, however, an important recent increase in the Eastern regions. The three years increase in the North of the country tends to stabilised.

2.2 Drug use in population

a. General population

To date, no national, large-scale population survey on drug use has been conduced. The NFP is currently contacting potential financial partners in order to raise funds for a future survey.

➢ *In the beginning of 1995 a pilot project on community based drug prevention has been launched by the CePT. Currently, 13 district councils spread all over the country are involved in the project, which also included a low scale study on drug consume in the general population. The results from the CePT study (**ref. b.1**) are currently the only reliable source providing a mere picture of the drug use prevalence in general population.*

MAIN RESULTS: Lifetime and last 30 days prevalence of :

Cannabis use in young adults (15-34 years) 15.8% and 5.6%, respectively
Ecstasy use in young adults: 1.2% and 0%, respectively

Heroin use in young adults: 1.9% and 0.3%, respectively
Cocaine use in young adults: 0.3% and 0.3%, respectively
LSD use in young adults: 1.3% and 0.0%, respectively
Magic mushrooms (psilocybin) use in young adults: 2.6% and 1.3%, respectively

REFERENCE b.1: Fischer U. CH. et Krieger W. (1999) Suchtpräventioun an der Gemeng – Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg.

Year	1998
Single/repeated study	single study
context	Drug Prevention - Public Health – Cross sectional
Area covered	7 council districts of the Grand Duchy of Luxembourg
Age range	12-60 years
Data coll. procedure	Anonymous self-administrated questionnaires
Sample size	667 valid cases
Response rate (M,F,T)	33.9%

➢ *A second survey, worth mentioning in the present context has been commissioned by the CePT in 1998 (**ref. b.2**). Although focusing on cannabis use prevalence, the referred survey included other drugs use and sampled cinema customers in Luxembourg-City.*

***MAIN RESULTS*:** (*Detailed results of both surveys are provided in EMCDDA standard tables).*

Lifetime and last 30 days prevalence of **cannabis** use in young adults (15-34 years) 36.6% and 20.1% respectively

REFERENCE b.2: Fischer U. CH. (2000) Cannabis in Luxembourg - Eine Analyse der aktuellen Situation, CePT, Luxembourg.

Year	1998
Single/repeated study	single study
context	Drug Prevention - Public Health – Cross sectional
Area covered	Cinemas in Luxembourg-City
Age range	15-64 years
Data coll. procedure	On-site interviews
Sample size	991 valid cases
sampling procedure	random sampling of cinema customers

b. School and Youth Populations

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

*As regards the **first category**, a single study has been conduced in 1992 (**ref.1**) and two repeated studies in 1983 and 1992)(**ref.2**) and in 1999 (**ref.3**), respectively. The 1999 survey, which is repeated each 4 years is the most representative school survey ever conduced at the national level. It is based on the WHO cross-national study on health and health behaviour among young people, last published in 2000 and is performed by the Directorate of Health in collaboration with the Ministry of Youth and Education. The results of the national HBSC study have not yet been published at the time of the present reporting. but first results have been provided to the NFP in order to detect emerging trends compared to previous school studies.*

*Surveys referred to in the second category are cross-sectional and focus on ecstasy prevalence (1998, **ref.4**) and on cannabis (2000, **ref.5**) respectively, including, however, additional items on the lifetime prevalence of other drugs.*

Surveys: category 1

REFERENCE **1**:	**Matheis J. *et al.*** (1995) 'Schüler an Drogen', IEES, Luxembourg**.** **EN.**: *Students and Drugs*
Year of data collection	1992
Single/repeated study	Repeated study 1983 - 92
context	Public Health
Area covered	Nation wide
Type of school	5th years of all types of secondary school classes at the national level
Age range	16-20 years (AGE ENTERING 5TH CLASS)
Data coll. procedure	Anonymous self-administrated questionnaires in school classes
Sample size	1,341
Response rate (M,F,T)	96%

REFERENCE **2**:	**Dickes P. *et al.*** (1995), La consommation de drogues légales et illégales des élèves des 6ième de l'enseignement secondaire et des 8ième de l'enseignement secondaire technique, CEPS/INSTEAD. Luxembourg. **EN.***: The use of licit and illicit drugs by students in 6th and 8th classes of national secondary schools.*
Year of data collection	1994
Single/repeated study	Single study
context	Drug prevention. Commissioned by the National Drug Prevention Centre (CePT)
Area covered	City of Luxembourg
Type of school	6th secondary school level and 8th secondary technical school level
Age range	13-16 years
Data coll. procedure	Anonymous self-administrated questionnaires in school classes
Sample size	650
Response rate (M,F,T)	100%

REFERENCE **3**:	Das Wohlbefinden der Jugend – HBSC Studie (in press), 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
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)	approx. 90%

Surveys: category 2

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

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

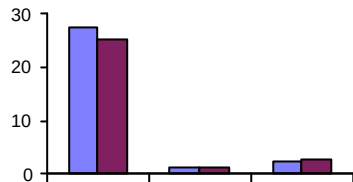
SYNOPSIS OF MAIN COMPARABLE RESULTS AND OBSERVED TRENDS

LIFETIME PREVALENCE: SCHOOL POPULATION:

Prevalence figures for age group 12-20, provided by HBSC (1999) 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 and higher prevalence of medicament use.

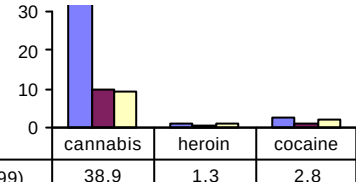
The HBSC study and the serial surveys by Matheis (1983/92) provide trends in lifetime prevalence between 1983 and 1999 applied to age group 16-20. Cannabis use has shown the most significant increase during the referred period. Also on the increase in order of importance are magic mushrooms, ecstasy, 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. 2.2.b.1 LIFETIME PREVALENCE: SCHOOL POPULATION - 12-20 years



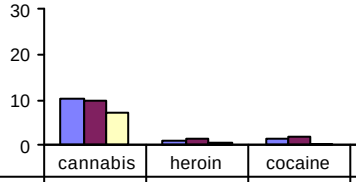
	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (1999)	27,4	1,2	2,3	3,7	3,1	2,1	4,8	2,5	3,8	1,6
Fischer (1999)	25,3	1,3	2,9		3,4	2,8	5,3			

Fig. 2.2.b.2 LIFETIME PREVALENCE: SCHOOL POPULATION - 16-20 years



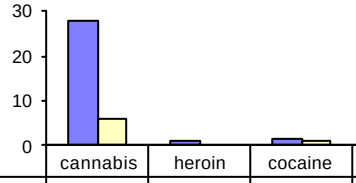
	cannabis	heroin	cocaine	amphetami	ecstasy	LSD	psilocybin	medicame	solvents	other
HBSC (1999)	38,9	1,3	2,8	4,6	5,2	2,7	7,1	3,3	3,8	1,7
Matheis (1992)	10,1	0,9	1,2	9,9	1,2	2,1			3,5	
Matheis (1983)	9,3	1,2	2			3,7			4,8	

Fig. 2.2.b.3 LIFETIME PREVALENCE: SCHOOL POPULATION - 13-14 years



	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (1999)	10,5	0,8	1,6	2,3	1,7	1,1	1,6	1,5	3,3	1,6
Fischer (1999)	9,7	1,6	2		2,4	1,9	2			
Meisch (1997)	7,2	0,6	0,3	2,3	1,4	0,6			4,3	

Fig. 2.2.b.4 LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years



	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medicame	solvents	other
HBSC (1999)	27,7	0,8	1,5	3,1	1,8	1,4	4,1	2,8	3,6	2
Matheis (1992)	6	0	0,9		0,9	0,9			2,6	

LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

The HBSC survey 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 survey 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.

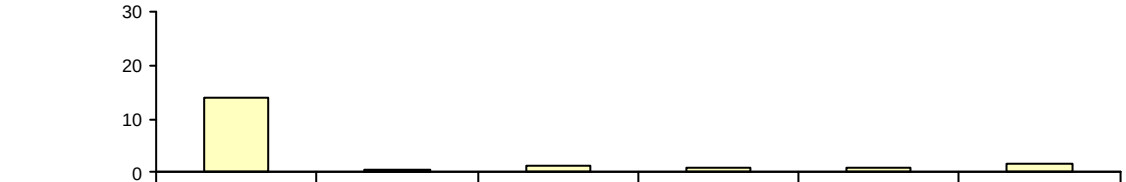
Fig. 2.2.b.5 LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION - 12-20 years (HBSC 99)

	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvants	other
male	25,8	0,7	1,6	2,4	1,9	1,2	4,6	1,2	1,6	1,1
TOTAL	22,5	0,7	1,5	2,2	1,7	1	3,3	1,5	1,5	0,8
female	19	0,6	1,5	2	1,4	0,9	2	1,8	1,4	0,8

LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

Fisher (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.

Fig. 2.2.b.6LAST 30 DAYS PREVALENCE: SCHOOL POPULATION - 13-20 years (Fischer U. 99)



	cannabis	heroin	cocaine	ecstasy	LSD	psilocybin
Fischer (1999)	13,8	0,6	1,3	1,1	1	1,8

c. Specific groups

➢ In 1998, the NFP launched a rapid assessment study on *the professional practice and perceptions of GPs and psychiatrists regarding drug treatment demanders (**ref. c.1**). The aim was to estimate the prevalence of drug users treated by the General Health network and to assess the information level and needs of liberal GPs and psychiatrists with regard to drug treatment.*

<u>MAIN RESULTS</u>:
- *GPs reported on average 3 different drug patients per year (highest rates in urban areas)*
- *main reasons of treatment demands: detoxification and associated somatic problems,*
- *main drugs of treatment demanders: 70.6% heroin iv., 5.9% heroin non-iv, 11% benzodiazepines, 12,5% other*
- *medicaments most prescribed to drug treatment demanders by GPs in order of importance:*

Methadone, Rohypnol, Tranxene, Temesta,

- *consistent information lack on national specialised drug treatment facilities on possible networking and on referral*

REFERENCE c. 1	**Origer, A.** (1998), Enquête auprès des médecins généralistes et des médecins psychiatres sur la prise en charge des patients toxicomanes, in Rapport RELIS/LINDDA 1997, Ministry of Health, NFP, Luxembourg, pp.96-106. **EN.:** *Study on professional practice and perceptions of GPs and psychiatrists regarding drug treatment demanders*
Year	1998
Single/repeated study	Single
Context	Public Health
Area covered	Nation wide
Type sample	Representative sample of freelance GP's and psychiatrists
Age range	30-65
Data coll. procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES
Sample size	80 valid cases
Sampling frame	Random sample of 233 GPs and psychiatrists listed in the national GPs/Psychiatrists register
Response rate (M,F,T)	35%

➢ *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. Data has been collected during two days on the current stock of prisoners (convicted and in custody) in all national prisons.*

MAIN RESULTS:

- *32% of prisoners qualified themselves as injecting drug users;*
- *28% reported to inject drugs in prison;*
- *9% have been initiated to injecting drug use in prison;*
- *8% report used needle exchange with other prisoners;*
- *IDUs have served more prison sentences than non drug users;*
- *IDUs showed lower average age than non drug users;*
- *a majority of imprisoned IDUs were natives*

REFERENCE c.2	***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*
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%*

2.3 Problem drug use

a. National and local prevalence

Overview of national drug prevalence studies

Table 2.3 Drug prevalence estimation methods applied in Luxembourg (1994 - 1999)

Year	Data	Method	Target Group	Prevalence	Rate/1,000	Rate 15-54/ 1,000
1995	- RELIS/LINDDA	- Multiple counting indicator - Drug-related death indicator, - Institutional contact indicator	problem HRC drugs users	± 2,000	4.8	8.3
1996	- RELIS/ LINDDA - Police registers	- Multiplier - Police data	problem HRC drugs users	1,900 - 2,300	4.5 - 5.5	7.9 - 9.5
1998	- EMCDDA Project (CT.97.EP.04)	- Back Calculation	IVDU	1,175 – 2,350	2.8 – 5.6	4.9 – 9.8
1999	- RELIS/LINDDA - Police registers	- Case finding - Multiple counting indicator & - Multiplier: law enforcement - Multiplier: drug related death - Capture - Re-Capture - Demographic multiplier	problem HRC drugs users and problem opiate users	Results by beginning of 2001		

Source: PFN

Table 2.3 provides an overview of prevalence data from 1994 to 1999. The first national drug prevalence study, performed by the NFP in 1995 provided a figure of approximately 2,000 HRC (High Risk Consume) problem drug users, which represented, at the time of the study, 4.8 per thousand inhabitants in general population and 8.3 per thousand of the national population aged 15 to 54 years. A further study performed in 1996 confirmed the 1995 figures. The 1998 study refers to injecting drug users. The NFP is currently conducing a national multi-indicator drug prevalence study. The referred study relies on both, RELIS data and complementary data and applies the following estimation methodologies:

Case finding
Multiple counting indicator
Capture – recapture (2 and 3 anchor points)
Law enforcement data multiplier
Drug-related deaths data multiplier
Demographic multiplier

The law enforcement multiplier method is based on multiple-counting-controlled data since relying on the RELIS code, which is specific to each drug user in contact with the institutional network. A clear distinction is made between HRC drug users and other drug law offenders by means of computer based and manual collected data from police records and the Special Overdose Register (SPJ). The exhaustive RELIS indexing will also allow for an accurate calculation of the multiple counting rate within the institutional network. In the light of these

methodological improvements, compared with previous studies - especially as regards law enforcement data - first, yet unpublished, results seem to confirm a higher prevalence margin than the one observed in 1995. The final study report is due in the beginning of 2001.

Local prevalence studies

The only local prevalence study on problem drug use in Luxembourg City has been performed in collaboration with the EMCDDA in 1997 by extrapolation of national prevalence figures. No further local prevalence study has been conduced to date.

Country	Grand Duchy of Luxembourg
City	Luxembourg (City)
Year (1)	1997
Methods (2)	multi-indicator register / extrapolation from police data / mortality multiplier
Case definition (3)	High risk drug (HRC) abusers
Data source a (4)	RELIS/LINDDA
Data source b (4)	General mortality and Special overdose register
Data source c (4)	Police register
Prevalence estimate (5)	760
Total population (6)	46,913
Age range (7)	15-54
Rate /1000 (8)	16.2
Reference (9)	**Origer A**., (1998), Local drug prevalence estimate for Luxembourg-City, in Annual report on the state of the drugs problem in the European Union. EMCDDA, Lisbon.

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. *Detailed data on sub-scenes within the cocaine using population is provided in the key-issues section of the present report.*

- *The "regional scenes" are mainly situated in the South of the country (higher prevalence than in the Centre for the last 3 years) but more recently also in a major city of the East of the country. The Northern districts have shown a notable increase between 1996 and 1998 and now tend to stabilise.*

Characteristics of problem drug users

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/LINDDA 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 drug users indexed by national institutions (including double counts) reveals for the first time since the set up of the RELIS monitoring system in 1994, a marked upward tendency. In 1999, 3,186 persons have been indexed. Compared with 1998 figures (2,250), this represents a relative increase of 42 per cent. Although the admission rate of specialised treatment agencies has increased from 714 in 1997 to 985 in 1999, the total increase mainly relies on the disproportional increase of the number of drug law offenders (1999: 1,939). The number of drug law offenders admitted to prison is the only indicator on decrease over the last 3 years.

Compared with 1998, the average age, applied to the total drug population (28 Y, 1M), has slightly increased, remaining, however, in the margins observed since 1995 (27Y, 6M to 28Y, 6M). The average ages of native and non-native problem drug users tend to balance. The difference in age in proportion to gender tends to diminish in non-natives but increases with regard to natives.

The educational level of RELIS respondents shows a slow but constant improvement, even though the average age at the end of studies remains stable.

Residential status of RELIS respondents has improved for the last 4 years, especially referring to the homeless rate (1999: 6% / 1997: 10%). 63 per cent of respondents reported current or past drug abuse within their family of origin and 78 per cent have been living with their parents at the time of their first use of illicit drugs. Special attention should also be paid to the constant increase of respondents living with drug abusing partners. Geographic distribution, according to electoral districts, suggests that 36 per cent come from the centre region and 44.5 per cent (↗) from cities in the South of the country. Eastern cantons figure 11.5 per cent (↗) and Northern cantons have been showing a stable trend for 2 years following a significant increase until 1997.

All indicators included, the employment status of respondents has declined for the last three years. The unemployment rate in problem drug users has grown in significance since 1997. Furthermore, the percentage of students (16%) within the national drug population tends to increase. Data on revenues confirm observed trends in occupational status:

- *weakening of financial autonomy associated to an increasing social dependency (e.g. Guaranteed Minimum Income: 25%);*
- *increased financial contribution by parents related to the growing proportion of students within the drug population.*

Illegal activities and revenues have seen a downward trend that has stabilised for the last 2 years. The proportion of respondents reporting major depths (41%) is still decreasing, however, proportionally less than in previous years.

Opiates are referred to as primary drug by 84 per cent (↗) of indexed respondents. Whilst the preference proportion has persisted over the past four years, significant changes have occurred as regards the route of administration. The 1999 data confirm the decisive reduction in iv opiates consume associated to an amplification of the inhalation mode (also known as 'blowing' or 'chasing the dragon') to 33 per cent (36 % in 1998). Consume of cocaine and magic mushrooms as secondary drugs have also gained in popularity. Applied to problem drug users, cannabis use has stabilised over the past 3 years as well as the proportion of multiple-drug use (82 %). 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 3 years. For instance, 22 per cent of current problem drug users (1999) were younger than 14 years at the moment of first cannabis use and 43 per cent were still underage (< 18 years) as they first injected opiates.

Cannabis prevalence among drug treatment demanders appears to be fairly stable. However, applied to youngsters in general (school and youth surveys), one observes a upward trend, especially in association with synthetic drugs use. Between 1994 and 1999, the average age at the moment of first illicit drug use has shown a decrease of 1 year. The time span between the first illicit drug use and the first injecting of drugs also diminishes. Referring to the latter indicators, one notices that differences according to gender tend to vanish.

*The RELIS/LINDDA protocol includes specific annually evaluated items on **risk factors**. Low education levels, unemployment, foreign nationality (especially recent immigrates 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).*

First results from the yet unpublished comparative study on drug-related deaths in the Grand Duchy of Luxembourg ,(Origer and Dellucci in press) suggest that female opiate user highly increase, in terms of statistical probability, their risk of a drug-related death after their first contact with law enforcement agencies, compared to male opiate users. In general terms, female drug abusers show shorter drug careers and higher risk of overdose compared with male problem drug users.

b. Risk behaviours and trends

*Intravenous drug use, mainly heroin and heroin/cocaine cocktails (speedball), prevail among indexed drug users. RELIS 99 data confirm the decisive reduction in iv opiates consume as main drug, associated to an amplification in 1997 of the **inhalation mode** ('blowing' or 'chasing the dragon') to 33 per cent (10 % in 1997). Intravenous cocaine use as main and secondary drug shows fairly stable figures.*

*In 1999, the average **duration of intravenous drug use** of RELIS respondents was 8 years and 10 months (1998: 7 years and 4 months). The time span between the first illicit*

drug use and the first iv use has also decreased (199: 3 years and 8 months), compared with 1998 (4 years and 7 months). Generally speaking, the duration of i.v. use increases while the average age at the moment of first iv use (1999: 19 years and 3 months) tends to decrease. The proportion of ***multiple drug users*** *has stabilised at a high level (82%) for the last 3 years.*

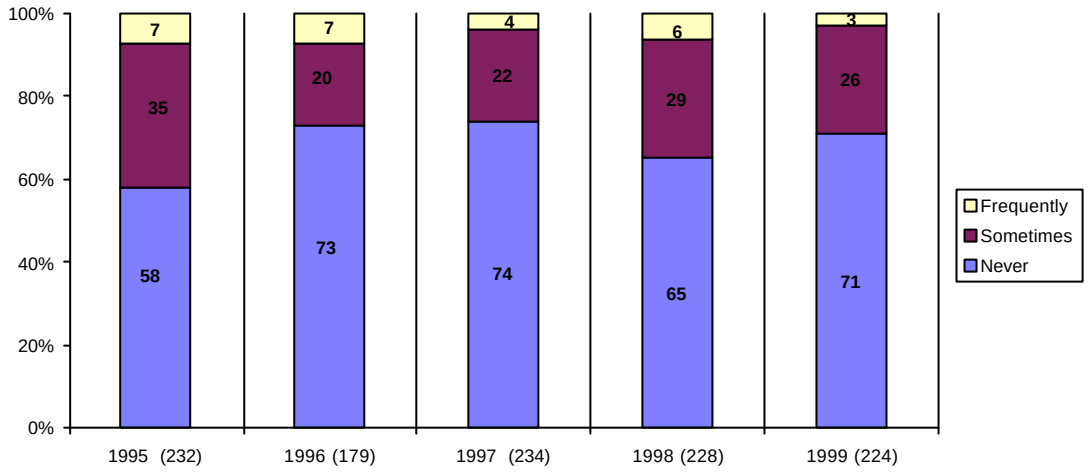
These trends have to be paid particular attention to since they are directly linked to the assessment of drug-related health risks, as are the data on the use of injection material.

The number of sterilised syringes distributed in the framework of the national needle exchange programme (1999:174,558 /1998: 109,743), has been rising right from the start of its implementation. The number of used syringes collected (1999: 98,764 (57%) / 1998: 58,886 (46%)) has increased as well but not in proportion to the growth rate of distribution. This evolution is partly explained by the fact that new agencies, addressing socially marginalised populations (prostitutes, homeless, etc.) have joined the needle exchange programme and that infectious disease prevention activities have been intensified. It is of utmost importance that needle exchange is also provided by 'non-specialised drug agencies', since several subgroups, as for instance sex workers, do not identify themselves with drug addicts and tend to avoid drug specific offers, even though they daily face hard drug addiction problems.

RELIS allows for further monitoring of risk behaviours:

Needle exchange: The needle exchange rate in indexed problem drug users has been showing a stable trend over the last 4 years. In 1999, 71% of RELIS respondents report not to exchange used needles. A stable majority of indexed drug users (41%) procure their injection material from pharmacies, followed by automatic dispensers and low threshold agencies. The referred figures have been confirmed by an exploratory survey on the involvement and perceptions of drug users as to the needle exchange programme, conduced by the National Surveillance Committee on AIDS in 1998.

Fig. 2.3.b.1 Needle sharing during the last month. Valid percentag
(1995-99)



Source: RELIS 1999

Saver sex: The use of condoms during sexual intercourse is a core item of the RELIS/LINDDA protocol. Male respondents report on whether they usually use condoms and women report on whether they ask partners to use them during sexual intercourse. Since 1997, 46 to 48% of RELIS respondents have reported condoms use. No notable trend has emerged since the set up of RELIS.

3. Health Consequences

3.1 Drug treatment demand

a/b. Characteristics of clients, patterns of use and trends / Client profiles in different treatment settings

The present section is based on RELIS data and on in-house statistics of all specialised drug treatment agencies at the national level. In general terms, the number of clients and number of admissions have constantly increased over the last ten years, regardless the type of treatment setting referred to. The proportion of first treatment demanders has only been increasing for the last two years (15%). For the sake of a comprehensive presentation of main observed trends, the following typology of treatment settings is applied:

- *Outpatient, adults*

National drug counselling and therapy centres show a clear upward trend as to the proportion of first treatment demanders, particularly significant during the last three years. Gender distribution has stabilised at 70/30% in Luxembourg City and at 60/40% in the South of the country. Age distributions have also to be analysed according to the geographical situation of treatment centres. For three years, the proportion of treatment demanders in the centre region of the Grand Duchy, aged 30 years and beyond (41.5%) has decreased, while the same age group has increased (55,5%) for seven years in the South of the country. In others words, the drug treatment population in the centre tends to grow younger and the one in the South is ageing. Treatment demands for problem opiate use or for multiple-use, including opiates, have slightly decreased (69% in 1999) and cannabis-related demands show a weak upward trend (3,5% in 1999). Occupational status of treatment demanders has impaired for the last four years.

- *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. Gender distribution is stable (70/30%) but the age of clients clearly tends to decrease. In 1997, the proportion of clients aged 15 years and below has passed from 7% in 1997 to 16.3% in 1999. Cannabis use is increasingly the main reason of demand (65%), followed by heroin, solvents and ecstasy.

- *Inpatient, drug therapy*

The proportion of new clients has remained stable for the last years. The proportion of male treatment demanders tends to decrease and the observed mean age clearly is on the increase. In 1997, 24% of clients were 30 years and beyond; in 1999, the same proportion figured 39%. A decrease is also observed as to the proportion of natives within the client population. All treatment demands are related to opiate abuse, mainly iv.

- *Inpatient, detoxification*

Drug detoxification units throughout the country do show a very steep decrease of first treatment demanders (24% in 1999). Gender distribution has remained fairly unchanged (70/30%) and the mean age of clients has been on the decrease for the last three 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 tends to saturate following a constant increase from 1989 onwards. An increasing proportion of female patients are admitted to substitution treatment (36% in 1999). Age of clients is on the decrease and the proportion of native substitution treatment demanders has stabilised (75% in 1999). The socio-economic situation of clients has slightly impaired during the last four years.

- *Low threshold services*

The proportion of new clients within street work, outreach and Drop-In settings has decreased for the last three years. The number of female clients shows a weak but constant increase, partly due to the increase of female drug using prostitutes. Data on age distribution is not available. About 70% of clients (stable) are natives.

a. Treatment demand according to types of drugs

The main substance involved in drug treatment demands is heroin. Over the last three years, however, one has observed a downward trend passing from 80% in 1997 to 71% in 1999. Likewise the trend observe in all indexed problem drug users, drug treatment demanders witness an increasing preference for heroin in inhalation mode as opposed to injection.

Cocaine use as main reason of treatment demand has been slowly increasing over the last four years (11%) especially with regard to iv use.

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 10% in 1999.

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 amphetamines use.

3.2 Drug-related mortality

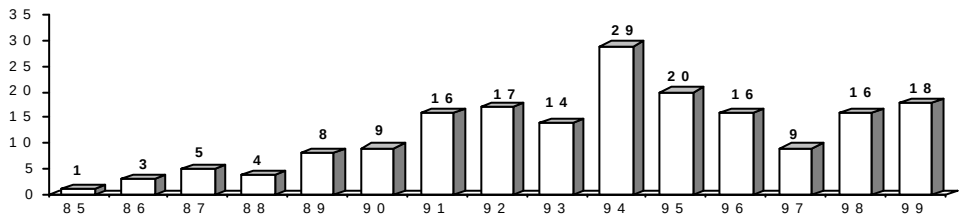
a. Drug-related deaths

➢ Direct/acute drug-related deaths

The number of officially recorded direct/acute overdose cases has increased steadily since 1985, peaking with 29 cases in 1994. Decrease was observed from 1995 and persisted throughout 1997 (9 cases). *During 1998, the first growth tendency (16) in four years has resumed reaching 18 cases in 1999. Until November 2000, 20 overdose cases have been recorded*

The SPJ Special Overdose Register applies the following definition of acute/direct drug-related death: *' Lethal intoxication, voluntary or accidental, confirmed by forensic autopsy, and caused directly by abuse of illicit drugs or by any other drug if the victim has been known to be a regular consumer of illicit drugs'*. Forensic autopsy is performed in cases of 'suspect deaths', if the legal authority (public persecutor) deems it necessary.

Fig. 3.2.a.1 Number of acute/direct drug-related deaths (1985-99)



Source: Special Overdose Register, SPJ, 1999

Since 1992, results of toxicological analysis performed on overdose victims refer to the presence of opiate traces in all cases. In 1999, 90 per cent of autopsy results reported heroin consume; a proportion that has remained stable for the last three years. Other substances involved mainly refer to cocaine and substitution drugs such as Methadone and Buprenorphine (SUBUTEX).

Table 3.2.a.1. Results from toxicological analyses on suspect deaths cases by the LNS (1999)

YEAR	AUTOPSIES (N)	N. of DEATHS HEROIN*	N. of DEATHS OTHER OPIATES *	TOTAL OPIATE DEATHS
1992	**38**	**11** of which 4x cocaine associated	**2**x DHC	**13**
1993	**45**	**11** of which 1x DHC + tilidine associated 1x cocaine associated	**3**x DHC **2**x DPX	**16**

1994	**49**	**22** of which 8x DPX associated 1x DHC associated 1x DHC + tilidine	**1**x DHC **6**x DPX of which 1x DHC associated 3x heroin associated	**29**
1995	**41**	**13** of which 3x DPX associated 1x MTD associated	**3**x DPX of which 1x heroin associated 1x MTD	**17**
1996	**40**	**13** of which 1x cocaine associated 1x MTD associated		**13**
1997	**42**	**8** of which 1x MTD associated	**1**x tilidine	**9**
1998	**39**	**16** of which 2x cocaine associated	**1**x MTD	**17**
1999	**61**	**17** of which 5x cocaine associated 1x MTD associated 1x tramadol associated	**1**x Buprenorphine **1**x morphine	**19**

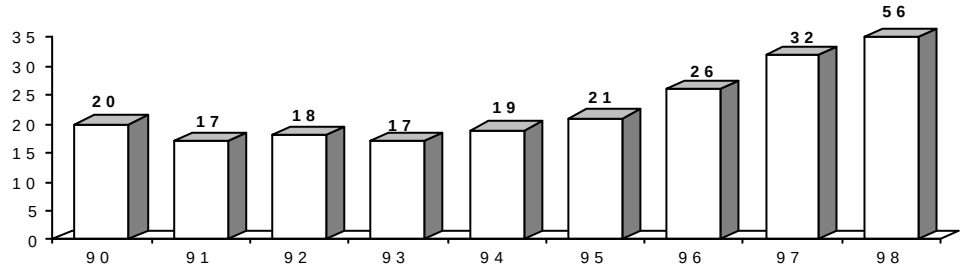
(*) In most cases in association with 'alcohol, benzodiazepines and other medicaments.
DHC= dihydrocodein, DPX= dextropropoxyphene, MTD= methadone

- Indirect drug-related deaths

The NFP is currently performing a comparative study on drug-related deaths including acute overdoses (SPJ) and indirect drug-related deaths (GMR), according to the DRD standard (Origer and Dellucci, in press). The publication of results is foreseen in the beginning of 2001. It is the first study on the prevalence of indirect drug-related deaths at the national level. First results have been available at the time of reporting, namely the number of indirect drug-related deaths according to the extensive DRD (ICD-9) standard.

It is remarkable that, as opposed to acute deaths figures, the number of indirect drug-related deaths has been constantly increasing from 1993 onwards. In 1998, the GMR has switched to IC-10 coding. Figures for 1999 are not yet available.

Fig. 3.2.a.2 Indirect drug-related deaths according to the extensive DRD standard (1990-98)



Source: National Death Register. Ministry of Health, 1999.

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. Applied to the total number of drug-related deaths (direct & indirect), one also observes a decrease in 1995, followed however by a stabilisation until 1997 and a significant increase in 1998, year in which the ICD-10 coding was first applied by the GMR.

Whether the upward trend from 1997 onwards is due to an increasing drug user prevalence, changing drug market profile and use patterns, remains uncertain at present. One should

bear in mind, however, that recent figures tend to confirm an increasing prevalence of problem drug users. On the other hand, an increase in non-iv heroin administration mode, observed for the last 2 years, should have reduced associated risk factors. Availability and quality of drugs distributed within the national market, multiple-drug use, associate morbidity and contexts of drug-related deaths are some of the relevant topics addressed by the upcoming study on drug-related deaths. The results will be analysed in the light of the outcome of two previous NFP studies (1993-94 / 1995-96).

B. Mortality and causes of death in drug users

- Mortality rate

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 and 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.

➢ Causes of death

The following charts present the exhaustive list of acute drug deaths as coded by the GMR by means of the ICD-10 standard. A vast majority of cases have been recorded as "accidental poisoning" (X40 – X49), which is consistent with the national definition of an acute overdose death.

Fig. 3.2.b.1 Distribution (%) of associated ICD-10 codes applied to acute overdose deaths (1998)

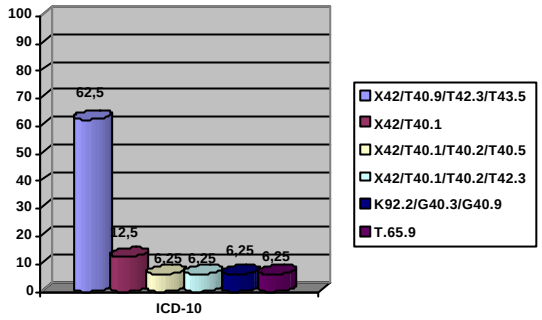
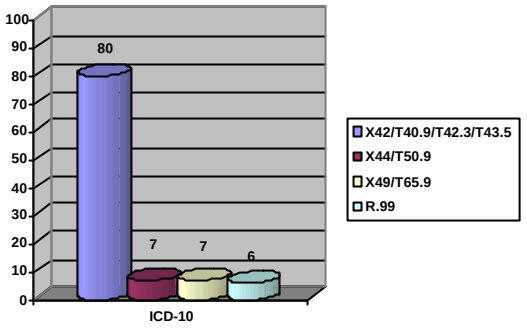


Fig. 3.2.b.2 Distribution (%) of associated ICD-10 codes applied to acute overdose deaths (1999)



As regards indirect drug-related deaths, first results of the comparative study on drug-related deaths performed by the NFP, reveal that the main causes of indirect deaths in 1998 and 1999 are, in order of importance: traffic accidents, associated illness (liver functions, AIDS, other infections), suicide and violence. The referred study will allow for more detailed analysis of indirect causes of deaths in the near future.

3.3 Drug-related infectious diseases

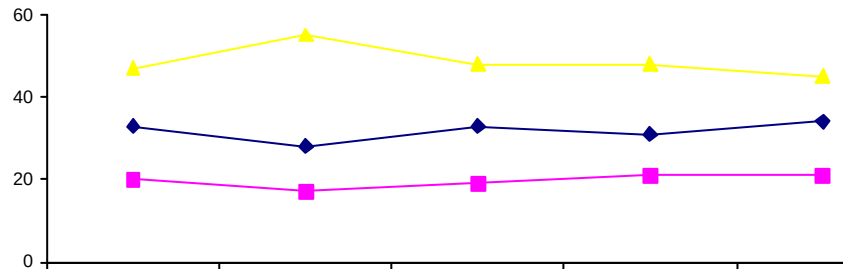
Please refer to key issue 14.

3.4 Other drug-related morbidity

a. Non fatal drug emergencies

Despite multiple efforts made by the NFP, official statistics on non-fatal drug emergencies are currently not available. Figure 3.4.a.1 refers to RELIS data on previous non fatal and medically assisted drug overdose experiences by respondents. The proportion of indexed drug users reporting at least one overdose (as defined) during lifetime has settle between 52

Fig. 3.4.a.1 Non fatal, medically assisted drug overdoses in RELIS respondents (1994-99)



	1995 (300)	1996 (193)	1997 (237)	1998 (263)	1999 (254)
More than one	33	28	33	31	34
One	20	17	19	21	21
None	47	55	48	48	45

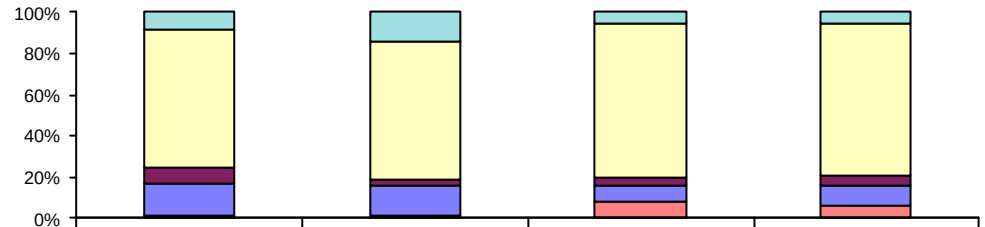
and 55 per cent for the last three years.
Source: RELIS 1999

b. Psychiatric co-morbidity

At the national level, there exist no specialised institution for dual diagnosis (e.g. drug addiction – psychosis). Generally, these patients are admitted in psychiatric units or, more frequently, referred to treatment agencies in border countries (mainly Germany). Since the referred clients are often registered as psychiatric patients, without any further clinical specifications, no reliable data on admission rates are currently available.

RELIS, however, provides data on previous contact(s) with psychiatric treatment agencies of indexed drug users. Distinction has to be made between psychiatric treatment and detoxification provided by psychiatric units. The proportion of RELIS respondents reporting previous psychiatric care, excluding detoxification treatment, is 22% (stable). Figure 3.4.b.1 shows the motives of previous psychiatric care demands by RELIS respondents.

Fig. 3.4.b.1 Motives of previous psychiatric ca
(1996-99)



	1996 (194)	1997 (218)	1998 (209)	1999 (211)
Emergency	8	14	6	6
Detoxification	67	67	74	73
Psychiatric comittal	8	3	4	5
Couselling	16	15	8	10
Other	1	1	8	6

Source: RELIS 1999

c. Other important health consequences

Health indicators retained by RELIS stress a slight improvement of the general health state of indexed users except for HCV prevalence. In 1999, 50 per cent of problem drug users reported a satisfying general health condition.

4 Social and Legal Correlates and Consequences

4.1 Social problems

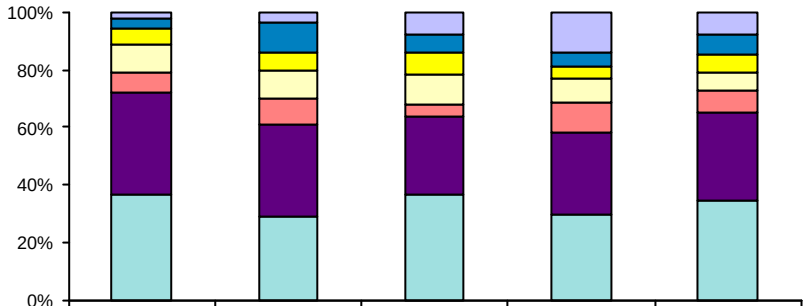
Generally speaking, drug addicts tend to be considered as people in need of help in the first place. Nonetheless, the opiate using drug population tends to be associated to the criminal behaviour by public. Social exclusion of drug addicts is to be linked to the lack of information mostly of the former generation. The emergence of synthetic drugs has contributed to somehow differentiate a highly undifferentiated view on drug abuse.

The geographical size of the Grand Duchy do often not allow intimacy or anonymity of people who are stated to behave in a socially deviant way. On one hand, native drug addicts are often known to relatives or the neighbourhood but on the other hand, for the same reason, they may be forced them to seek treatment abroad in order to avoid public stigmatisation.

*The **educational level** of RELIS respondents shows a slow but constant improvement, even though the average age at the end of studies remains stable.*

***Residential status** of registered drug users has improved for the last 4 years, especially referring to the homeless rate (1999: 6% / 1997: 10%). 63 per cent of respondents reported current or past drug abuse within their family of origin and 78% have been living with their parents at the time of their first use of illicit drugs. Special attention should also be paid to the constant increase of respondents living with drug abusing partners.*

Fig. 4.1.a Last known residence of problem drug us
(1995 - 99)



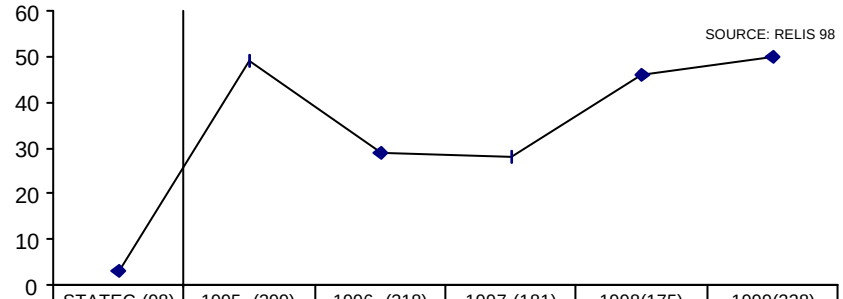
	1995 (385)	1996 (289)	1997 (234)	1998 (232)	1999 (278)
other	2	4	8	14	8
with friends	4	10	6	5	7
with mb. of family	5	6	8	4	6
homeless	10	10	10	8	6
community	7	9	4	11	8
with parents	35	32	27	28	30
private accomodation	37	29	37	30	35

SOURCE: RELIS 98

*All indicators included, the **employment status** of respondents has declined for the last three years. The unemployment rate in problem drug users has grown in significance since 1997. Furthermore, the percentage of students (16%) tends to increase. Data on revenues confirm observed trends in occupational status:*

- *weakening of financial autonomy associated to an increasing social dependency (e.g. Guaranteed Minimum Income: 25%);*
- *increased financial contribution by parents related to the growing proportion of students within the problem drug population.*

Fig. 4.1.b Unemployment rate in problem drug users (1995 - 9

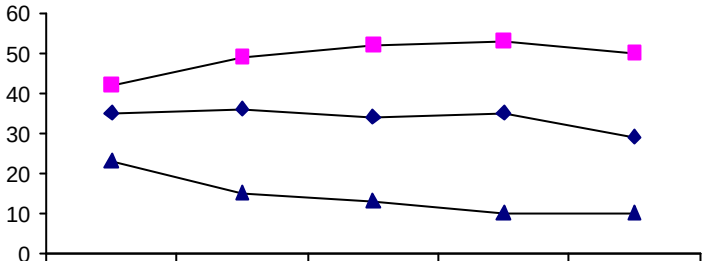


	STATEC (98)	1995 (399)	1996 (318)	1997 (181)	1998(175)	1999(228)
unemployed	3,2	49	29	28	46	50

Remark: *STATEC: Statistical Department of State – Unemployment rate in active general population in 1998.*

Illegal activities and ***revenues*** *have seen a downward tendency and tend to stabilise for 2 years. The proportion of respondents reporting major* ***depths*** *(≥2,500 EURO) (41%) is still decreasing, however, proportionally less than in previous years (1995: 59%).*

Fig. 4.1.c Primary source of income of problem drug users (1995 - 99



	1995 (407)	1996 (269)	1997 (243)	1998 (276)	1999 (321)
Autonomy	35	36	34	35	29
Social wefare	42	49	52	53	50
Illegal income	23	15	13	10	10
Others	0	0	1	2	1

SOURCE: RELIS 98

4.2 Drug offences and drug-related crime

Definition of legal concepts and law enforcement interventions

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.

- *Détention (Eng. imprisonment) :*

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

a. Law enforcement interventions and 'prévenus' 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 in 1999 (1,187). The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 1998. In 1999, however, an inverse trend has been observed peaking at 1,939 drug law offenders. The number of arrests on the same charge has decreased from 154 in 1997 to 108 in 1999 ***(see table 4.2.a.1)****.*

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. Within the same period, non-natives have been representing the majority of drug law offenders (except in 1994). Regarding the proportion of first drug law offenders (33%), no trend-line can be observed. The percentage of minors (< 18 years) among drug law offenders has increased since 1993 (3%) (1999: 5%) ***(see table 4.2.a.4/5)****.*

Table 4.2.a.1 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), Gendarmerie, Police and Board of Customs from 1995 to 1999.

Table 4.2.a.1 Number of national law enforcement interventions (1995-1999)

	DRUG LAW ENFORCEMENT RECORDS					PREVENUS				
Year	**95**	**96**	**97**	**98**	**99**	**95**	**96**	**97**	**98**	**99**
S.P.J.	123	117	137	192	343	152	141	182	224	434
Gendarmerie	198	232	255	265	782	319	322	335	339	916
Police	199	179	177	243	189	371	344	280	386	283
Customs	244	336	236	125	173	421	561	408	221	306
Total	**764**	**864**	**805**	**825**	**1,187**	**1,263**	**1,368**	**1,205**	**1,170**	**1,939**

Source: Specialised Drug Department of the Judicial Police

Table 4.2.a.2 *Socio demographic data on 'prévenus' (1985-1999)*

	YEAR	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
AGE	**0-14**	5	9	5			7	2	6	12	1	12	3	6	7	27
	15-19	121	121	179	212	173	179	293	320	146	169	205	270	257	249	415
	20-24	234	264	262	569	461	383	520	527	242	403	456	447	369	321	519
	25-29	100	119	110	220	232	278	275	371	255	309	256	304	269	220	448
	30-34	65	49	71	67	58	124	98	159	104	186	167	191	151	187	269
	35-39	10	17	22	29	21	27	34	52	49	65	98	80	73	76	131
	≥40	11	17	28	19	30	43	35	46	29	21	33	42	45	78	84

	unknown	9	27	11	21	25	30	19	50	53	20	36	31	35	32	46
TOTAL		**555**	**623**	**688**	**1,137**	**1,000**	**1,071**	**1,276**	**1,531**	**890**	**1,174**	**1,263**	**1,368**	**1,205**	**1,170**	**1,939**
Male		431	503	574	970	887	851	1045	1248	674	938	1035	1138	1009	958	1658
Female		122	120	114	166	113	220	213	256	183	209	186	173	174	193	248
	gender unknown	2	0	0	1	0	0	18	27	33	27	41	57	22	19	33

Source: Specialised Drug Department of the Judicial Police 1999.

***Remark** : In 1999, 951 cases on 1,198 (79%) have been recorded multiple-drug users.*

***Table 4.2.a.3** Type of drug law offences broken down by substances involved (1999)*

Substance	**Offence**	**N**	**Mode i.v.**	**TOTAL**
Heroin	Use & Traffic	329	157	
	Traffic	75		**1.050**
	Use	646	361	
Cocaine	Use & Traffic	85	34	
	Traffic	31		**204**
	Use	88	31	
Cannabis	Use & Traffic	326		
	Traffic	43		**995**
	Use	626		
Amphetamines	Use & Traffic	2		
	Traffic	3		**12**
	Use	7		
Ecstasy (MDMA, etc.)	Use & Traffic	10		
	Traffic	2		**25**
	Use	13		
LSD	Use & Traffic	4		
	Traffic	1		**10**
	Use	5		
Total number of *'interpellation'* motives	**Use & Traffic**		**175**	**756**
	Traffic			**155**
	Use		**384**	**1,385**
	Total			**2,296**
Total number of 'prévenus'				**1,939**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP 1999.

Remark : The number of 'prévenus' per substance type is higher than the total number of 'prévenus', since one individual may have been in possession of several substances at the time of his/her 'interpellation'.

***Table 4.2.a.4** Distribution of 'prévenus' according to first offence and underage status (1992-1999)*

	1992	***1993***	***1994***	***1995***	***1996***	***1997***	***1998***	***1999***
First offenders	*697*	*331*	*382*	*498*	*508*	*389*	*422*	*645*
Number of offenders underage	*96*	*48*	*57*	*92*	*102*	*84*	*79*	*155*
TOTAL ('Prévenus')	**1.531**	**890**	**1.174**	**1.263**	**1.368**	**1.205**	**1.170**	**1.939**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 1999.

Table 4.2.a.5 *Distribution of 'prévenus' according to first offence (use and use/traffic) and substance involved ad minima (1992-99)*

	1992	***1993***	***1994***	***1995***	***1996***	***1997***	***1998***	***1999***
Substance involved ad minima								
Heroin	*162*	*91*	*154*	*170*	*121*	*104*	*109*	*157*
Cocaine	*64*	*15*	*39*	*46*	*34*	*20*	*30*	*60*
Amphetamines	*5*	*0*	*15*	*11*	*11*	*12*	*18*	*14*
Type ' Ecstasy '	*1*	*3*	*9*	*47*	*20*	*26*	*26*	*6*
Illicitly acquired medicaments	*1*	*0*	*3*	*0*	*0*	*0*	*1*	*0*
Illicitly acquired substitution substances	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*
TOTAL (substances HRC)	**233**	**109**	**221**	**274**	**186**	**162**	**184**	**237**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 1999.

Arrests data

Table 4.2.a.6 *Arrests broken down by type of offence and substances involved (1995-1999)*

Substance	**Offence**	**1995**	**1996**	**1997**	**1998**	**1999**
Heroin	Use & Traffic	68	51	57	59	48
	Traffic/Deal	21	56	53	9	18
	Use	24	6	7	17	27
	Total	**113**	**113**	**117**	**85**	**93**
Cocaine	Use & Traffic	20	29	27	16	21
	Traffic/Deal	7	27	23	7	9
	Use	10	1	6	6	12
	Total	**37**	**57**	**56**	**29**	**42**
Cannabis	Use & Traffic	25	13	18	19	32
	Traffic/Deal	1	14	11	3	8
	Use	4	5	4	8	3
	Total	**30**	**32**	**33**	**30**	**43**
Amphetamines	Use & Traffic		2	2	4	1
	Traffic/Deal		1			
	Use	2			4	
	Total	**2**	**3**	**2**	**8**	**1**
Ecstasy (MDMA, etc.)	Use & Traffic	3	3	3	1	3
	Traffic/Deal	1	4	3		
	Use	1				
	Total	**5**	**7**	**6**	**1**	**3**
LSD	Use & Traffic		1	1		1
	Traffic/Deal		1			
	Use					
	Total		**2**	**1**		**1**
Total number of *arrest* motives	**Use & Traffic**	**116**	**99**	**108**	**99**	**106**
	Traffic/Deal	**30**	**104**	**90**	**19**	**35**
	Use	**41**	**12**	**17**	**35**	**42**
	Total	**187**	**215**	**215**	**153**	**183**
Total number of arrests notwithstanding arrest motives		**128**	**149**	**154**	**100**	**108**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP)1999.

b. Court data

Prison data

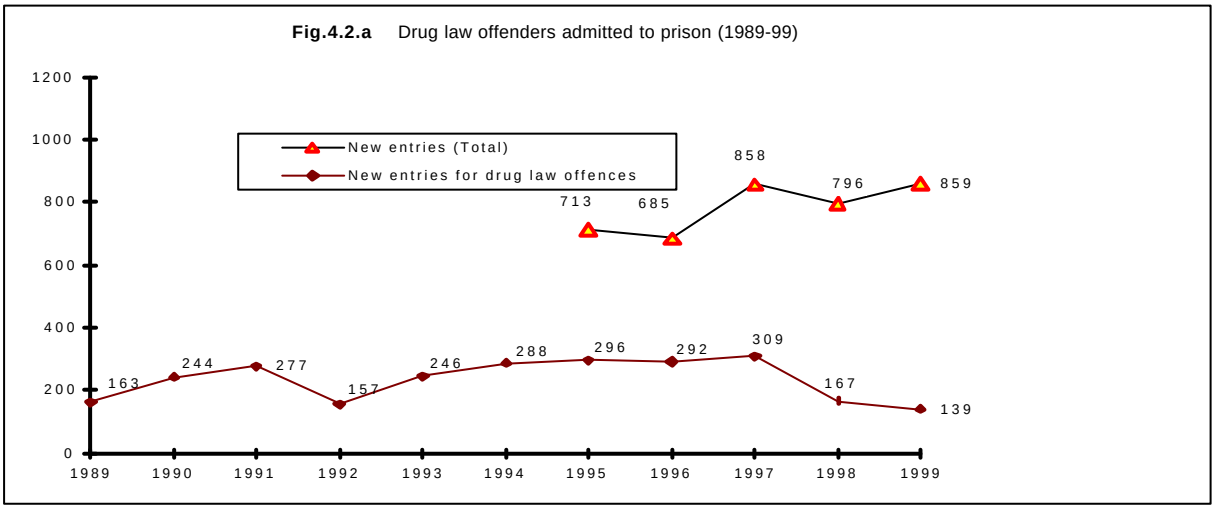
In the Grand Duchy of Luxembourg there are two state prisons, one situated in the vicinity of Luxembourg-City (CPL) and the other in the North of the country (CPG). *The proportion of prison sentences for drug law offences has decreased significantly compared with 1997 data. In 1999, 139 new entries (16 %) (1997: 36%) in national penal institutions referred to the ' DELIT- STUP ' (Drug law offence) code have been reported (of a total number of entries in 1999: 859).*

Table 4.2.b.1 *Prison entries for drug offences*

YEAR	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
New prison entries (Total)							713	685	858	796	859
New entries of drug law offenders	163	244	277	157	246	288	296 *41.5%*	292 *42.6%*	309 36%	167 *21%*	139 *16%*

Source : Central Prison Administration 1999.

Fig.4.2.a Drug law offenders admitted to prison (1989-99)



Source : Central Prison Administration 1999.

Remark: *No further data on convictions and court sentences for drug offences currently available*

c. Drug-related crime

The RELIS/LINDDA database provides the following figures for 1999:

- *83% (↗) of drug users indexed[9] by specialised health care institutions have already been in conflict with law enforcement agencies during lifetime. 66% (↗) of the latter show multiple law enforcement contacts.*
- *the number of 'interpellations' for other reasons than presumed offences against the dug law (e.g. petty crime) has been decreasing since 1997, reaching for the first time (since reported) a lower figure than the number of drug law offences.*
- *71% of indexed addicts have already served at least one prison sentence during lifetime. 60% of the latter have been in prison once and 40 % report more than one prison*

[9] Persons who have been indexed by the RELIS/LINDDA network during a reporting year

journey. Compared with previous years, a significant deterioration of the penal situation of indexed drug user must be stressed; associated, however, to a decrease of the duration of served prison sentences. The steep increase of first prison sentences might contribute to the observed situation.

4.3 Social and economic costs of drug consumption

The budget of the Ministry of Health directly allocated to actions against drugs and drug addiction shows an increase from 1.14 million € in 1999 to 2.13 million € in 2000, following the centralisation of demand reduction activities by the Ministry of Health. The provisional budget of 2001 foresees a supplementary increase of 49 per cent, figuring 3,15 million €. In order to optimise the implementation of the drugs action plan, the Minister of Health has appointed a national drug co-ordinator and the Directorate of Health is setting up a special division for social medicine and drug addiction. A national study and the socio-economic costs of drug use is currently performed by the NFP (Origer and Cloos, in press). Results are due in the course of 2001.

5 Drug Markets

5.1 Availability and supply

Different reliable information sources indicate that 90 per cent 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 quantities of drugs in order to sell them within a restricted local network. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market. Law enforcement agencies do stress the negative impact of the abolishment of border controls on the fight against drug trafficking.

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.

Furthermore, no production units (e.g. clandestine laboratories) have been discovered at the national level thus far. The local production of cannabis and magic mushrooms is rather insignificant in terms of quantity and quality.

5.2 Seizures

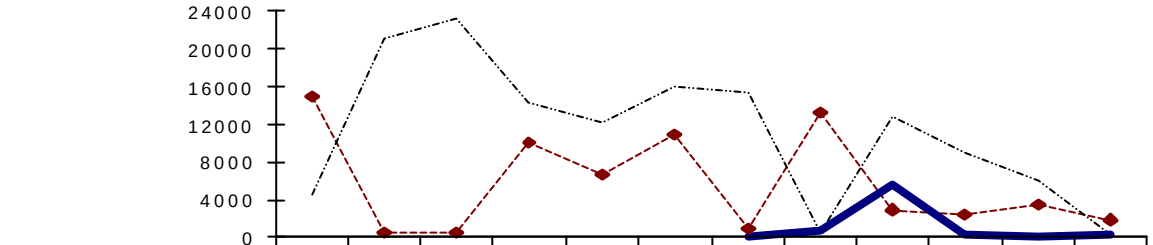
Striking variations have been observed as to the quantity of illicit substances seized since 1984 ***(see fig. 5.2.1)****. Since 1996, however, one observes a general downward trend as regards seized quantities of heroin, cocaine and ecstasy type substances. Heroin, cocaine, cannabis leaves and resin are the only substances that have been seized on an annual basis since 1980.*

Notwithstanding the quantities seized, the number of seizures has grown steadily until 1996 (1999: 806), with the exception of cocaine, amphetamines and ecstasy. The number of persons involved in heroin traffic has followed a constant uphill trend which has remained remarkably homogeneous until 1999 (570) (except in 1998). The same trend, although proportionally less important, has been observed with respect to the total number of persons involved in drug seizures. Summarily, quantities of seizures have been decreasing since

1996, while the number of persons involved shows a significant increase, especially in 1999. The development of distribution micro networks may partly contribute to the current situation.

PCP or Crack (cocaine-base) seizures have not been reported by national authorities thus far. The first national seizures of MDMA, MDA, etc. (ecstasy-type substances) were recorded in 1994. The availability of ecstasy appeared to soar from 1994 onwards whilst seizures, in terms of quantity, have significantly decreased in 1997 and remained fairly stable for 3 years now (1999: 357 pills). Nevertheless, it would not be wise to draw conclusions at this stage on the prevalence of ecstasy-type substances, in the light of divergent data resulting from other sources (e.g. recent school surveys). Further attention should also be paid to the increased number of magic mushrooms (psilocybin) seizures observed since 1997.

Fig. 5.2.1 Total quantity of seizures: heroin, cocaine, ecstasy type (1988 - 99)



	88	89	90	91	92	93	94	95	96	97	98	99
Heroin (gr.)	14888	540	527	9988	6682	10839	906	13248	2934	2525	3592	1914
Cocaine (gr.)	4579	21117	23260	14222	12092	15949	15459	525	12891	8983	5995	327
Ecstasy (pills)							172	784	5545	367	145	357

Source: Specialised Drug Department of the Judicial Police 1999.

Table 5.2.1 *Number and quantities of drug seizures – Police/Gendarmerie 1996-1999*

		1996		1997		1998		1999	
Substance	Unit	*N*	Quantity	*N*	Quantity	*N*	Quantity	*N*	Quantity
Cannabis (total)	kg	116	23.852	113	32.116	127	1.941	263	3.211
Haschisch	kg	38	10.320	28	0.215	29	1.419	73	0.987
Marihuana	kg	72	13.467	84	31.901	96	0.522	185	2.224
Plants	units	6	14 + (15 gr)	1	5	2	222	5	93
Heroin	kg	112	2.136	97	1.903	123	2.069	218	1.133
Cocaine	kg	19	7.502	15	3.612	21	4.437	29	0.216
Amphetamines	gr	1	2,1	2	3,41	8	23.235	3	14.6
	pills	1	6						
Ecstasy type	pills	6	5,020	9	378	10	127	9	156
	gr	1	2,9						
LSD	doses	2	11	3	4	0			
Psilocybin	gr	0		1	57,6	2	295	4	24,76
Methadone	flask	3	9	4	3	3	12	2	41
	mg			1	840				
MEPHENON	pills	6	112	8	115	2	70	5	169

Medicaments	pills		17	68	15	59	10	386	21	260	
(illicitly acquired)	kg		1	25							

Source: Specialised Drug Department of the Judicial Police 1999.

Table 5.2.2 *Number and quantities of drug seizures – Customs 1996-1999*

			1996		**1997**		**1998**		**1999**		
Substance	Unit		*N*	Quantity	*N*	Quantity	*N*	Quantity	*N*	Quantity	
Cannabis (total)	kg		164	5.526	96	3.165	64	3.398	110	2.681	
Haschisch	kg		97	2.275	38	0.648	20	1.587	41	0.910	
Marihuana	kg		67	3.251	58	2.517	44	1.811	69	1.771	
Plants	units		0		0		0		0		
Heroin	kg		157	0.879	152	1.055	73	0.680	86	0.750	
Cocaine	kg		39	5.399	44	3.043	10	1.525	27	0.111	
Amphetamines	gr		6	19.7	1	0.5	3	21.5	2	2	
	pills										
Ecstasy type	pills		22	549	6	16	7	49	1	201	
	gr										
LSD	doses		11	113	0		0		1	1	
Psilocybin	gr		0		0		4	16.5	9	125.5	
Methadone	flask		0		1	9	1	1	0		
	mg										
Mephenon	pills		0		0		1	1	2	71	
Medicaments	pills		6	184	3	13	2	28	6	3,168	
(illicitly acquired)	kg										

Source: Specialised Drug Department of the Judicial Police 1999.

5.3 Price / purity

Average street retail prices of illicit drug have been remaining quite stable during past years (brown heroin: 90 €/gram, ecstasy: 12.5 €/pill), with the exception of cannabis, on the increase (haschisch: 7.4 €/gram, marijuana: 6.2 €/gram) and cocaine on the decrease (90 € /gram).

Table 5.3.1 *Price per unit evolution at the street level (1994-2000)*

	1994	**1995**	**1996**	**1997**	**1998**	**1999**			**2000**		
	Price	Price	Price	Price	Price	Price			Price		
						MIN.	MAX.	MOYEN	MIN.	MAX.	MOYEN
Cannabis Haschisch Marijuana	5 - 6	5 - 6	5 - 6	5 – 6 2,5 - 3	5 – 6 2,5 - 3			7,4 6,2	6,7 6	7,9 6,7	7,4 6,2
Cocaine	100 -150	100 -150	100 -150	120 -170	120 -170			90	74,4	90	90
Heroin (brown)	65 -150	65 -150	65 -150	90 -150	90 -150			90	50	74,4	74,4
Amphet.			15-26	25-30	25-30			?	?	?	?
Ecstasy				9 - 13	9 - 13			12,4	8,7	12,4	10,7
LSD	11 - 13	11 - 13	11 -13	11 -13	11 -13			?	?	?	?

Sources: Specialised Drug Department of the Judicial Police 2000.

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.

In terms of purity, the samples of 'suspect substances' analysed by the National Laboratory of Health (LNS) in 1999, revealed the following margins of purity of active substance: brown heroin: 7.2 to 27.7 per cent; cocaine: 45.8 to 88.76 per cent; haschisch: 2 to 5.13 per cent). Toxicological analysis of samples sold as ecstasy reported the presence of MDMA in 15 per cent of samples in 1999 and in 25 per cent of the samples in 1998. Associated substances most frequently included in ecstasy pills were: amphetamine-sulfate, caffeine, codeine, benzodiazepines, ephedrine.

Table 5.3.2 *Purity per unit evolution at the street level (1994-2000)*

	1994	1995	1996	1997	1998	1999			2000		
	Purity (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)	Pur. (%)			Pur. (%)		
						MIN.	MAX.	MOYEN	MIN.	MAX.	MOYEN
Cannabis Haschisch Marijuana						2	5,13	3,46			
Cocaine	60-90	60-90	60-90	60-90	60-85	45,8	88,76	70,66	28,3	43,85	33,83
Heroin (brown)			15-23	20-25	17-25	7,2	27,7	12,17	8,45	22,3	16.07
Ecstasy									27,1	42,2	37

Sources: Specialised Drug Department of the Judicial Police 2000.
Purity: For cocaine, heroin and amphetamines, purity is expressed in percentages of pure active substance at the street level.
For cannabis, purity refer to percentage of THC.
For ecstasy-type substances, purity refer to percentage of MDMA-HCL in relation to total mass.

6 Trends per Drug

➢ Cannabis

Data from school and youth surveys *(see chapter 2.2) have revealed a most significant increase of cannabis prevalence (lifetime, 12 months, 30 days) over the past 8 years in youngsters aged between 12 and 20 years).*

Cannabis use in indexed ***problem drug users*** *are on a slight decrease as main (primary) drug. However, one notices a significant increase of cannabis consume as a secondary drug. The average ages at the time of first consume of the current main drug and illicit drugs in general have shown a slow but constant downward trend for the last 3 years. For instance, 22 per cent of current problem drug users (1999) were younger than 14 years at the time of first cannabis use.*

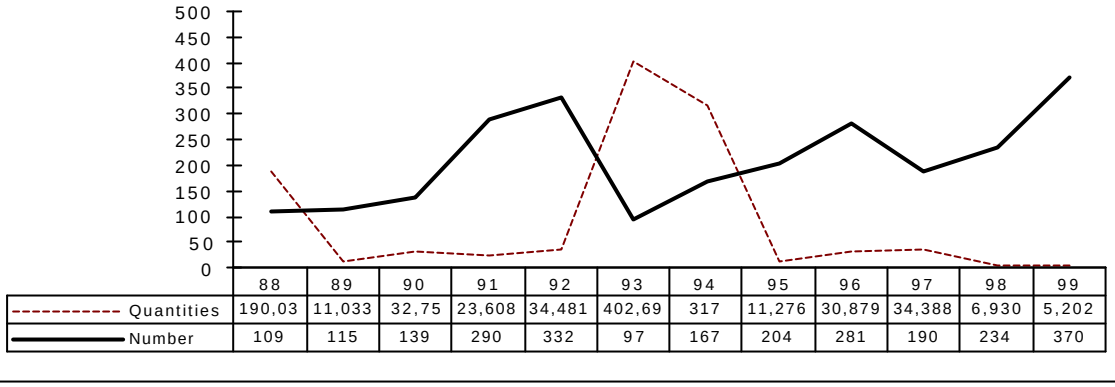
Table 6.1 *Preferential drug consume of problem drug users - Cannabis. Valid percentages. (1995-99)*

Preferential substance	Primary drug					PREF. 2					PREF. 3				
	95	96	97	98	99	95	96	97	98	99	95	96	97	98	99
CANNABIS ET DERIVATIVES	5	5	4	3	3	20	16	14	29	24	22	33	29	41	40
N	405	283	237	574	677	362	241	229	397	440	235	193	198	255	280

Source: RELIS/LINDDA

Seizure data *do not confirm prevalence trends as to the seized quantities. However, one observes a rather continuos increase of the number of seizures since 1993, which to a certain extent confirms youth and problem drug user data.*

Fig. 6.1 Seizures: Cannabis and derivatives (1988 - 99) (gr.)



	88	89	90	91	92	93	94	95	96	97	98	99
Quantities	190,03	11,033	32,75	23,608	34,481	402,69	317	11,276	30,879	34,388	6,930	5,202
Number	109	115	139	290	332	97	167	204	281	190	234	370

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 1999.

➢ Synthetic drugs

Data from school and youth surveys *suggest a slight increase in ecstasy consume. LSD, amphetamines and solvents use show fairly stable figures since 1992.*

Synthetic drugs figure poorly as main drug of ***problem drug users****. As regards secondary drug prevalence, no significant trend is currently observed.*

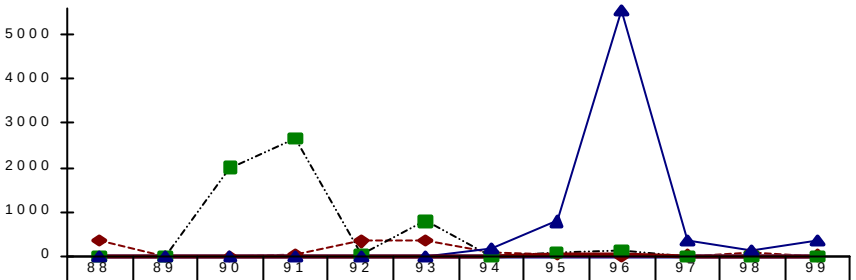
Table 6.2 *Preferential drug consume of problem drug users – Synthetic drugs. Valid percentages. (1995-99)*

Preferential substance	Primary drug					PREF. 2					PREF. 3				
	95	96	97	98	99	95	96	97	98	99	95	96	97	98	99
LSD				1		3	3	3	4	1	3	8	5	5	5
ECSTASY-TYPE	1	2	1	6	2	4	6	6	7	4	5	8	11	10	10
AMPHETAMINES			1	2	1	4	3		3	1	4	2	6	6	3
N	**405**	**283**	**237**	**574**	**677**	**362**	**241**	**229**	**397**	**440**	**235**	**193**	**198**	**255**	**280**

Source: RELIS/LINDDA

Seizure data *do partly confirm prevalence trends in particular referred to increasing number of ecstasy seizures and low LSD and amphetamines figures.*

Figure 6.2 Seizures Amphetamines, Ecstasy, LSD (1988 - 99) (units)



	88	89	90	91	92	93	94	95	96	97	98	99
Amphetamines (Q.) (gr.)	353	0	0	53	333	351	103	30	21	10	66	16
Amphetamines (N.)	7	0	0	2	9	11	7	9	11	3	5	5
LSD (Q.) (trips)	1	0	2000	2648	39	793	0	100	122	4	0	1
LSD (N.)	1	0	1	3	8	2	0	8	15	3	0	1
Ecstasy (Q.) (pills)	0	0	0	0	0	0	172	784	5545	367	145	357
Ecstasy (N.)	0	0	0	0	0	0	8	25	26	12	22	10

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 1999.

➢ Heroin / Opiates

*Most recent data from **school and youth surveys** (HBSC, 2000; Fischer 1999) reveal low lifetime prevalence of opiates use in youngsters (12-20 years), which has poorly increased during the referred period (1999: 1.2%). Last 12 months and last 30 days prevalence figures converge (1998/99: 0.6 – 0.7 %).*

*Opiates are referred to as primary drug by 84 per cent (↗) of indexed **problem drug users**. Whilst the preference proportion has persisted over the past four years, significant changes have occurred as regards the route of administration. The 1999 data confirm the decisive reduction in iv opiates consume associated to an amplification of the inhalation mode to 33 per cent (36 % in 1998). The mean 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 3 years. For instance, 43 per cent of current problem drug users (1999) were still underage (< 18 years) as they first injected opiates.*

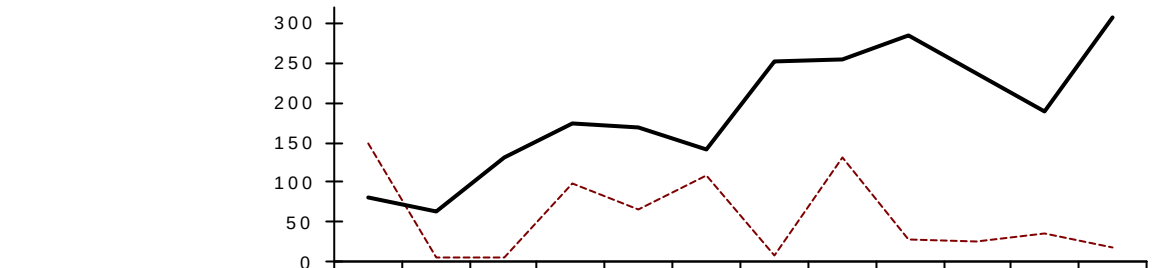
Table 6.3 *Preferential drug consume of problem drug users - Opiates. Valid percentages. (1995-99)*

Preferential substance	Primary drug					PREF. 2					PREF. 3				
	95	96	97	98	99	95	96	97	98	99	95	96	97	98	99
HEROIN / OPIATES (i.v.)	17	17	10	36	33	17	10	8	4	9	3	5	9	3	4
HEROIN / OPIATES (other route)	64	58	70	41	51	10	11	10	7	7	8	5		3	4
N	**405**	**283**	**237**	**574**	**677**	**362**	**241**	**229**	**397**	**440**	**235**	**193**	**198**	**255**	**280**

Source: RELIS/LINDDA

***Seizure data** on opiates mirror the observed trends in cannabis seizures. A downward trend in quantities of seized opiates but an overall increase of the number of opiate seizures since 1988. Data support the hypothesis of the development of micro-networks and increased availability at the street level.*

Fig. 6.3 Seizures: Heroin (1988 - 99) (x 100 gr.)



	88	89	90	91	92	93	94	95	96	97	98	99
Héroin (Q.) x 100 gr.	148,9	5,40	5,27	99,88	66,82	108,4	9,06	132,5	29,34	25	36	19
Heroin (N.)	81	63	133	175	169	141	251	255	284	237	189	306

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

➢ Cocaine / Crack

*Data from **school and youth surveys** (HBSC, 2000 / Fischer 1999) reveal low lifetime prevalence of cocaine use in youngsters, which has poorly increased over the last 8 years (1999: 2.3 – 2.9%). Last 12 months and last 30 days prevalence figures, provided by the same studies, are similar (1998/99: 1.3-1.6 %)*

*I.v. and non i.v use of cocaine as main drug by **problem drug users** show fairly stable figures. As far as secondary use is concerned, a yet to be confirmed increase seems to emerge. Crack use is insignificant at each preference level.*

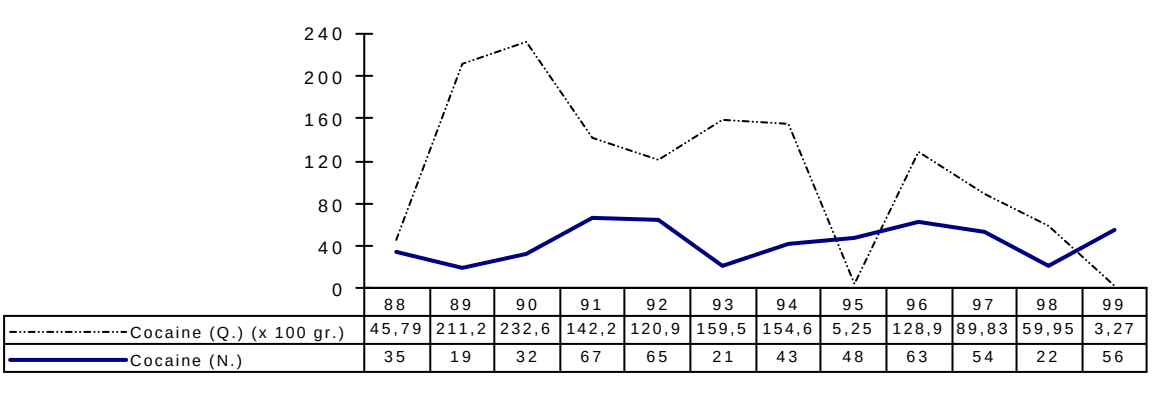
***Table 6.4** Preferential drug consume of problem drug users - Cocaine. Valid percentages. (1995-99)*

Preferential substance	Primary drug					PREF. 2					PREF. 3				
	95	96	97	98	99	95	96	97	98	99	95	96	97	98	99
COCAINE (i.v.)	3	5	2	4	4	8	12	9	18	16	6	3	4	7	5
COCAINE (other route)	5	8	9	3	5	17	24	22	15	21	6	6	5	7	5
N	**405**	**283**	**237**	**574**	**677**	**362**	**241**	**229**	**397**	**440**	**235**	**193**	**198**	**255**	**280**

Source: RELIS/LINDDA

***Seizure data** on cocaine show an overall yet disrupted decrease from the beginning of the nineties onwards. The number of cocaine seizures has been stable over the last 5 years (except in 1998). No seizure of crack has been reported thus far by national authorities.*

Fig. 6.4 Seizures: Cocaine (1988 -99)(x 100 gr.)



	88	89	90	91	92	93	94	95	96	97	98	99
Cocaine (Q.) (x 100 gr.)	45,79	211,2	232,6	142,2	120,9	159,5	154,6	5,25	128,9	89,83	59,95	3,27
Cocaine (N.)	35	19	32	67	65	21	43	48	63	54	22	56

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 1999.

➢ **Multiple use**

RELIS/LINDDA data from 1999 have shown that up to 82% of drug treatment demanders are multiple-drug users. The referred rate has shown great stability since the beginning of the monitoring system. Data on recorded drug law offenders confirm referred figures. 78% of drug law offenders have been reported multiple-drug users in 1999. Alcohol and tobacco use is associated to the profile of a vast majority of multiple-drug users.

The HBSC (2000) ***school survey*** *reported that 2.4% of 12 to 20 years old students have used more than one illegal drug during the last 12 months. Male students figure higher multiple-use rates than females. The HBSC (2000) and Matheis (1992) surveys (see chapter 2.2) reveal low lifetime prevalence of solvent use in youngsters (16-20 years), which has poorly increased over the last 8 years (1999: 3.8% – 1992: 3.5%). Last 12 months prevalence (HBSC, 2000) figures 1.6 per cent in 12 – 20 year old students. Differences in solvent use according to gender are not significant. A possible explanation of these low figures might be seen in the hale socio-economic situation of the country. Youngsters tend to dispose of financial means that allow them to acquire more expensive or more potential drugs as for instance ecstasy, amphetamines or cocaine*

Use of hypnotics and sedatives in youngsters has also witnessed an increase during the last 8 years. One, finally should underline the steep increase in consume prevalence and seizures of magic mushrooms (psilocybin) in youngsters.

7 Conclusions

7.1 Consistency between indicators

Major efforts have been made during the last years as to the quality, the reliability and the consistency of RELIS/LINDDA data. Since RELIS/LINDDA is the only national drug monitoring system on problem drug users, consistent cross-validation procedures can not be performed. However, the RELIS monitoring system is operational since 1995 and provides annually updated data in comparable form. The RELIS standard protocol includes a series of internal consistency items that allow to assess quality and consistency of provided data and to detect unreliable data. Thus far, results provided by RELIS did not show outstanding variations or unrealistic trend-lines. Observed trends have indeed been in pace with results from other official and unofficial sources. In-house statistics provided by specialised drug agencies confirm all major trends observed by means of RELIS/LINDDA and independent surveys and studies on drug prevalence and patterns of use. Law enforcement indicators, which quality has been largely improved by means of close collaboration between the SPJ and the NFP, show some inconsistencies with the treatment demand indicators. However, one should bear in mind that variations for instance in seizure data often rely on numerous external factors and as such are difficult to link to other more direct indicators. Also, trends provided by RELIS are confirmed by data on drug law offenders and on number of drug seizures. Quantity of drug seizures is actually the only indicator, which does not confirm data from other sources.

Although, RELIS addresses a different clientele, data from youth and school settings generally confirm trends as regards prevalence and new use patterns.

7.2 Implications for policy and interventions

Likewise other NFPs, the Luxembourgish Focal Point first of all had to prove its reliability in terms of scientific expertise and quality of produced data. This objective was difficult to reach since the attributions of the NFP are multiple, namely, the management of the national information system on drugs and drug addiction, the support of political decisions with scientific advice and the co-ordination of national research activities in the field of drugs. Policy makers, Parliament, researches and national media have witnessed an increasing demand of NFP's services. A recent example of the recognition by the policy level has been the inclusion of data produced by the NFP in the bill n°4349, which proposes the revision of the current drug law. More recently, the NFP and the AST have been charged to draw up current priorities in the field of therapeutic facilities at the national level. The referred recommendations have been included in the recent tri-annual action plan on drugs.

Very summarily and in the light of past experience, the following trends, confirmed by several data sources over the last years and reported by the NFP, has appeared to be of particular relevance to the policy level (possible reasons and hypotheses for observed trends are quoted between brackets) :

- ***increase of admission and contact rates of treatment and law enforcement agencies,***
  (overall increase of prevalence and diversification of treatment offers previously not existent, etc.)

- ***high and increasing problem drug use prevalence,***
  (increased drug availability, problematic socio-cultural integration of an increasing number of non-natives in general population, correlation with high suicide rates, etc.)

- ***high and increasing recreational drug use prevalence,***
  (high purchasing power of youngsters, banalisation of LRC drug use, development and valorisation of new (anonymous) communication technologies impairing social and human interaction competencies of youngsters, etc.)

- ***reasons and patterns of first illicit drug use,***
  (curiosity as the main reason of first drug used might be analysed in its reactional components linked to a lack of communication and social alternatives to drug use, merchandising strategies by soft alcohol producers, etc.)

- ***decrease of iv opiate use vs. increase of other administration modes,***
  (impact of infectious disease prevention campaigns, increased availability of brown heroin, new generation of increasingly younger hard drug users, etc.)

- ***socio-demographic changes in problem drug users as for instance ageing, nationality, occupational and social status,***
  (diversification of available (synthetic) drugs multiplying alternatives to iv opiate use, need of foreign workers especially in the primary sector, lack of socio-cultural integration initiatives for immigrates at the nation level, high financial support of parents to drug using children, need of further development of lodging and socio-professional reintegration programmes, etc.)

- ***spread of infectious diseases in drug population (especially HIV and HCV),***
  (regarding low HIV prevalence: high medical coverage, availability of medical services, impact of prevention campaigns / regarding increasing HCV prevalence: lack of hepatitis specific prevention measures, inconsistencies in harm reduction strategies, as for instance the free of charge distribution of syringes vs. the non distribution of absorbing filters or other injection utensils as potential infections transmitters, etc.)

- ***increase of cannabis, ecstasy and psilocybin in youngsters,***

(as regards cannabis and psilocybin use: inconsistencies between drug law and its pragmatic enforcement, lack of information of the legal status of LRC drugs, etc.)

- ***geographical spread of problem drug use towards rural settings,***
(development in drug distribution strategies, rural isolation, etc.)

- ***risk behaviour of problem and recreational drug users,***
(social components as for instance the promotion of a fast and intensive way of life by media and the devalorisation of introspective life competence, etc.)

- ***increasing prevalence and changing profiles of drug-related deaths victims***
(need of further development of harm and risk reduction measures, necessary changes in drug legislation as for instance no penalties for drug using witnesses of drug overdoses and the creation of a legal framework for substitution, maintenance and harm reduction offers as foreseen by the new drug law, development of specialised drug treatment facilities and reintegration programmes in prison settings, etc.)

7.3 Methodological limitations and data quality

Data on non-specialised treatment and counselling agencies or units are scarce since separate indexing of drug patients do generally not take place. Moreover, NFP's means to improve data management strategies within those institutions are rather limited, since the latter do not directly rely on the Ministry of Health. New conventions between drug agencies and the Ministry of Health applied since 2000 include a paragraph on mandatory data providing to the Ministry of Health. The National Drug Co-ordinator and head of NFP has largely promoted the referred change in the convention document since it allows for data quality insurance in the long run. In 1999, two further treatment agencies have joined the RELIS network. One of the latter participates in the experimental implementation of drug monitoring in low threshold settings.

A major achievement during year 1999 has to be seen in the redesign and pilot use of the drug law offenders' register held by the special drug department of the Judicial Police. The RELIS identification code is currently included in the referred registration files. Furthermore, the "Special Overdose Register" has been linked to the RELIS database in order to improve the quality of data on drug related victims. Finally, the recently achieved compatibility between the RELIS code and the General Mortality Register allows further analysis of drug-related deaths and highly contributes to validate current trends.

GP's are known to be difficult to include in any drug monitoring system. A step by step approach has allowed the NFP to involved GPs in the early warning system on synthetic drugs. The long term objective is to include GPs in the routine RELIS data network so as to improve data especially related to first drug treatment demanders. Moreover, the NFP will continue its efforts towards the inclusion of drug-related emergencies and non fatal drug overdoses in the monitoring network.

In accordance to the above referred gaps, main priorities in terms of data collection and improvement of data quality are as follows:

- *Improvement of reporting system coverage at the inter institutional level;*
- *Inclusion of general practitioners and emergency rooms in the information network (in progress – first step: involvement of GPs in the EWS);*
- *Evaluation of implemented TDI standard (in progress);*
- *Improvement of prevalence estimation data (see recent multi-method drug prevalence study due in the beginning of year 2001);*

- *General population survey on illicit drug use (no deadlines thus far);*
- *Hidden population studies;*
- *Promotion of ethnographic research;*
- *Common definition and harmonisation of drug-related concepts and methodologies;*
- *Compatibility of drug-related death registers and implementation of the DRD standard – ICD-10 (in progress);*
- *Compatibility between drug law offenders' register and the RELIS standard;*
- *Access to court data.*

PART III
DEMAND REDUCTION INTERVENTIONS

8 Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

In 1992, the Interministerial Group on drugs has commissioned a work group to draw a conceptual framework for future activities in the field of drug prevention. The work group published an expert report in October 92; (*Suchtprävention in Luxemburg : Konzeptioneller Rahmen und Praktische Vorschläge,* Luxemburg, Oktober 1992). Meanwhile, a series of recommendations of the work group, as for instance the set-up of a national drug prevention centre have been concretised.

The tri-annual drug action plan (2000-2002) includes future orientations in the field of demand reduction activities. The co-ordination of primary drug prevention interventions is co-ordinated by the Division of Preventive Medicine of the Directorate of Health in close collaboration with the CePT. Remaining drug demand reduction areas are covered by the AST, future Division of Social Medicine of the Directorate of Health.

8.2 Approaches and new developments

The current approach, as outlined in the recent drugs action plan, focus on prevention and treatment interventions best integrated in existing ***socio-cultural networks*** *in order to take advantage of* ***cross-sectorial synergies****. Objective and comprehensive information on substances are still a major part of drug prevention strategies. Currently, however, prevention messages enhance the role of other actors than the consumer him/herself in drug prevention as well* ***as existing alternatives*** *to drug use and* ***peer education****. A holistic approach addressing the general topic of addictive behaviours, not exclusively based on substance abuse has gained the attention of national drug demand reduction experts.* ***Clear definition of expected outputs, time-limited project funding rather than permanent service funding, scientific evaluation of defined objective and project execution frameworks and the promotion of continuos training*** *are some of the major elements defining the new approach towards a more effective national demand reduction strategy.*

Furthermore, a broad offer of activities for youngsters integrating drug prevention topic as one of the various components of ***Health education****, has developed. 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" combine a ***non drug-centred approach*** *with* ***intercultural components*** *in organising corporate leisure activities for youngsters from border countries.*

CePT has gained increasing expertise in the development of ***community-based prevention measures*** *in order to reach youngsters in their daily social environment. For three years, the CePT has been running a community based drug prevention programme, that involves an increasing number of council districts throughout the country. The referred programme is a good example of an decentralised health education setting that goes beyond the prevention of drug use.*

*Finally, special emphasis is put on **first childhood interventions, school-based projects, mass media campaigns** and, with respect to the important proportion of non native residents, on socio-cultural integration projects.*

Specific events during 1999

***January 99 (22)** : Second seminar on synthetic drugs organised by the CePT in collaboration with the Ministry of Youth. the Ministry of Health and the Fund Against Drug Trafficking.*

***February 99** : Inauguration of the JDH antenna in the North of the country (Ettelbrück).*

***February 99 :** Conference ' Women and drug use' organised by the CePT.*

***March 99 (26)**: Seminar on drugs held by the 'Conseil Interparlementaire Consultatif de BENELUX' (Courtrai, Belgium).*

***June 99** : Launch and press conference : National report on the situation of the drugs problem (RELIS), by the NFP.*

***June 99 (7)** : Inauguration of ABRIGADO, by CNDS.*

***June 99 (20-30)**: Trans-border adventure days – Drug prevention, organised by the Mondorf Group (Worriken, Belgium).*

.***September 99 (21)**: 60th conference SAR-LOR-LUX on Public Health.*

***October 99 (15) :** Conference on Methadone prescription organised in the framework of the 10th anniversary of the national methadone programme by JDH.*

***November 99 (24) :** Conference on SUBUTEX Ò (Buprenorphine) prescription by Schering-Plough.*

***November 99 (29) :** Inauguration of the 'Centre Emmanuel asbl' in Luxembourg City.*

***December 99** : Start of the drug prevention training programme, organised by CePT.*

9 Interventions Areas

9.1 Prevention

9.1.1 Infancy and 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 action plan, there are a series of 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 exists. Special interest is given to the role of the father in children's education since, due to professional constraints, the latter is usually bound to neglect his active involvement in the educational process.

CePT has recently launched the distribution of so called 'prevention boxes' including didactic and ludic 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 2000.

Information campaigns on drugs organised by the CePT or the Division of Preventive Medicine (Directorate of Health) generally reach parents trough different channels. National counselling centres provide information or therapeutic services to families on demand. To date, however, there exists no outreach prevention programme specifically aiming at parents, pregnant women, childbirth or young parents.

9.1.2 School programmes

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 1995, the CePT.

Drug prevention campaigns in schools are jointly organised by the Ministry of Education, the Ministry of Health, the CePT and the Foundation against Cancer.

The national Psychological Care and Educational Orientation Department (CPOS) is permanently represented in all secondary schools by at least one trained psychologist and several ad hoc teachers (27 psychologists in 22 different schools). In major schools there are trained social workers who 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 1999, CePT, has participated in a project called ' d'Schoul op der Sich' (School on quest). The project includes interested educational institutions on a voluntary basis and aims aiming at:

Primary school : initiated by the Mentor Foundation, the Ministry of Education, IFT NORD, in collaboration with the CePT, the project is meant to ensure a 'smooth' integration of primary drug prevention within primary schools. Based on general health education models, proposed interventions aim at the development of psychosocial competence and better management of daily life, conflict and stress situations.

Grammar school: implemented by CePT in collaboration with the Health Education Department of the Ministry of Education, the secondary school sub-project aims at the constitution and training of prevention groups focusing on the theme : school as a daily life and drug environment. The referred groups, composed of school directors, teachers, parents, students and prevention professionals are supposed to promote a new image of

drug prevention in school and should be able to manage drug-related incidents when occurring.

MSF (Project Youth Solidarity) is associated to the project at the level of crisis intervention. 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.

9.1.3 Youth programmes outside schools

Effective drug prevention should stick to live as it happens now and here. Prevention maybe is the most complex and at the same time the most unspecific pillar of drug demand reduction interventions since it has to analyse, to understand and to respond to the amazingly fast changes in perceptual and behavioural benchmarks of human kind and particularly in young people. Are professional prevention planners up-to-date or sufficiently informed of new elements that influence and sometimes determine the way young people behave or react? This question should worry professionals since they are well aware that drug prevention only has a chance to work if drug use is not approached as a symptom but as a observable behaviour of a human being in all its complexity. The concept of 'real time' monitoring of youth scenes, fairly close to the more established notion of Early Warning System as referred to substance use, should draw our attention. For instance, Gameboys, Play Stations, Pokémon, Warhammer, Alco-pops, Powerbelts, roller-skates, movies, teen music scenes, are to be fully integrated in the conceptual premises of drug demand reduction strategies.

Numerous youth programmes outside schools take place in community, church and youth organisations or sport-orientated clubs. The latter are, however, fairly difficult to index exhaustively.

Since its creation in 1996, the CePT, has initiated many 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:
- 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

The Mondorf Group, jointly with the CePT ad SNJ organises numerous activities based on the concept of 'adventure pedagogy'. 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 project also includes training activities for youth animators.

In the framework of the European Prevention Week on Drug Addiction, CePT has developed an interactive game kit called ‘FUNPARADE V.1.0/1998’ promoting the knowledge on ecstasy-like substances and medicaments (especially those administrated in form of pills). Following a first evaluation phase the game kit has been renamed 'Ecstasia' and applied to different youth settings and distributed and integrated in appropriate school courses (see. EDDRA).

9.1.4 Community programmes

In the beginning of 1995, a pilot project on community-based drug prevention has been launched by CePT. The main idea was to focus prevention activities on the very environment and daily life experiences of young people. Various demand reduction activities have been undertaken, either developed by CePT, SNJ and several youth centres, or initiated by the respective District Councils. *13 district councils are currently involved in the project*. In July 1995, a first project evaluation has assessed the feasibility, the required conceptual modification and the future needs regarding financial and human resources. The funding of this community project is jointly ensured by the involved district councils, the EU (Drug Prevention Programme DG-V) and CePT.

The first evaluation report edited by a specialised department (ZePF) of the University of Landau (Germany) was presented during an European Congress in March 1998

The community-based prevention network is an ongoing project. In 1999, six new council districts have joined the project. The thus achieved network will be used in the future to implement more targeted actions at the community level.

9.1.5 Telephone help lines

The first national 24 hours telephone drug help line, financially supported by the European Commission, has been inaugurated by the CePT on the 1st of October 1995. Special trained and supervised agents are providing information to drug addicts, students, parents, professionals, etc. 24/24 hours, 7 days a week. The staff includes 2 administrative agents, 2 psychologists and 1 pedagogue. In 1999, special emphasis has been laid on training, crisis intervention and collaboration with other non drug specific telephone help lines.

The CePT is part of the 'Fondation Européenne des Services d'Aide Téléphonique Drogues – FESAT'. Activitiy reports have shown that there is an increasing demand towards this specific information source. One may add that the help line team is exclusively constituted by volunteers and that at present time, calls are not free of charge.

Table 9.1.5.1 *Client core statistics from telephone drug help line (1997-99)*

CLIENTS CORE STATISTICS	**1999**	**1998**	**1997**
Number of calls:	626	717	653
Gender of callers: male	36%	50%	40%
female	64%	50%	60%
Self implied demander status:	76%	83%	75%
Involved substances for drug-related calls:			
Alcohol:	42.6%	50.5%	45%
Pharmaceutics:	29.3%	40.6%	38%
Heroin:	10.6%	10.9%	14%
Cannabis:	11.1%	9%	6.5%
Cocaine	2.7%		
Crack	0.5%		
Tobacco:		1,7%	1%
Ecstasy like:	0.5%	2.8%	0.5%
Age distribution			
≤ 15	0.5%	0.8%	0.7%
16-19	2.6%	2%	2%
20-24	4.1%	2%	5%

25-30	10.9%	7.2%	4%
31-40	26.4%	40.6%	24%
41-50	42.6%	34.8%	52%
> 50	12.9%	12.6%	4%

Source: CePT 1999

9.1.6 Mass media campaigns

In the past, a large majority of national mass media campaigns on substances' abuse have been focusing specifically on alcohol and related driving risk behaviours, initiated by the traffic security department of the Ministry of Transport, or on tobacco and health damages as well as on infectious diseases (AIDS campaigns), initiated by the Ministry of Health and by the Ministry of Family or organisations depending on those ministries. The creation in 1996 of CePT had as a result that more mass media campaigns including both, illicit and licit drugs have been conduced. Those campaigns are mostly event-related as for instance those performed during the European Prevention Week or the presentation of national reports, etc. Newspapers, radio broadcasting and public posters are the main used media supports. The production of TV or cinema spots and trailers has been rather exceptional.

To date, several media campaigns have been diffused, mainly under the responsibility of specific departments of the Ministry of Health. More targeted information campaigns on specific topics such as ecstasy or designer drugs and a recent campaign on cannabis (posters, leaflets, press articles, broadcasting, etc.) are usually designed and co-ordinated by the CePT and the SNJ, however, financially supported by the government.

In 1999, two mass media campaigns on illicit drugs have been launched by the CePT. The first has been addressing ecstasy-like substances and the second, focused on cannabis and combines traditional information providing with analysis of social perception of cannabis use within general population and professional settings by means of an exploratory study applying questionnaires, interviews and internet facilities.

The CePT is currently conceiving the first nation-wide, interactive mass media campaign on drugs and addictive behaviour. The campaign is scheduled for a three year period (2001-2003) and estimated at 300.000 Euro. The funds requested for the first phase, are provided by the Ministry of Health. Cost sharing is envisaged especially by means of cinemas' participation in the diffusion of prevention trailers.

9.1.7 Internet

The use of new information technologies as for instance Internet in the field of drug demand reduction is still fairly limited at the national level. The NFP maintains an Internet homepage since 1996, which mainly provides research and monitoring data. During the recent cannabis action-research, CePT has used the Internet as interface for information diffusion and provided an online questionnaire for the small scale population survey on cannabis. CePT plans to launch a proper home site (www.cept.lu) by the end of the year. The use of Internet by treatment institutions and law enforcement agencies aiming at the promotion, dissemination or information sharing is presently very low.

9.2 Reduction of drug-related harm

Harm reduction activities have long been - and still are under the present legal situation - developed as a necessary reaction to a rapidly increasing hard drug population in absence of any legal framework regulating their implementation. This situation should change as the

1999 Governmental declaration stresses the opportunity of the further development of harm reduction activities at the national level. As a consequence, the parliamentary bill n° 4349 of 25 August 1997, modifying the modified drug law of 17 February 1973, foresees, among other amendments, the creation of a legal framework for drug substitution treatment (including heroin prescription), needle exchange programmes and the establishment of injection rooms (shooting galleries). The referred bill has been advised by State Council and amended threefold. The vote by the parliament, however, has not yet taken place (November 2000).

9.2.1 Outreach work

In addition to the outreach work done in the framework of the above described community programme, a street-work programme for drug addicts, co-ordinated by JDH, is fully operational since 1989. The programme is currently implemented in the South of the country in a series of major cities. Special trained social workers ensure activities ranging from active contact making with high risk group and low threshold interventions, to HIV and hepatitis testing, condoms providing and advice to treatment reluctant drug users. *In 1999, the street work team has spent 186 (206) hours within local drug scenes and established about 300 contacts with non- or low-treated drug addicts. No scientific evaluation of the programme has been performed as yet. However, one notices a decrease in outreach activity since the open drug scenes in the South of the country tends to reduce in number of consumers while the open scene in Luxembourg City grows in size. In this respect, the JDH counselling centre in Luxembourg City plans to provide outreach work in the framework of their new low threshold service (Kontakt 25), inaugurated in September 2000.*

The national AIDS prevention agency (AIDSBERODUNG – Croix Rouge), established in 1988, and conventioned by the Ministry of Health, among a wide range of activities, has set up a local street-work project aiming at young people (not exclusively drug addicts). Moreover, outreach interventions aimed at prostitutes in order to establish contact and to prevent dissemination of infectious diseases have taken place.

The activities of the below mentioned ABRIGADO project, are also to be considered as being part of the outreach work sector as its low threshold service is implemented 'in the very heart' of the opiate using drug scene.

9.2.2 Low threshold services

The first low threshold service targeting problem drug users and marginalised minorities has been implemented in Luxembourg City in 1993 by the *Comité National de Défense Sociale* (CNDS)(National Committee for Social Welfare). The 'Projet Camionnette – SZENE KONTAKT' (Van project – Scene Contact) consisted in a specially equipped van placed five afternoons a week in the vicinity of Luxembourg-City's central railway station and provided individual assistance, medical care, injection equipment mainly to socially deprived drug addicts. *In the beginning of 1999, the intervention van has been replaced by a convertible container unit next the railway station, called* ***ABRIGADO****, which has the same objectives that the former Van Project.* The team is composed of the project leader and two educators assisted by several volunteers. *From 1996 to 1999, the project has been conventioned by the Ministry of Family. In 2000, the project reached a financial convention with the Ministry of Health.*

Table 9.2.2.1 *Clients core statistics from ABRIGADO – SZENE KONTAKT 1996-99*

	1996	**1997**	**1998**	***1999***
Days of presence within the scene	238	248	248	*251*

Total number of contacts		6,456	8,734	8,525	*10.,602↗*
Average number of demanding persons per day		30	35	34.4	*42,2↗*
First recourse		364	388	+/- 216	*215*
Number of new clients per day		**1.5**	**1.6**	**0.87**	***0.84***
Number of distributed syringes		22,729	46,993	42,621	*55,436↗*
Number of collected used syringes		20,.090	43,987	37,587	*48,747↗*
Return rate of used syringes		88.4%	93,6%	82.2%	*88%*
Proportion of clients aged 18 to 35 years		83.7%	77.51%	80.64%	*86.59%↗*
Proportion of women with at least 1 child				48.82%	*47.17%*
Gender distribution	male	72.16%	72.4%	71.7%	*70%*
	female	27.48%	27.6%	28.3%	*30%*
Nationality	Luxembourg	64.74%	70.68%	71.52%	*68.84%*
	other	35.26%	29.32%	29.48%	*31.16%*
Drug-related care demands		87.4%	87.14%	87.43%	*87.44%*
Proportion of prostitutes in female clients		46.70%	52.42%	50%	*50.63%*
Previous prison sentences	none	41.85%	49.79%	49.49%	*50.52%*
	1	26.39%	23.02%	22.69%	*23.61%*
	more than 1	31.75%	27.17%	27.80%	*25.87%*

Source: CNDS 1999

JDH co-ordinates a project called **'OPPEN DIR'** (OPEN DOOR) in the South of the Grand Duchy (Esch/Alzette). Demanders, mainly drug addicts, are provided with information or counselling, injection material, condoms, medical care, clothes and washing opportunities, without any administrative constraints.

Table 9.2.2.2 *Clients core statistics from 'OPPEN DIR ' JDH -ESCH/ALZETTE 1996-99*

	1996	**1997**	**1998**	***1999***
Total number of contacts	804	1,050	1,818	*1,676*
First recourse	171	113	181	*126*
Number of distributed syringes	854	1,701	3,068	*4,948↗*
Number of collected used syringes	360	990	1,400	*3,150↗*
Return rate of used syringes	42%	58%	46%	*64%↗*

Source: Fondation JDH. 1999

In the framework of the national tri-annual drug action plan, two further initiatives are to be mentioned.

The first concerns the set-up of an ***emergency centre*** *offering short term lodging and socio-medical assistance to deprived drug addicts. The project is harm- and public nuisance reduction orientated and includes law enforcement actors as to its conceptualisation. An adequate location as well as the required staff have been provided by the Ministry of Health, allowing the project to be operational in the course of 2001.*

*The second project has already been mentioned, namely the recently established (September 2000) low threshold service (**KONTAKT 25**), co-ordinated by JDH. ABRIGADO and KONTAKT 25 have to be seen as complementary offers since they address a slightly different clientele and thus increase the low threshold services' capacity in Luxembourg City, which prior to the creation of KONTAKT 25 reached its admission limits.*

9.2.3 Prevention of infectious diseases

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. *Automatic syringes dispensers and collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy. Few technical modifications as well as changes with respect to dispensers' locations have lead to a clearly increased user rate since 1994. As can be seen in table 9.2.3.a, an increase of 64,814 distributed syringes has been recorded in 1999. Return rates are also on the increase (except for automatic dispensers). The needle exchange program will reach legal status by the vote of the amended drug law.*

Table 9.2.3.1 *National needle exchange programme 1996-99*

	Distributed syringes				**Collected used syringes**			
	1996	**1997**	**1998**	**1999**	**1996**	**1997**	**1998**	**1999**
JDH, Esch s/ Alzette **- Streetwork** **- Counselling centre**	122 854	47 1,701	58 3,068	159↗ 4,948↗	360 (42%)	990 (58%)	1,400 (46%)	3.150 (64%)↗
JDH, Luxembourg	6,801	9,339	16,800	28,000↗	5,000 (74%)	6.340 (68%)	7,660 (46%) ↗	17,700 (62,5%)↗
Oppen Dir, Esch s/ Alzette (Réseau PSY)	2,829	2,263	3,849	8,772↗	1,696 (60%)	1,556 (69%)	2,439 (63%) ↗	7,479 (88%)↗
ABRIGADO SZENE-KONTAKT	22,729	46,993	42,621	55,436↗	20,090 (88%)	43,987 (94%)	37,587 (88%) ↘	48,747 (88%)↗
Automatic dispensers	42,924	24,507	43,347	55,671↗	1,500 (3,5%)	600 (2.5%)	1,800 (4%) ↗	1,300 (2%)↘
DROP-IN				21,372				20,388
TOTAL	**76,259**	**84,850**	**109,743 ↗**	**174,558 ↗**	**28,646 (38%)**	**53,473 (63%)**	**58,886 (46%) ↗**	**98,764 (57%)↗**

Source: RELIS/LINDDA

*In 1999, 106,000 condoms have been 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. Treatment of above mentioned infections is covered by the insurance scheme. Furthermore, HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison.*

*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 recently created **'Drop In'** centre for drug users and prostitutes.*

***AIDSBERODUNG** (CROIX ROUGE), is the main national counselling and prevention centre for HIV and AIDS. The proportion of iv drug users in HIV positive clients has been increasing over the last 3 years (eg.1999: 27% / 1998: 19%). In 1999, the percentage of iv users admitted in the AIDSBERODUNG proper home (supervised accommodation facility) figured 40 per cent.*

ABRIGADO *also provides injection equipment, condoms and advice on drug consume and safer sex*.

9.3 Treatments

9.3.1 Treatment and health care at national level

A vast majority of drug treatment infrastructures, general hospitals excluded, are relying on governmental support and control. Either they are governmental departments or they have signed a ministerial convention, which guarantees their annual funding. Over the last years, one has observed a tendency towards the legal restructuration of a series of state health- and drug care institutions into foundations, providing a more flexible management framework. NGOs involved in drug treatment fall under the obligation of the so-called 'ASFT' law (8 /10 /98) and the subsequent Grand Ducal decree of 18 December 1998 , 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 listed institutions work in close collaboration and have to be viewed as an interdependent therapeutic chain even though there are no formal agreements between them.

Law regulates continuous training to be provided to conventioned institutions. Each staff member has the right to participated in training sessions 5 days a year or 15 days over a 3-year period. The content of the training programme, often suggested by the concerned staff members themselves, has to be approved by the respective management committee.

With regard to evaluation procedures, one might stress that the methadone programme is evaluated on basis of a specially design software. Conventioned drug agencies are evaluated by means of the RELIS/LINDDA system.

No compulsory treatment measures do exist at the national level. However, the public prosecutor can instruct 'Injonction therapeutic' which gives the convicted person the right to choose between imprisonment or treatment. Those demands are treated by a specialised department of the Directorate of Health, namely the "Service Multidisciplinaire de Lutte contre la Drogue".

Figure 9.3.1.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 1999. Low threshold, harm reduction and drug substitution facilities are listed in respective sub-chapters

Table 9.3.1.1 *Clients admission statistics of drug treatment institutions (1994-1999)*

INSTITUTION	NUMBER OF ADMISSIONS (A) AND/ OR CONSULTATIONS (C) AND/OR CONTACTS (CO)						NUMBER OF TREATMENT DEMANDERS (multiple counts excluded)					
	1994	1995	1996	997	1998	1999	1994	1995	1996	1997	1998	1999
INPATIENT DETOXIFICATION												
CHNP-BU - V	249 A	277A	251 A	226 A	251A	272 C	148	166	157	150	158	179
CHL							≈ 70	80	≈ 70	50	≈ 50	≈ 50
HVEA							≈ 90	107	37	37	28	58
CLINIQUE ST. LOUIS							n.a.	n.a.	13	15	15	15

OUTPATIENT TREATMENT												
JDH LUXEMBOURG **JDH ESCH / ALZETTE** **JDH ETTELBRÜCK**	1,662 C 754 C	1,523 C 1,120 C	1,086 C 949 C	773 C 883 C	829 C 974 C	961 C 1,009 C 32 C	284 130	339 178	308 175	244 166	270 209	299 213 24
MSF-SOLIDARITE-JEUNES										27	46	99
CENTRE EMMANUEL	2C	4C	7 C	17 C	15 C	34 C	2	4	7	15	10	21
INPATIENT TREATMENT												
CT MANTERNACH	48 A	48 A	58A	62 A	39 A	47 A	48	44	55	55	56	59
WEESSEKAR							n.a.	n.a.	n.a.	n.a	n.a.	n.a.
DRUG TREATMENT ABROAD							≈ 50	81	55	57	71	91

Detoxification inpatient institution

Physical drug detoxification is provided by four different hospitals via their respective psychiatric units. The most important detoxification unit is implemented within a specialised department of the CHNP (foundation) formerly known as the state's neuro-psychiatric hospital (HNPE BU-5). Medical interventions and psycho-social support are provided to control and facilitate withdrawal symptoms in the framework of a 1-2 week detoxification programme. Ideally, detoxificated patients are referred to other more therapeutic oriented institutions. The other three detoxification services are provided by psychiatric units within 3 general hospitals: Clinique St. Louis – Ettelbrück (North) / Hôpital de la Ville d'Esch-sur-Alzette - HVEA (South) / Centre Hospitalier de Luxembourg - CHL (Centre). The interventions of the latter are basically limited to physical detoxification.

Centre Hospitalier Neuropsychiatrique (CHNP) - Section BU-5 (North)

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

Table 9.3.1.2 *Clients core statistics BU-V CHNP 1997-99*

		1997	**1998**	**1999**
Number of admissions		226	251 ↗	272 ↗
Number of first admissions			70	62↘
Number of patients *(multiple counts excluded)*			158	155
Gender distribution	male	72%	80,5%	70↘
	female	28%	19,5%	30
Age distribution	< 15	1%	0.20%	0%
1997: m=28 Y 2 M	15-19	1%	4.80%	8%
1998: m=28 Y 1 M	20-24	31%	24%	23%
1999: m=27 Y 5 M↘	25-29	25%	32%	32%
	30-34	26%	21%	25%
	35-39	13%	16%	9%

	≥ 40	3%	2%	3%
Duration of treatment	Mean	13.47 days	14,37 days	2.83 days↘
	Minimum	1 day	1 day	1 day
	Maximum	88 days	71 days	63 days
	Standard deviation	11.85 days	11.99 days	10.15 days
Post detoxification referral	Home or family	42%	23%	25%
	Return to drug scene	29%	46%	31%
	Return to drug scene or home			20%
	Inpatient therapeutic treatment	11%	12%	9%
	Treatment abroad	10%	10%	6%
	Institution / 'Foyer'	5%	3%	4%
	Transfer intra-CHNP	2%	1%	2%
	Other	1%	5%	3%

Source: CHNP - RELIS 1999

Outpatient treatment

The most relevant national outpatient treatment facility is the 'JDH Foundation' offering long and short term therapies, counselling, crisis intervention, street-work, social assistance, methadone dispensing and further therapeutic referral. Regional antenna of JDH are respectively implemented in Luxembourg City, in the South and in the North of the Grand Duchy and are entirely funded by the Ministry of Health. 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 Drogenhëllef Foundation. (JDH) Luxembourg

Prevention, counselling and orientation
Therapeutic interventions
Methadone programme
Needle exchange
Social assistance
On-site counselling (Hospitals and prison)
Preparation to residential care and post cure facilities
Team: 6 staff members

Table 9.3.1.3.a *Clients core statistics - JDH Luxembourg-City 1997-99*

		1997	1998	1999
Number of treatment demanders		244	270	299 ↗
Number of first demanders		120	130	180 ↗
Gender distribution	male	68%	70%	70%
	female	32%	30%	30%
Number of counselling sessions	individual	534	654	628
	couple / family	167	175	241↗
External counselling sessions (Prison / hospitals)		72	77	92
Age distribution	< 20	4%	10%	11%
	20-24	21%	20.5%	24.5%↗
	25-29	25%	23.5%	23%
	30-34	23%	22%	17.5%↘
	35-39	14%	9%	8.5%↘
	≥ 40	12%	13.5%	13%

	age unknown	1%	1.5%	2.5%
Demand motive	opiate abuse / multiple use	72%	71%	69%
	drug addiction of relative	13%	12%	10.5%
	psychosocial or psychiatric problems	7%	9%	9%
	after care	2%	2%	1.5%
	alcohol abuse	2%	0.5%	0,5%
	cannabis	1%	3,5%	3.5%
	amphetamines/cocaine/LSD/ecstasy	1%		2.5% ↗
	general information request	1%	0.5	0.5%
	other (Medicaments, bulimia, etc.)	1%	1.5	3%

Source: Fondation JDH. 1999

Table 9.3.1.3.b *Intervention in prisons JDH Luxembourg-City 1998 - 99*

		1998	1999
Number of clients (prisoners)		43	61
Number of counselling sessions		260	401
Proportion of clients showing no previous contact with JDH		63%	36%
Gender distribution	male	17%	8%
	female	83%	92%
Age distribution	15-19		3%
	20-24	28%	14%
	25-29	35%	52%
	> 30	37%	31%
Main substance involved	heroin	44%	31%
	multiple use	42%	44%
	cocaine and heroin	5%	18%
	other	9%	7%

Source: Fondation JDH 1999

Jugend- and Drogenhëllef Foundation (JDH) Esch-sur-Alzette

Prevention, counselling and orientation
Therapeutic interventions
Methadone programme
Needle exchange
Social assistance
On-site counselling (Hospitals and prison)
Preparation to residential care and post cure facilities
Street work / Outreach
Open Door
Team: 5 staff members

Table 9.3.1.4 *Clients core statistics JDH Esch-sur-Alzette 1997-99*

		1997	1998	1999
Number of treatment demanders		166	183	169

Number of first treatment demanders ***Number of clients not previously admitted by another JDH regional service***		59 (36%)	64(35%) *48 (75%)*	54(32%) *24 (78%)*
Gender distribution	male female	62% 38%	62% 38%	57% 43%↗
Number of counselling sessions (individual and family)		883	974	965
Number of external counselling sessions		173	245	148↘
Age distribution	< 20 20-30 >30	6% 48% 46%	7% 43% 50%	5% 46% 49%

Source: Fondation JDH 1999

Jugend- and Drogenhëllef Foundation (JDH) ETTELBRÜCK

Prevention, counselling and orientation
Therapeutic interventions
Needle exchange
Social assistance
On-site counselling (Hospitals and prison)
Preparation to residential care and post cure facilities
Team: 2 staff members

Table 9.3.1.5 *Clients statistics JDH Ettelbrück 1999*

	1999
Number of demanders	24
Number of counselling sessions (individual / family)	32

Source: Fondation JDH 1999

Médecins Sans Frontières (MSF)-Solidarité Jeunes *(Addressing minors presenting drug-related problems)*

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

Table 9.3.1.6 *Clients core statistics MSF SOLIDARITE-JEUNES 1997 - 99*

		1997	**1998**	**1999**
Number of clients		27	46	99
Number of first clients		n.a.	35	70
Gender distribution	female male	26% 74%	28% 72%	26.3% 73.7%
Age distribution	< 15 15-18 > 18	7% 82% 11%	11% 81% 8%	16.1% 73.8% 10.1%
Main substance involved	Cannabis Heroin Solvents Ecstasy Cocaine LSD other	45% 33% 7% 4% 4% 7%	49% 22% 11% 12% 3% 3%	65.7% 21.2% 5.1% 3% 1% 1% 3%

Source: Solidarité Jeunes (MSF). 1999

The 'Centre Emmanuel association' *is subsidised by the Ministry of Health and may reach a convention in 2001. The team,* composed of former drug addicts, one psychologist and one pedagogue offers former drug addicts and addicts' parents the opportunity to meet on a regular basis. The centre is the national interface for the Italian treatment communities 'Communita Emmanuel'. 21 admissions have been recorded in 1999.

Inpatient treatment

Centre Thérapeutique de Manternach (East)

Two therapeutic communities currently exist in the Grand Duchy. The first called "WEESSEKAER" is situated in the North of the country and basically offers to addicted, alcoholic and socially distressed people the opportunity to live in a secured environment. The therapeutic community 'Syrdallschlass' (CTM), part of the CHNP, is situated in the East of the G. D. of Luxembourg in a fairly rural setting. The therapeutic programme of the CTM is divided in three progressive phases that have been revised during 1997: 1. Motivation (2 months), 2. Development (4-7 months), 3. Release (2-3 months). Individual treatment programmes are agreed with concerned persons during the first two months. Constraints, responsibilities and priorities are defined for each phase. 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. 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.

Staff members: 12

- psychologist / therapist
- sport therapist
- social worker
- educators
- psychiatric nurses
- nurses
- carpenter
- worker

Therapeutic offer:

- individual therapies
- family-orientated therapies
- theme related talking groups
- gender specific groups
- work based therapy
- sport therapy
- professional training
- preparation to post-cure facilities
- corporal therapy and relaxation
- leisure activities
- puppet theatre

Table 9.3.1.7 *Clients core statistics Centre Thérapeutique de Manternach - Syrdallschlass (1997-99)*

		1997	1998	1999
Total number of patients (new patients and patients from previous year still in treatment)		55	55	59

Number of admissions (during 1999)			39	47
Number of admitted patients (during 1999)		36	37	40
Average monthly occupation (patients)				20,1
Provided therapy days		6,580	8,101	7,348
Gender distribution	male	82%	87.5%	77.9%
	female	18%	12.5%	22.1%↗
Age distribution	< 20	6.5%	7.2%	3.4%↘
	20-25	43.5%	35.7%	32.2%↘
	26-30	25.8%	23.2%	25.4%
	> 30	24.2%	33.9%	39%↗
Nationality	Luxembourg	69.4%	66%	64.4%↘
	Portugal	9.7%	12.4%	18.6%↗
	Italy	6.5%	8.9%	6.8%
	Spain		3.6%	3.4%
	Germany	4.8%		1.7%
	France	4.8%	1.8%	1.7%
	Belgium	1.6%	1.8%	1.7%
	Ex-Yugoslavia	1.6%	1.8%	
	Morocco		1.8%	
	Stateless	1.6%	1.9%	1.7%
Civil status	bachelor	82.3%	85.7%	81.3%
	married	1.6%	3.6%	8.5%↗
	separated	3.2%	1.9%	3.4%
	divorced	12.9%	8.8%	6.8%↘

Source: CTM. 1999

"Weessekaer" (Foundation: Maison de la porte ouverte) (North)

Community for drug addicts, alcoholics and socially distressed people
Social assistance
Team: 2 psychologists

Drug treatment abroad covered by health insurance scheme

Table 9.3.1.8 *Drug treatment abroad covered by health insurance scheme*

YEAR OF BIRTH	TOTAL (1996)	TOTAL (1997)	TOTAL (1998)	TOTAL (1999)	*MEN (1999)*		*WOMEN (1999)*	
	N	N	N	N	*N*	*%*	*N*	*%*
1935-1939			1	1	*0*	*0*	*1*	*100*
1940-1944			5	2	*0*	*0*	*2*	*100*
1945-1949			3	3	*2*	*66.66*	*1*	*33.33*
1950-1954	1	1	2	0	*0*	*0*	*0*	*0*
1955-1959	3	3	4	4	*4*	*100*	*0*	*0*
1960-1964	3	3	13	9	*9*	*100*	*0*	*0*
1965-1969	13	13	9	19	*13*	*69,42*	*6*	*31,58*
1970-1974	19	20	18	21	*17*	*80,95*	*4*	*19,05*
1975-1979	16	17	12	22	*19*	*86,36*	*3*	*13,64*
1980-1984			4	10	*2*	*20*	*8*	*80*
TOTAL	**55**	**57**	**71**	**91**	***66***	***72,53***	***25***	***27,47***

Source : Administration du Contrôle Médical : Cures de désintoxication (drogues dures et polytoxicomanie) à l'étranger - Exercices 1996/99.

9.3.2 Substitution and maintenance programmes

The currently existing **oral administration methadone programme** has been set up in 1989 under the co-ordination of the Ministry of Health and JDH. Initially, the programme targeted Luxembourg City and immediate surroundings. Since 1994, efforts have been made

towards its progressive regionalisation. *In addition to the official national methadone programme exists a so-called 'unofficial substitution programme', which refers to GPs prescribing* ***MEPHENONÓ*** *(Methadone in pill form also prescribed in pain therapy). It appears to be difficult to assess the number of patients under regular MEPHENONÓ prescription. Recent estimations refer to 300 - 400 patients.*

To date there exists no ***legal framework*** *regulating drug substitution treatment. However, the yet to be voted bill (n°4349) that proposes a revision of the modified drug law of 19 February 1973, introduced by the Parliament on 25 August 1997, precisely foresees a legal framework for substitution and maintenance programmes including medically controlled heroin prescription by means of the future extension of the list of medically prescribed drugs in the framework of drug substitution treatment. Attention has to be paid to the fact that at present state, the new law intends to regulate drug substitution treatment in general rather than the legalisation of a single national substitution programme. The law may do so by means of substitution treatment licenses granted to GPs and adequate control mechanisms on multiple prescriptions (e.g. centralised register of substituted patients). In this respect, it has been brought to the attention of the NFP that diverted MEPHENON © is increasingly available on the national black market.*

In 1997, the Minister of Health commissioned an expert group to assess the opportunity and feasibility of a national medically controlled ***heroin distribution programme****. In 1998, the group published an expert report and approved the set up of a low scale heroin distribution project in Luxembourg City. In 2000, experts from the Ministry of Health and the JDH have been commissioned to work out an operational concept paper on the implementation of a heroin distribution pilot project. The tri-annual drugs plan foresees its implementation in the course of 2002.*

Methadone, and Buprenorphine are prescribed as part of a long-term treatment with an abstinence **goal**. There are, however, some cases for which substitution treatment has to be considered rather as a harm reduction or maintenance intervention than a abstinence oriented therapeutic action.

Moreover, the internal rules and the evaluation process have been adapted in the light of past experiences.

programme contract between JDH and the treatment demander,
random urine tests,
selling or distribution of the prescribed doses to third parties is endorsed by prescription stop,
more flexibility in the distribution time schedule,
establishment of regional distribution points,
parallel consume of alcohol or other non prescribed drugs is not allowed,
oral ingestion of liquid methadone in presence of a team member or the delivering person
stabilised patients are allowed under certain conditions to receive 'carry-doses' for the weekend,
patient who can not come to one of the distribution points due to illness for instance (medical attestation required) must delegate a person of their choice who collects the daily doses,
weekly medical visit,
a first evaluation occurs after an adaptation phase of 4 month. After 4 months of negative urine tests, the patient enters in phase 1. (presentation at the centre every second day, medical visit only in two weeks interval), after another 4 month of positive evaluation the patient enters phase 2. (presentation at the centre twice a week and medical visit once in a month).

The so called '**Methadone Commission',** established by ministerial decree and composed of delegates from the programme, the Directorate of Health, the AST, two pharmacists and two GPs affiliated to the programme, is in charge of admissions, releases and exclusions of substitution treatment demanders or patients. In the course of 1998 the revised **admission criteria** for the national methadone programme, introduced by the JDH in1997, have been effectively applied. The following modifications have to be stressed:

age > 18 years,
resident of the Grand Duchy of Luxembourg,
confirmed dependency (DSM IV, urine test),
several unsuccessful detoxification attempts
priority admission for pregnant women and persons who are HIV positive
possible programme inclusion of prisoners two months before their release from prison.

Until 1999, the official methadone substitution programme has only been delivering liquid oral methadone. Buprenorphine (SUBUTEX®) has been included in the **prescription list** in the beginning of 2000. Discussions are currently held on the inclusion of other substances, namely LAAM, naltrexone-antagoniste, etc. Those substances have been evaluated by the programme managers regarding their potential use and indications. The decision to include further substances in the substitution list will depend on the outcome of the above referred bill n°4349. The Methadone Commission is charged to evaluate and advice the inclusion of new substances in the official programme.

In addition to the drug prescription and medical care, the methadone programme provides a wide range of psycho-social **counselling facilities**:

counselling and support,
Information and orientation,
social assistance,
job finding activities,
accommodation finding activities,
cloth providing,
discussion groups,
self confidence and physical expression groups,
short, medium and long term therapies.
gender specific and pregnancy counselling

The national drug substitution programme had a total capacity of 30 places in 1993, 50 places were financed in 1994; in 1996 there have been 100 places and 158 places in 1997. *In year 1998 and 1999, 186 and 164 patients respectively have been admitted in the official methadone programme. A temporary stagnation of the number of treatment demanders is observed. The in- and outflow seem to mutually annul their respective effects.*

Table 9.3.2.1 *Clients Statistics: National Drug Substitution Programme (JDH) – 1997-99*

		1997	**1998**	**1999**
Number of clients		158	186	164
Gender distribution	male	68%	70.5%	64%
	female	32%	29.5%	36%
Nationality	Luxembourg	73%	74%	76%↗
	Portugal	13%	13%	13%
	Italy	6%	5%	5%
	France	4%	3%	2%
	Belgium	1%	1.5%	1%
	Cap-Verde	1%	1.5%	2%
	Spain	1%	1%	0.5%
	Germany		1%	0.5%

	Ex-Yugoslavia	1%		
Age distribution	< 20	n.a.	0.5%	
	20-24	n.a.	10.5%	11%
	25-29	n.a.	29%	25.5%
	30-34	n.a.	33%	32%
	35-39	n.a.	18%	20.5%
	≥ 40	n.a.	9%	11%
Duration of drug dependency	< 3 years	1%	2%	2%
	3-5 years	16%	16%	17%
	6-10 years	42%	46%	45%
	11-15 years	28%	24%	24%
	>15 years	13%	12%	12%
Geographical distribution	South	47%	44.5%	48%
	Luxembourg City	30%	29%	24%
	(surroundings)	16%	22%	23%
	North	6%	4%	5%
	East	1%	0.5%	
	West			
Motives of treatment release	Abandonment	n.a.	54%	62.5%↗
	End of agreed treatment period	n.a.	22%	16%
	Referral to residential	n.a.	15%	9%
	treatment	n.a.	3.5%	7%
	Prison	n.a.	3.5%	
	Death	n.a.	2%	5.5%
	Exclusion			

Source: Fondation JDH 1999

A first scientific **evaluation** of the methadone programme occurred in 1995. In 1998, a 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/LINDDA database. This software is currently in its testing phase.

The number of drug-related deaths is not positively 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 individual careers (health and law enforcement institutions) and for instance enables the NFP to assess the impact of substitution treatment. The first evaluation study is foreseen for 2001.

9.4 After-care and re-integration

Prior to the tri-annual (2000-2002) drugs action plan, there has been no official or centralised socio-professional reintegration programme for drug addicts at the national level. Drug agencies have been developing proper initiatives based on the existing network. Socio-professional integration measures are part of conventioned drug agencies' missions as laid down by the convention text. As such, those activities are supervised by the Ministry of Health.

The drugs action plan has introduced the dimension of co-ordinated synergies in the field of housing, training and other socio-professional reintegration measures. JDH has been

allocated the necessary funds and human resources to set-up a ***housing project*** *aiming at problem drug users. The first phase of the project (5-10 accommodation facilities) has started in September 2000. According to the drugs action plan, the National Drug Co-ordinator in collaboration with JDH has been commissioned to work out the conceptual framework for a nation wide housing network. The concept has been presented to the Minister of Health in November 2000. The implementation of the project is scheduled for 2001.*

Professional training *is provided only by inpatient drug agencies. Bilateral agreements between potential employers and drug agencies exist at each treatment level, although there is no structured strategy. The Mondorf Group, is currently working out a proposal for a interregional training and* ***job opportunity network*** *for former or current drug addicts. The project is meant to take advantage of socio-economic differences of border regions between Luxembourg, Germany, France and Belgium.*

In 1995, a national **after care centre**, jointly co-ordinated by the JDH and the CTM and supervised by the Ministry of Health has been created. The population is mainly composed by patients who have terminated the therapeutic programme at CTM. The centre has a maximum capacity of 6 residents who are offered the possibility to stay and to profit from minimum psychological framing for 6 to 12 months. A weekly discussion group is organised between the residents and members of the CTM and JDH. Most of the residents have a professional occupation at this stage. Thus, the after care centre represents the last level of a long term rehabilitation process that in certain cases ranges from emergency detoxification to socio-professional reintegration, although other treatment sequences or pattern are frequently observed. Average occupation rate during 1999: 5-8 persons. *The after care centre will be an integral part of the socio-professional reintegration strategy yet to be implemented*

9.5 Specific targets and settings

Gender – Specific Issues

Very few research or interventions specifically aimed at women and/or children have been undertaken thus far. RELIS/LINDDA figures have witnessed a fairly stable sex ratio applied to drug users. From 1994 to 1999 the rate of indexed female problem drug users varied between 19 and 23 per cent. The yet to be finalised comparative study on drug-related deaths (Origer and Dellucci, in press) will focus on gender specific users' profiles since first results have shown significant differences between male and female drug users. Statistically speaking, female opiate users for instance, show a significantly higher risk of drug-related death after their first contact with law enforcement agencies, compared to male opiate users.

In February 99, the CePT organised the first national Conference on Women and Drug Addiction.

As far as treatment facilities are concerned, the CTM offers a range of gender specific facilities and interventions. Currently there exist a range of counselling and shelter facilities for women (e.g. Drop In for prostitutes, homes for women in difficulties) and children. Most of the latter facilities have, however, not specifically been designed for drug users.

The drugs action plan, largely based on RELIS monitoring data in this respect, stressed the necessity of therapeutic and rehabilitation units exclusively reserved to drug addicted women, pregnant women, couples and their children. The specific units will be geographically and logistically attached to the CTM, which will allow for resources and infrastructure sharing. The first projet proposal has not reached the requested funds. A second proposal will be finalised by the end of 2000 and introduced to the Fund Against Drug Trafficking in the course of 2001.

Children of drug users

No specialised care facilities for the referred target group do currently exist.

Parents of drug users

The anonymous drug addicts' parents group (Elternkreis Drogenhilfe Anonym E.D.A.) is a long established self help group. This group includes exclusively parents of former or current drug addicts and give the former the possibility to share personal experiences, to provide mutual advice and to organise different kinds of activities mainly in the field of drug prevention.

The 'Centre Emmanuel association.' which staff is composed of two former drug addicts and specialised staff, 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 'Communita Emmanuel' and acts as an intermediary between parents and their children during the treatment phase

Drugs at the workplace

Some local projects or interventions including alcohol and illicit drug use have been initiated by the CePT. There exists no national wide programme or even merely a co-ordinated action plan.

In May 1998, the Ministry of Health published the results of the study '*Alcohol and Drugs at the workplace – Attitudes, policies and programmes in Luxembourg*'. Summarily the following statements can be retained:

The legislation ruling the use of alcohol at the workplace is very limited and obsolete (grand-ducal decree of 28.08.1924). Concerning health and security at work, two laws based on the directive 89/391 have been adopted in 1994 (Laws of 17 June 1994). These two laws do not specify any rules on the use of illicit drugs at the workplace. The employer is held responsible for health and security of his workers in all aspects of the workplace. Thus, each employer is free to implement the policy on alcohol and drugs, he deems adequate.

The drug problem is frequently regulated by internal rules of the company. Major companies do address the drugs and alcohol problem by means of their proper occupational health departments or their employers' and workers' organisations. The occupational health service of the iron and steel industry (about 6,000 workers) reported only a few problematic drug consumers within their companies. The health department of the chemical industry (1,300 workers) have registered 3 cases of drug addiction within a 2-year period.

Indeed, unlike alcohol consume, the use of illicit drugs is generally said to be unknown to most enterprises. Many companies keep silence on their experience with illicit drugs and employers are fairly reluctant to report on the few cases they have experienced in order not to spoil the image of their enterprise.

In the framework of the activities co-ordinated by the Mondorf Group, an agreement has recently been signed regarding the participation in a interregional drug and alcohol prevention programme at the workplace. The project should have been financed by the EU programme : Safety and Health Protection at the workplace (VP/1999/010) and co-ordinated by the 'Landes Arbeitsgemeinschaft für Gesundheitsföderung - Saarland' (Germany) (LAGS). The main objective of the project aims at the conception and implementation of short training and prevention modules within different work settings. The project has been postponed since it has not been granted by the EU.

Ethnic minorities

Between 1995 and 1997, up to 50% of foreign drug treatment demanders indexed by specialised treatment institutions in Luxembourg were of Portuguese origin. The same ethnic group is also over-represented within the drug-related death register. These observations have led the EMCDDA focal point of Luxembourg to commission a study on three sub-populations: native drug treatment demanders, Portuguese drug treatment demanders living in Luxembourg and finally a sample of Portuguese drug addicts treated in Portugal. The comparison of core socio-demographic data has revealed important differences between the selected samples. Portuguese drug addicts treated in Luxembourg appear to be very low aged (M=25 years, 9 months) and show a noticeably lower educational level than the other studied samples. Regarding substance-related data, it should be stressed that 98% of Portuguese native addicts consume opiates as a primary drug, compared with 82% for the Portuguese addicts treated in Luxembourg. 75% are IVDU's whereas only 51.5% of Portuguese native addicts were injecting their primary drug at the moment of data collection. The Portuguese addicts resident in Luxembourg present the lowest needle sharing rate (32%) whilst 21.9% of the Portuguese native drug treatment demanders are HIV positive compared with 4 % for both of the other populations.

The referred study has to be seen as a strategic step towards the development of a more ethno-specific drug prevention and care approach. Recent monitoring figures confirm the still increasing number of Portuguese citizens in both, drug-related death cases and the problem drug user population. Meanwhile, drug agencies have been urged to take the necessary steps to include Portuguese speaking members in there work team. Furthermore, the CePT is working on solutions for better integration of ethno-specific approaches within the national drug prevention strategy.

Self-help groups

The users self help group '*Junklife asbl*' has been created in 1996 following the joint initiative of the Ministry of Health and former drug addicts. The major objective of *Junklife* is to offer a mutual support to ex or current drug addicts and to promote the right of drug addicted people.

'Narcotiques anonymes' as the national branch of the internationally known network, organises group meetings for addicted people in a larger sense.

Alternatives to prison

Alternative measures to criminal proceedings by the Prosecuting authority (art. 23/1973)

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

- *to close the case without proceedings with a caution (e.g. in case the recorded drug user has been admitted to detoxification treatment prior to the drug use offence record),*
- *to propose to a recorded drug user to undergo detoxification treatment on a voluntary basis. If treatment is successfully completed (report from the Health Service), the case will be closed without proceedings (if not completed, the offender is prosecuted).*

Alternatives to sentence by Court (art. 24 / 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 from the Multidisciplinary Committee), the case will be closed without proceedings (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. The "Multidisciplinary Committee" has been set up by law within the Ministry of Health and commissioned to co-ordinate and control ordered and proposed alternative treatment measures and report to the 'Parquet'.*

- *decide to postpone the sentencing (sentence suspension) for an determinate length of time, but he 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 3 types of postponements: simple postponement, postponement accompanied by probation, postponement accompanied by therapy*

  A custodial sentence may be suspended (totally or partially), under the monitoring of the 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 by a requirement to perform community work. The legal term for community work is Work of General Interest (TIG). The TIG sentence, introduced by the law of 26 July 1986 on sentence suspension and probation, usually applies to 3 different scenarios:

1. Main sentence; 2. Assigned reprieve; 3. If sentence is less than 6 months imprisonment

The 'suspension du prononcé' may be applied once a person has been found guilty but before he/she actually 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.

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.

10 Quality Assurance

10.1 Quality assurance procedures

One should bear in mind that funding of drug demand reduction activities is centralised at state level. Respective ministries or governmental departments, according to their

attributions, are co-ordinating the creation, the funding, the implementation and the quality control of respective services. NGOs involved in drug prevention, treatment or research activities have either signed an agreement called 'convention de collaboration' with one or more concerned ministries or are financed on basis of regular subventions.

Prior to 1998, the convention between the ministries and NGOs entitles the former to control the functioning, applied methodologies and the financial management of each NGOs via a governmental delegate within a management committee.

The previously referred to law 'ASFT' of 8 October 1998 regulates the relation between State and NGOs or organisations providing psycho-medico-social and therapeutic care. The subsequent Grand Ducal decree of 18 December 1998, introduced the obligation for respective organisation to obtain a governmental quality standard certification, which entitles them to provided socio-medical and therapeutic offers following standardised quality requirements. 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, be they of administrative or conceptual nature have to be approved by the ministerial representative. Quality control thus occurs by means of the ' collaboration convention', the quality standard certification, on-the-spot controls and the ministerial delegate within the management platform. Applied quality standards include minimal requirements in terms of infrastructure, security management, admission policy, composition and training of staff, as well as applied therapeutic methodologies..

10.2 Treatment and prevention evaluation

To date, no common standards for evaluation of prevention or treatment activities exist at a centralised level. Thus, funding is not directly related to clearly defined evaluation requirements The quality standard certification encourages respective NGOs to undertake necessary evaluation measures of their activities by all means they deem adequate.

Since the creation of the CePT, evaluation methodologies have been increasingly developed in collaboration with the NFP. Evaluation of prevention activities are developed by CePT by means of a multidisciplinary network including independent, mostly foreign, research institutes, which participate in the evaluation of prevention and research activities. CePT is the only national agencies providing basic training in evaluation methodologies.

EDDRA has largely contributed to the promotion of a more scientific orientated evaluation approach at the national level. As previously referred to, 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. A practical example of this recent development is the evaluation of activities ensured during the European Drug Prevention Week and their subsequent inclusion into the national EDDRA database

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 an computer based evaluation procedure by the national methadone programme as well as the development of the RELIS/LINDDA monitoring system towards its use as an evaluation tool.

The RELIS/LINDDA 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 to follow 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.

10.3 Research

Co-ordination *of drug demand reduction research has been largely promoted since the set-up of the NFP and the CePT. The NFP is in charge of the overall co-ordination of drug research activities at the national level, by means of an updated inventory and bilateral contacts with national research actors be they of logistic, financial or conceptual nature.*

Drug demand reduction research areas covered by NFP refer to prevalence estimates, monitoring methodologies cost/effectiveness of demand reduction activities, epidemiological monitoring as a tool for evaluation purposes, ethnic minorities and drug treatment by non-specialised health care networks.

CePT is mostly involved in drug demand reduction research ranging from community-based action-research, prevalence and consume patterns in general population to evaluation and training interventions. Most of referred research activities are jointly developed with the NFP and the Division for Preventive Medicine of the Directorate of Health.

The 'Institut des Etudes Educatives et Sociales' (IEES) and the ' Centre d'Etudes de Population, de Pauvreté et de Politiques Socio-Économiques (CEPS)' are involved in research activities focusing on school population.

Public research centres (CRP – Gabriel Lippmann, CRP-Santé and CRP-Henri Tudor), created following the law of 9 March 1987, are active in bio-medical and technological research areas applied to drug topics.

The majority of drug demand reduction research rely on public ***funding****. ' Conventioned' drug agencies (e.g. CePT) receive a global funding which is partly allocated to research activities as foreseen by mission statements of respective agencies. The same comment applies to the funding of the NFP.*

The Fund Against Drug Trafficking, established in 1992 following the recommendations of the UN Convention of 1988 may be considered as the major fund provider for drug-related prevention and research activities. The Fund manages assets and capitals confiscated in the framework of drug law offences and co-ordinates, among other tasks, the allocation of respective financial resources to selected drug-related prevention or research projects. Prior to funding decisions made by the Fund, competent ministries are requested to advice respective projects and justify the need for complementary funding. Other private funds are solicited but to a much lesser extend than the Fund Against Drug Trafficking.

More recently, the law of 31 May 1999, established the ' Fonds national de la recherche dans le secteur public' (National Public Research Fund), under the tutelage of the Ministry of Culture, Education and Research. Beneficiaries of the Fund are: Public research Centres, foundations and CEPS.

The Public Research Fund relies on following revenues :

- *annual allocations from state budget,*

- *service providing related revenues,*
- *donations and legacy*
- *interest and investment revenues*

The Ministry of Culture, Education and Research runs the Department for Scientific and Applied Research in charge of the co-ordination and allocation of research grants to independent researchers or research trainees. Drug-related topics fall under its selection criteria as witnessed by the recent co-funding of the research (NFP) on socio-economic cost of drug addiction and the fight against drugs.

***Training** in drug demand reduction research activities is poorly developed at the national level. The CePT offer limited training activities in the referred field and the Department for Scientific and Applied Research may grant training activities following request. Most of national researchers have been trained abroad whether in academic settings or in the framework of continuos training programs.*

10.4 Training for professionals

At the national level, specialised training facilities in the field of drugs and drug addiction are very limited. Even though there is a well-developed national education and training network for nurses, educators and social workers, there is an obvious lack of specific drug training courses. The present situation is partly due to the fact that Luxembourg has no proper University. The 'Cours Universitaire de Luxembourg' offers a limited range of first cycle university courses, which do, however, not address the drug topic. Although there are several national training facilities, people interested in mid or long term specialised drug-related training activities have often no other choice than to follow courses abroad (mainly Germany, France and Belgium). The right of continuous training for people working in the drug sector is guaranteed by law. Usually drug workers contact training institutes in border countries or attend training seminars organised by foreign experts.

*The situation, however, has fairly changed since the set-up of the CePT. The latter provides training targeted at **drug prevention and public health actors, educators, youth animators and teachers** in the fields of primary prevention, intervention methodologies and evaluation strategies.*

A series of training activities have been organised in collaboration with the programme: 'Recherche et Innovation Pédagogiques et Technologiques (SCRIPT)' and the 'Institut Supérieur d'Etudes et de Recherches Pédagogiques – ISERP' which are both relying on the Ministry of Education and Professional Training.

As regards ad-hoc continuous training of national field actors, most of the involved structures are conventioned by the government and are as such relying on the Ministry of Health's regulation on continuos training. The latter refers to the application and recognition procedures as well as to the number of days attributed to each staff member.

Supervision of the staff members, which is foreseen by budget, in ensured by external supervisors. Mainly foreign trainers or supervisors ensure these activities.

11 Conclusions: Future Trends

The multi-annual action plan on drugs and drug addiction outlines future priority areas in the field of drug demand reduction, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and low threshold services.

The current approach, as outlined in the drugs action plan, focus on prevention and treatment interventions best integrated in existing socio-cultural networks in order to take advantage of cross-sectorial synergies. Drug prevention messages increasingly enhance the role of other actors than the consumer him/herself in drug prevention as well as existing alternatives to drug use and peer education. A holistic approach addressing the general topic of addictive behaviours, not exclusively referred to substance abuse, has gained the attention of national drug demand reduction experts. Clear definition of expected outputs, time limited project funding rather than permanent service funding, scientific evaluation of defined objectives and project execution frameworks and the promotion of continuos quality training are some of the major elements defining the new approach towards a more effective national demand reduction strategy.

Special emphasis is put on first childhood interventions, school-based projects, mass media campaigns and, with respect to the important proportion of non-native residents, on socio-cultural integration projects. Furthermore, a broad offer of activities for youngsters integrating drug prevention topic as one of the various components of Health education, has developed, especially in community-based settings.

The development and diversification of the national drug treatment network is clearly regarded as a future priority. Treatment offers for specific target groups as for instance pregnant women, drug addicted couples and substituted patients will be developed. Special attention is also paid to harm reduction interventions, post-therapeutic settings and socio-professional reintegration measures, as well as the creation of an adequate legal framework allowing their further development.

Research, training and evaluation activities in the field of drug demand reduction need to be developed at the national level. Further development of national expertise in these fields should be reached by increased funding and enhanced international collaboration and experience sharing.

PART IV

KEY ISSUES

12 Drug Strategies in European Union Member States

12.1/2 National policies and strategies - Application

National drug policies and strategies have known significant changes over the last years. Schematically, two periods could be distinguished, namely the pre- and post-1999 periods.

***Prior to 1999**, the government was composed of the Christian Social People's Party (CSV) and the Democratic Party (DP). Drug policies were subject to little amendments during that period, although a lot of preparatory work took place. The most relevant issue has been of legislative nature, namely the creation of a Special Parliamentary Commission on drugs and the subsequent publication in March 1996 of the Special Commission report, which took into account a series of reflections and motions on the revision of the 1973 basic drug law, introduced by members of the parliament. Based on the recommendations of the above-mentioned commission, the bill n°4349, that outlines the revision of the current drug legislation, has been introduced.*

National drug policy have always known shared political competencies and responsibilities. Governmental departments most involved in drug policies until 1999 were: the Ministry of Justice, the Ministry of Health, the Ministry of Family, the Ministry of Education and Youth, Home Office and the Ministry of Foreign Affairs. Rather than to implement a centralised global national drug strategy, Luxembourg privileged an approach that enables the co-ordination of known heterogeneous, and sometimes opposed policy levels. This has been achieved trough the ' Interministerial Commission on Drugs' chaired by a member of the Ministry of Justice and composed of delegates from the following governmental departments or NGOs:

- *PARQUET GENERAL (Prosecution authority)*
- *JUDICIAL POLICE*
- *GENDARMERIE GRAND-DUCALE*
- *BOARD OF CUSTOMS*
- *MINISTRY OF JUSTICE*
- *MINISTRY OF FOREIGN AFFAIRS*
- *MINISTRY OF PUBLIC FORCE*
- *MINISTRY OF HEALTH*
- *DIRECTORATE OF HEALTH*
- *MINISTRY OF FAMILY AND SOLIDARITY*
- *MINISTRY OF NATIONAL EDUCATION AND YOUTH*
- *SNJ*
- *CePT*
- *IEES*

The interminsiterial Commsion on Drugs constitutes the top decision, co-ordincation and orientation level with respect to national drug policies. 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. The "Multidisciplinary Committee" has been set up by law within the Ministry of Health and commissioned to co-ordinate and control ordered and proposed alternative treatment measures (injonction thérapeutique) and report to the Prosecution authority ('Parquet').

The parliamentary elections of ***June 1999*** *(referred to as the beginning of the second period) have led to the constitution of a new government composed by the Christian Social People's Party (CSV) and the Democratic Party (DP). After a 15 years coalition with the CSV, the Socialist Workers' Party (LSAP) had to join the opposition. The new Minister of Health, Mr. Carlo WAGNER is member of the Democratic Party.*

The governmental declaration of August 1999 [10]*, and the subsequent coalition agreements, confirmed an already visible approach emphasising 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 new Government thus decided to charge de the Ministry of Health with national drug co-ordination in the fields of demand and harm reduction. The Minister of Health appointed a national drug co-ordinator and took the necessary steps to transfer collaboration conventions with drug-related NGOs, previously held by other ministry to the Ministry of Health. Furthermore, the Directorate of Health is currently setting up a special division for social medicine and drug addiction. Supply reduction strategies have remained under the responsibility of the Ministry of Justice.

The various decisions of the new government 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 order to guarantee a consistent approach towards national and international drug strategies, the National Drug Co-ordinator has also be appointed, head of the national delegation of the HDG, Permanent Correspondent to the Pompidou Group and Head of EMCDDA focal point..

In February 2000, the Minster of Health charged the National Drug Co-ordinator with the conceptualisation and implementation of a nation action plan on drugs. The tri-annual drugs action plan (2000-2001) has been made public in October 2000. The referred action plan relies on six intervention areas, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and low threshold services. In addition to the creation of new treatment facilities, synergies between the already existing network are enhanced. A clear distinction is made between primary drug prevention strategies co-ordinated by the Division of Preventive Medicine and all remaining demand and harm reduction activities supervised by the National Drug Co-ordinator, attached to the yet to be created Division of Social Medicine and Drug Addiction (former AST), which also integrates the national EMCCDA foal point.

Summarily, the tri-annual drugs action plan focus of the following needs:

- *required amendments of the national drug law (harm reduction activities, substitution, on-site pill testing, etc.)*
- *further development and diversification of the drug care and harm reduction network*
- *co-ordination of national and international drug strategies*
- *future collaboration between Justice and Health*
- *promotion of drug research and monitoring activities and definition of the role of the NFP*
- *expansion of the early warning system on synthetic drugs*

The Ministry of Justice although not relying on a specific action plan, currently focus on three major priorities with regard to drug policy:

[10] **ANNEX IV:** Déclaration gouvernementale du 12 août 1999, http://www.gouvernement.lu:80/gouv/fr/gouv/progg/declu.html

The first refers to the amendment of the current drug legislation by means of the above referred bill n°4349. Among other amendment the referred bill introduces:

- *the creation of a legal framework for drug substitution treatment (including heroin prescription), needle exchange programmes as well as the creation of shelter and injection rooms;*
- *the decriminalisation of the possession of small quantities and the use of cannabis as well as the re-scaling of penalties according to the type of controlled substances involved.*

To date the Council of State has advised the bill threefold, meaning that the amendment procedure is currently (October 2000) still in progress.

A second priority concerns money laundering. The law of 7 July 1989, modifying the modified drug law of 19 February 1973 penalises the practice of money laundering referred to revenues or assets associated to drug traffic. The law of 22 August 1998 regulates the incrimination of criminal organisations involved in money laundering and includes further primary offences as well as the number of professional domains obliged to collaborate with the national prosecution authority as regards the reporting of money laundering offences.

A third intervention priority refers to drug use and health care in prison. The law of 27 July 1997 regulates the creation of specialised medical units for drug addicts and psychiatric patients within prison. A proposal has been presented to the Minister of Justice in 1999 and advised by the Minister of Health.

In addition, a expert group mandated by the Minister of Justice 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. A project proposal has been presented by the prison direction of CPL to the delegate State Prosecutor. The implementation of referred infrastructures in scheduled for mid 2001.

12.3 Evaluation of national strategies

In terms of evaluation of national drug strategies, the former 'Interministerial Commission on Drugs' plays a decisive role. The ministerial decree of 12 October 2000 defines the new composition and future missions of the restructured and renamed 'Interministerial Group on Drug Addiction', chaired by the Ministry of Health.

The newly defined missions of the Group are as follows:
- *information exchange between involved governmental departments*
- *follow-up the implementation of the national drugs action plan*
- *monitoring of emerging trends and advice possible responses*
- *co-ordination of the national early warning system on new synthetic drugs*
- *acknowledge and debate European and International requirements and orientations.*
- *report to the Minster of Health*

In the light of its future mission the Interministerial Group includes delegates from the:

- *Ministry of Health*
- *Ministry of Justice*
- *Home Office*
- *Grand-Ducal Police*
- *Ministry of Family and Youth*

- *Ministry of Education, Professional Training and Sports*
- *Ministry of Finances*
- *Ministry of Foreign Affairs*

A further evaluation mechanism is the mandatory bi-annual progress reporting to the Government on actions included in the Governmental Declaration and the coalition agreements.

With regard to the national drugs action plan (2000-2001), the effective implementation of clear goals to be reached within defined time periods, is monitored by means of both referred control mechanisms.

.

13 Cocaine and Base / Crack Cocaine

Preliminary remark: Data presented under section 13. has been compiled from the following sources: Law enforcement agencies, specialised drug enforcement units, RELIS network, and toxicological laboratories.

Data exclusively refer to cocaine as the prevalence of crack is insignificant at the national level both in terms of consume and seizures figures (no seizures of crack have been registered by the national authorities thus far).

13.1 Different patterns and user groups

a. Administration, patterns and effects sought

Summarily, three structurally different cocaine user scenes have to be distinguished at the national level:

***Scene A**: The street scene as part of in the intravenous heroin scene is described as an open multiple user scene. Cocaine is mainly mixed up with heroin and benzodiazepines or used alternatively in seek of their conjugated effects. There is virtually no cocaine sub-scene since exclusive use of cocaine is very rare within the referred user group. If consumed, cocaine is mainly injected. A quite recent evolution might be seen in the increasing use of cocaine by drug patients admitted to substitution treatment (Methodone/Mephenon). Scene A is mainly composed of socially deprived people showing the same characteristics as HRC users as indexed by RELIS.*

***Scene B:** The second scene mainly refers to nightlife settings in particular cabarets, night clubs, prostitution and certain types of restaurants (especially Italian pizzerias). Cocaine is either consumed (non-iv) for its proper effect and/or largely associated to alcohol use. Stimulation as well as the enhancement of physical endurance are the main effects sought by the referred scene. Abuse patterns are frequent but more likely to be determined by functional criteria than recreational purposes. It happens to be a semi-closed scene as involved persons (employers and licensees) are relying on a proper distribution network and dispose of financial resources, which allow them to avoid the street scene and eventually provide their own staff. This explains that social status of involved users varies from wealthy proprietors using drugs for recreational purposes to prostitutes or artists relying on uncertain incomes. Furthermore, night life workers and prostitute are more likely to be of foreign origin, mainly from Eastern Europe, while the ' Restaurant scene ' mainly include Italian natives.*

***Scene C:** The private scene is considered to be a very hermetic one and largely composed of native users with high socio-economic status often associated to liberal professions. Multiple illicit drug use appears to be rare. Little is know about these users since they do not rely on national supply and the rarely choose to undergo treatment in national health care facilities. Cocaine is mainly imported from the Netherlands in larger quantities.*

b. Prevalence

***Table 13.1.b.1** Cocaine use prevalence in general and school populations*

Survey	Year	Target Group	Age Group	Lifetime Prevalence	12 Months Prevalence	30 Days Prevalence
Fischer and Krieger	1998	General population	15-34	0.3%		0.3%
HBSC	1999	School population	12-20	2.3%	1.5%	
Fischer and Krieger	1998		13-20	2.9%		1.3%

HBSC	1999	16-20	2.8%		
Matheis *et al*	1992		1.2%		
HBSC	1999	13-14	1.6%		
Fischer and Krieger	1998		2%		
Meisch	1997		0.3%		
HBSC	1999	15-16	1.5%		
Matheis *et al*	1992		0.9%		

Table 13.1.b.1 presents a synopsis of the most relevant and comparable national prevalence data originating mostly from school surveys. References may be consulted in section 2.2.

Lifetime and last year cocaine prevalence rates are provided by a single study on young adults figuring both 0.3%. The most representative survey namely the HBSC survey provides a lifetime and a last 12 months prevalence figure in 12 to 18 years school children of 2.3 per cent and 1.5 per cent, respectively. Applied to age group 16-20 and 15-16 years, one observes a significant increase of lifetime cocaine prevalence compared to 1992 data. Last 30 days prevalence figures are provided by a single study on 13 to 20 years old schoolchildren (1.3%)

Raw estimations (source law enforcement) that have not been validated to date refer to approximately 3000 regular cocaine users at the national level.

13.2 Problems and needs for services

Referred to the above mentioned user groups different demand patterns emerge. Users of scene A mainly seek treatment for multiple drug use or intravenous opiates use. Treatment demands exclusively for problem cocaine use are exceptional in all referred user groups. Users belonging to scenes B and C, apart prostitutes, are fairly hidden in terms of social or health problems. If the latter should occur, specialised health care is often sought abroad for privacy reasons.

RELIS provides the following data on problem cocaine users:

Problem drug users indexed by health care and law enforcement institutions:
*The proportion of RELIS respondents reporting cocaine as **main drug** has been stable over the last three years (1999: 9%). As regards the route of administration, one observes a downward trend of iv consume (1999: 5%) associated to a slight increase of non-iv consume (1999: 4%)*
*Concerning cocaine use as **first secondary drug**, a clear upward trend has been observed for the last three years (1999: 37%). The observed trend is mainly due to the increase of cocaine non-iv use (1999: 16%)*

Problem drug users indexed only by health care institutions (treatment demand):
*The proportion of RELIS respondents reporting cocaine as **main drug** has been stable over the last four years (1999: 11%). As opposed to the total problem drug user population one notices a downward trend of non-iv consume (1999: 1%) associated to constant increase of iv consume (1999: 10%).*
*As far as **secondary drug** consume is concerned, an upward trend in cocaine use has been observed for the last three years (1999: 34%) almost exclusively due to the important increase of iv use (1999: 25%).*

Summarily, retained data sources suggest a stabilisation of cocaine use as main drug and a significant increase in cocaine use as a secondary drug. Moreover, forensic evidence has shown cocaine use has increasingly been associated to fatal drug overdoses during the last for years.

13.3 Market

a. Description

In 1999, national law enforcement agencies have registered 1,708 drug using drug law offenders of which 173 have been associated to cocaine use. Table 13.3.a.1 provides an overview of substances associated to cocaine use and possession in drug law offenders (1999). The presented data confirm the close link between the cocaine and opiate scenes.

Table 13.3.a.1 *Substances associated to cocaine use in drug law offenders*

Associated substances	Number of users[11]
Cocaine * Heroin	93
Cocaine * Haschisch	39
Cocaine * Marihuana	31
Cocaine * LSD	4
Cocaine * Amphetamines	1
Cocaine * Ecstasy	7

b. Price / purity at user's level

Following a decrease in 1996/97, the street retail price tends to settle between 75 and 100 € per gram. Purity figures largely depend on the level of distribution. The higher the level (import/export) the higher the quality. Data from the toxicological unit of the National Laboratory of Health show that purity figures vary in accordance to high distribution level and low user levels (Street level) from 20 to 80 per cent. Purity at street level has decreased during past years and are currently situated between 20 and 45 per cent.

c. Availability

Quantities of cocaine seizures have decreased from 1996 (1996: 12,9kg /1999: 0.3kg) onwards while the number of seizures has proportional increased (1998: 31/ 1999: 56), which supports the idea of micro-networking and increasing street level consume. Law enforcement agencies report indeed an increasing prevalence, especially with regard to scenes A and B. Police 'Interpellations' for cocaine use, possession of small quantities tend to become more frequent. Key informants and field actors confirm an increasing availability of cocaine on the national market.

d. Supply and distribution patterns

*Supply and distribution patterns of cocaine vary largely according to the above described user groups. Scene A users rely on local micro supply and distribution network. Most of drug dealers are problem users and sell opiates and cocaine to finance their own consume. Scene B and C are supplied by more or less important quantities imported from abroad. SPJ believes that up to 90 per cent of cocaine consumed in Luxembourg has been purchased in the Netherlands, mostly by natives***.**

According to Customs' information the number of drug couriers using the air route has constantly decreased following a previous wave of cocaine seizures at the national airport. Occasional seizures only occur in case a non scheduled aeroplane has to land in Luxembourg for technical or meteorological reasons for instance. Since the opening of borders, drug traffic heavily and increasingly relies on road transport.

The link between criminality and cocaine use is particularly obvious in scene A since involved users commit recidivist petty crimes in order to guarantee proper consume needs. Scene B is more likely to be associated to physical violence. Defence of commercial territories,

[11] Cocaine use is the minimum required condition to be included in the referred database, meaning traffic is not necessarily excluded. Data refer to iv and non iv users.

pandering, vendetta, human trade and money laundering are common. Scene C seems to be less associated to any kind of criminality, although little information is available.

13.4 Intervention projects

The previous presentation stress two important facts. Firstly, unlike opiate use, cocaine use occurs in several very heterogeneous settings. Secondly, problem drug use in terms of health risks and criminality are most associated to the street scene, which has been described as being part of the open opiate scene. Since criminality and health risk are the main concern of involved national authorities, problem cocaine use has been framed by existing offer and demand reduction interventions aimed at drug users in general. This approach has been justified since cocaine use has long known a low prevalence and specialised services have been able to handle different types of problem drug users. While exclusive cocaine problem use is rather rare, multiple use including cocaine or cocaine as incidental substance, is becoming more prevalent. Taking into account the current national situation, one should, however, not necessarily envisage the set-up of cocaine specific services. Instead, the development of expertise in the field of multiple drug use and they set up of flexible treatment units seems to be the more advisable alternative.

In terms of law enforcement, it might be said that the cocaine scenes are more often associated to traffic than opiate users. As the priorities of law enforcement agencies clearly lies in the fight against drug trafficking, cocaine scenes are clearly targeted but less because of the substance itself than the distribution pattern behind.

14 Infectious Diseases

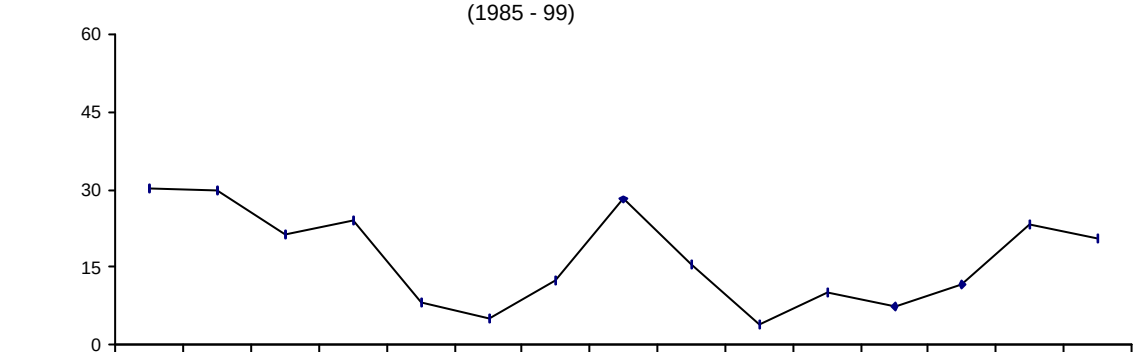
14.1 Prevalence and of HCV, HBV and HIV among drug users

a. 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 1999, 426 HIV infected persons have been registered at the national level; 74 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 17 per cent since the registration of the first HIV case in Luxembourg in 1984. 88% of registered IDUs/HIV patients are male.*

Intravenous drug use appears to be the third most reported transmission mode of HIV infection (new HIV infections and declared AIDS cases) after homosexual and heterosexual status. This sequence has remained fairly stable for the last two years, although the proportion of intravenous drug use transmission modus has noticeably increased from 1996 onwards to reach 33 per cent in 1998.

Fig. 14.1.a.1 Proportion (%) ofIDUs in newly infected HIV patien
(1985 - 99)



	1985 (7)	1986 (9)	1987 (7)	1988 (6)	1989 (2)	1990 (1)	1991 (4)	1992 (11)	1993 (5)	1994 (1)	1995 (3)	1996 (2)	1997 (3)	1998 (7)	1999 (6)
Total	30,4	30	21,2	24	8,3	5	12,5	28,2	15,6	3,8	10,1	7,4	11,5	23,3	20,6

Source: Laboratoire de Retrovirologie – CRP-Santé. 1999

Since 1996, RELIS allows for breakdowns of HIV data by IDUs and institutional contact status. In 1997, a significant decrease of ***HIV rates in drug users*** *and especially in IDUs occurred. In 1999, HIV rates have stabilised, varying between 2.9 and 3.9% depending on the reference group*. HIV rate in IDU treatment demanders, although the highest among the described target groups, has decreased in a most significant way.

A study on HIV and HCV prevalence in prison, commissioned by the Ministry of Justice in 1998 (Schlinck 1998), tends to confirm RELIS figures. The study included 90% of the total national prison population and applied saliva antibody testing. The following HIV prevalence figures have been calculated:

- *HIV prevalence in IDU prisoners : 4.4%*
- *HIV prevalence in total prison population (1998): 1.5%*

Table 14.1.a.1 *Synopsis of national data on* ***HIV*** *infection rate in drug using populations (valid %)*

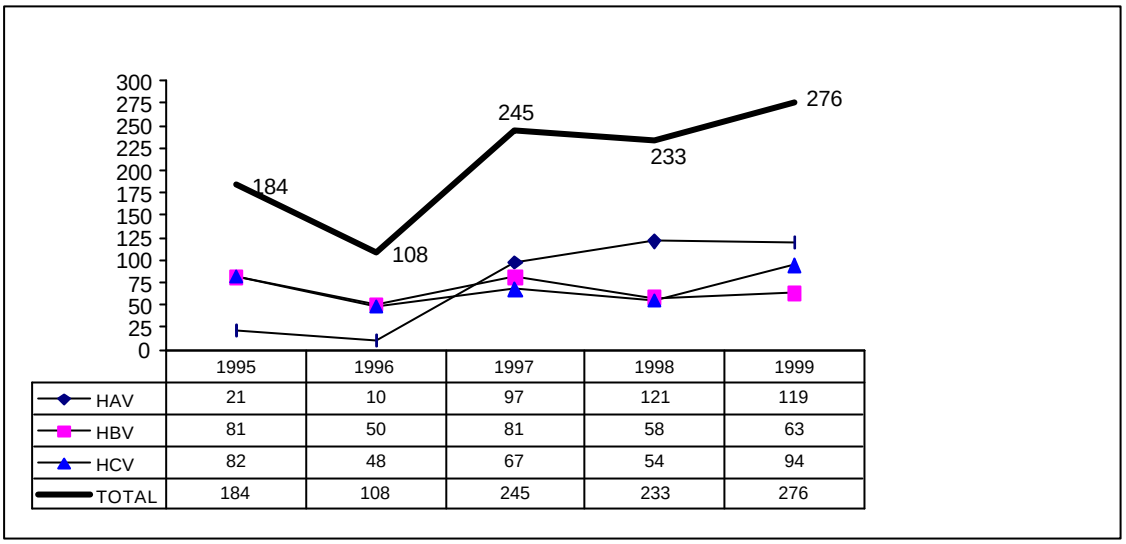
YEAR	1996	1997	1998	1999
HIV rate in problem drug users (RELIS)	4.8	3	2.9	2.9
HIV rate in drug treatment demanders	6.5	3.8	2.6	3.4
HIV rate in IDUs (RELIS)	**6.9**	**3.6**	**3.5**	**3.3**
HIV rate in IDUs treatment demanders	8.6	4.5	3.4	3.9
HIV rate in IDUs prisoners	/	/	4.4	/

Sources: RELIS/LINDDA and Schlinck J., 1999

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. I4.1.b.2 Notified hepatitis diagnosis in general population (1995-99)



	1995	1996	1997	1998	1999
HAV	21	10	97	121	119
HBV	81	50	81	58	63
HCV	82	48	67	54	94
TOTAL	184	108	245	233	276

Source: Division de l'Inspection Sanitaire. Direction de la Santé. 1999

Hepatitis B and C indicators have been included in the RELIS/LINDDA protocol in 1997. The prevalence of HBV infection in problem drug users has remained stable over the last three years but has increased with regard to HCV. The increase of the HCV infection rate is particularly significant in drug treatment demanders, reaching 29% in 1999. The above referred prison study (Schlinck 1999), provides a 37% HCV infection rate in IDU prisoners. Data on viral hepatitis related to drug use (IVDUs) are currently not available from the National Health Laboratory.

Table 14.1.b.1 *Synopsis of national data on* ***HBV*** *infection rate in drug using populations (valid %)*

YEAR	1997	1998	1999
HBV rate in drug users (RELIS)	24	25	24
HBV rate in drug treatment demanders	24	22	25

Source: RELIS/LINDDA 1999

Table 14.1.b.2 *Synopsis of national data on* ***HCV*** *infection rate in drug using populations (valid %)*

YEAR	1997	1998	1999
HCV rate in drug users (RELIS)	22	21	25
HCV rate in drug treatment demanders	22	24	29
HCV rate in IDU prisoners	/	37	/

Sources: RELIS/LINDDA and Schlinck J., 1999

In terms of future research activities, the NFP plans to participate in a EMCDDA co-ordinated study aiming at the estimation of HCV prevalence in recent drug injectors.

14.2 Determinants and consequences

Injecting drug use and the sharing of injection material are important risk factors as to HIV infection and other infectious diseases.

***Intravenous drug use**, mainly heroin and heroin/cocaine cocktails (speedball), prevail among problem drug users. RELIS 99 data confirm the decisive reduction in iv opiates consume associated to an amplification of the inhalation mode to 33 per cent (36 % in 1998).*

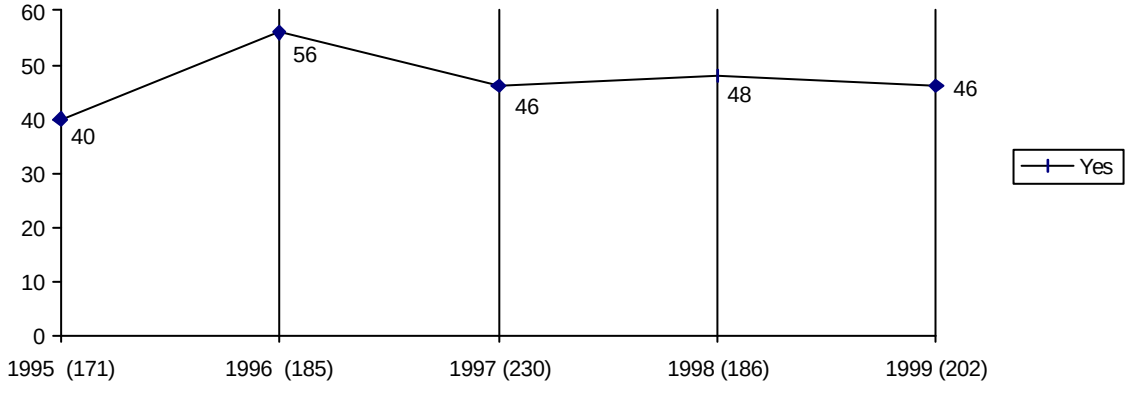
*In 1999, the average **duration of intravenous drug use** of RELIS respondents was 8 years and 10 months (1998: 7 years and 4 months). The time span between the first illicit drug use and the first iv use has also decreased (199: 3 years and 8 months), compared with 1998 data (4 years and 7 months). Generally speaking, the duration of iv use increases while the average age at the moment of first iv use (1999: 19 years and 3 months) tends to decrease.*

The number of sterilised syringes distributed (1999: 109,743 / 1996 : 76.259) has been rising right from the start of the needle exchange programme, which reunites institutions from all levels of specialised drug treatment. The number of used syringes collected (1999: 98.764 (57%) / 1996: 28.646) has increased accordingly.

The needle exchange rate in indexed problem drug users has been showing a stable trend over the last 4 years. In 1999, 71% of RELIS respondents report not to exchange used needles. A stable majority of indexed drug users (41%) procure their injection material from pharmacies, followed by automatic dispensers and low threshold agencies. The referred figures have been confirmed by an exploratory survey on the involvement and perceptions of drug users as to the needle exchange programme, conduced by the National Surveillance Committee on AIDS in 1998.

*The **use of condoms** during sexual intercourse is a core item of the RELIS/LINDDA protocol. Male respondents are asked if they usually use condoms and women report on whether they ask partners to use them during sexual intercourse. Figure 14.2.1 shows that less than half of the RELIS respondents use condoms witnessing a stable trend for the past 3 years.*

Fig 14.2.1 Use of condoms by problem drug users. (%) (1995-98)



Source: RELIS/LINDDA

Most indicators related to iv use stress a high acceptance of risk reduction offers associated, however, to an increased exposition to risk factors in problem drug users. RELIS-provided syringes sharing and condom use rates have stabilised. The significant switch from iv opiate use to inhalation mode, however, suggest an opposite trend. Research should address the

question whether non-iv opiate users prevail among recent drug users or refer to established long term users.

14.3 New developments and uptake of prevention, harm reduction and care

Even though the HIV prevalence in problem drug users and AIDS incidence have stabilised (partly due to more efficient medication), infectious diseases are again high on the agenda since the total number of HIV infections has significantly increased during the first semester of 2000 and HCV prevalence in drug users is constantly increasing.

In terms of prevention, the Grand Duchy of Luxembourg disposes of 3 agencies specialised in the prevention of and the counselling in HIV- and AIDS-related problems. Two of the latter are private initiatives and the third one, called 'AIDSBERODUNG –CROIX ROUGE', is financed by the Ministry of Health. AIDSBERODUNG is also the only national agency providing housing facilities to HIV and AIDS patients as well as therapeutic care. The Ministry of Health has significantly and constantly increased financial and infrastructural resources of AIDSBERODUNG during the last five years.

One tends to believe that currently available prevention means in the field of HIV and AIDS are sufficient to guarantee a good national coverage. One of the major problems, however, has to be seen in the spread of hepatitis in different populations at risk. The existing prevention agencies are not specialised or prepared, in terms of financial and human resources, to respond to a phenomenon, which only starts to gain political awareness. On the other hand, public tends to loose interest in the HIV prevention initiatives, partly due to the false belief that the epidemic is regressing.

It is somehow significant that drug harm reduction settings tend to be associated to the overall, cross-sectional prevention of infectious diseases and, as such, may have hindered the creation of specialised prevention infrastructures.

Needle exchange for instance only reaches a specific and limited target group. Furthermore, experience has shown that often the preventive message is exclusively associated to the use of clean needles and that minor attention is paid to other injection material as for instance absorption filters and spoons as potential transmitters of infectious diseases. The four national low threshold drug agencies have adopted those recommendations, which are also likely to be considered by other types of low threshold services.

A fist step in the direction of a more holistic approach towards infectious diseases might be seen in the implementation of a first 'Drop In' centre for sex workers and other populations at risk in 1999. First client statistics clearly support the need of further similar infrastructures as well as the creation of non client specific and easy accessible testing facilities.

In 1999, an expert group mandated by the Minister of Justice has worked out a proposal for a pilot project (2000 – 2005) providing a global framework for specialised drug care associated to a in-house drug prevention programme on drugs and ***infectious diseases in prison****. A project proposal has been presented by the prison direction of CPL to the delegate State Prosecutor. The implementation of referred infrastructures in scheduled for mid 2001.*

END OF REPORT

REFERENCES

BIBLIOGRAPHY

ABRIGADO (2000), *Rapport d'activités 1999, CNDS,* Luxembourg

AST - Point Focal O.E.D.T Luxembourg - Direction de la Santé (2000), *Réseau National d'Information sur les Drogues et les Toxicomanies - RELIS / LINDDA - Rapport National 1999*, PFN, Luxembourg.

AST - Point Focal O.E.D.T Luxembourg - Direction de la Santé (2000)**,** *Récapitulatif des lois, des règlements grand-ducaux et des conventions des Nations Unies réglementant la détention, l'usage, la production et le commerce de certaines substances et préparations psychotropes, stupéfiantes et toxiques et de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes, PFN,* Luxembourg,.

Centre d'Etudes de Populations, de Pauvreté et de Politiques Socio-Economiques (1996), Atlas des communes - *La population du Luxembourg*, ISBN 2-87987-121-2, CEPS/ INSTEAD, Luxembourg.

Centre de Prévention des Toxicomanies (2000), *Bilan d'activités 1999*, CePT, Luxembourg.

Comité de surveillance du Sida, (1999), *Rapport d'activités 1998*, Luxembourg.

Comité de surveillance du Sida, (2000), *Rapport d'activités 1999*, Luxembourg.

Dickes, P., Houssemand, Cl., Martin, R., (1996), *La consommation de drogues légales et illégales des élèves des 6èmes de l'enseignement secondaire et des 8èmes de l'enseignement professionnel et technique*, CEPS/INSTEAD-Division F.E.E, Luxembourg.

EDDRA, *Système d'information sur les échanges en matière d'activités de réduction de la demande,* http://www.reitox.emcdda.org:8000/eddra/

European Monitoring Centre for Drugs and Drug Addiction (1999), *Annual report on the state of the drugs problem in the European Union 1998, EMCDDA,* Lisbon,

European Monitoring Centre for Drugs and Drug Addiction (2000), *Annual report on the state of the drugs problem in the European Union 1999 EMCDDA,* Lisbon,

Fischer, U. Ch., Krieger, W. (1998), *Suchtpräventioun an der Gemeng - Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg.*

Fischer, U. CH. (2000), *Cannabis - Eine Analyse der aktuellen Situation*, CePT, Luxembourg.

Fonds de Lutte contre le Trafic des Stupéfiants (2000), *Rapport d'activités 1999*, Ministère des Finances, Luxembourg.

Goerens, R. Dr, (1998), *Alcohol and Drugs at the workplace – Attitudes, policies and programmes in Luxembourg*, Ministry of Health, Luxembourg.

Groupe de Mondorf (1996), *Bulletin de Liaison n°1*, Metz.

Hartnoll R., (1994), *Drug treatment systems and first treatment demand indicator - Definitive protocol*, Pompidou Group, Council of Europe, Strasbourg.

Jugend an Drogenhëllef (1993), *Zweiter Bericht zur Evaluation des Methadonprogramms*, JDH, Luxemburg..

Jugend an Drogenhëllef (2000), *Jahresbericht 1999*, JDH, Luxemburg.

Matheis J. et al. (1995) '*Schüler an Drogen'*, IEES, Luxembourg.

Ministère de la Santé (1999), *Rapport d'activités 1998,* Luxembourg.

Ministère de la Santé (2000) *Rapport d'activités 1999,* Luxembourg.

Ministère de la Santé (in press), *Das Wohlbefinden der Jugend – HBSC Studie*, Direction de la Santé, Luxembourg.

Meisch, P. (1998), Les drogues de type ecstasy au Grand-Duché de Luxembourg, CePT, Luxembourg.

MSF Solidarité Jeunes (2000), *Rapport d'activités 1999*, Luxembourg.

O.M.S. (1997), *CIM-10 / ICD-10 - Classification internationale des troubles mentaux et des troubles du comportement,* ISBN: 2-225-84609-X, Masson, Paris.

Origer, A, (1995), *Etude épidémiologique de la population toxicomane en milieu carcéral au Grand-Duché de Luxembourg*. In rapport du Réseau National d'Information sur les Drogues et les Toxicomanies, Luxembourg. AST - Point Focal OEDT- Ministère de la Santé, Luxembourg.

Origer, A. (1996), *Procedures to avoid double counting in drug treatment reporting systems*. Luxembourg. AST - Point Focal O.E.D.T Luxembourg - Ministère de la Santé, Luxembourg.

Origer, A. (1997), *Etude comparative des cas de décès par overdose au Grand-Duché de Luxembourg* 1993/ 1994 et 1995/1996, in rapport du Réseau National d'Information sur les Drogues et les Toxicomanies , Luxembourg. AST - Point Focal OEDT - Ministère de la Santé, Luxembourg.

Origer, A. (1998*), Enquête auprès des médecins généralistes et des médecins psychiatres sur la prise en charge des patients toxicomanes,* in Rapport RELIS/LINDDA 1997, Ministry of Health, NFP, Luxembourg.

Origer ,A. (1998) *Local drug prevalence estimate for Luxembourg-City*, in Annual report on the state of the drugs problem in the European Union, EMCDDA, Lisbon.

Origer, A. (1999), *Comparative study on the drug population of Portugal and a representative sample of Portuguese drug addicts residents of the Grand Duchy of Luxembourg*, Luxembourg. Point Focal OEDT Luxembourg - Ministère de la Santé, Luxembourg.

Origer, A., **Pauly R.** (2000) *Mortality rate in problem drug users, Direction de la Santé NFP, Luxembourg.*

Origer, A., **Dellucci, H.** (in press), *Comparative study on drug-related deaths 1991 – 1999, Direction de la Santé NFP, Luxembourg.*

Origer, A., **Cloos, J.-M. Dr.** (in press), Study on *socio-economic costs of drug addiction and the fight against drugs,* Direction de la Santé NFP, Luxembourg.

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

Service Central de la Statistique et des Etudes Economiques (2000), *Annuaire Statistique du Luxembourg 1999*, STATEC, Luxembourg

ANNEX

a. RELIS/LINDDA 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/LINDDA 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-LINDDA 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 selection.

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-LINDDA is based on a 9-digit numerical code obtained by indating 3 core variables (attributers) namely: gender (i.e. 01/02), date of birth (i.e., 10051967), and country of birth into a code – calculator developed by the NFP in collaboration with the CRP-Henri Tudor. The solution found is time and cost effective because it relies on a simple HP calculator that runs an attributer-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 indata 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 attributers on the indexed persons, which is undoubtedly one of the major preoccupation of field institutions.

RELIS data processing is based on ORACLE ® Database software and allows for multiple variable breakdown as well as separation 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/LINDDA 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. This procedures 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-elated 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 as well as centralised co-ordination of key data providers' activities. The national co-ordination unit of EWS is implemented within the NFP (AST- Directorate General of Health). 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, expressively 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 fist 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 by the SPJ, or sent 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.

Agreement 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 night clubs, public events or rave parties. No such activities have been planned or carried out under the authority of public administrations. Taking into account that the first official seizure of 'ecstasy' have only been recorded in 1994, harm reduction and close monitoring activities in this particular field were previously not viewed as a priority. A legal framework might be included in the bill n°4349 according to the recommendations of the above referred drug policy orientation paper.

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 subcultural 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 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 2,700 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 focus 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.

Governmental declaration of 12 August 1999 (excerpt p. 12)

(…) Nous pouvons pratiquer la politique de l'autruche autant que nous le voulons, mais nous avons bel et bien un problème substantiel de drogue au Luxembourg. Nous ne pourrons pas le résoudre, cela dépasserait la capacité de l'Etat. Mais nous pouvons l'alléger, l'encadrer, l'assouplir, en aidant d'un point de vue de mentalité et d'attitude, en ne considérant pas les drogués comme des criminels mais comme des malades, pour aller jusqu'à modifier nos lois et les peines y assorties.

Concrètement, cela reviendra à créer chez nous des centres thérapeutiques, de faciliter l'accès à ces centres à l'étranger, de créer des infrastructures où, **sous contrôle médical, nous dispenserons de l'héroïne aux drogués** afin d'endiguer la criminalité due à l'approvisionnement, de développer les **programmes basés sur la méthadone**, de mettre à disposition des centres de conseils pour les parents d'enfants et d'adolescents dépendants et de multiplier les **programmes de prévention** et d'information. Il n'est en tout cas pas question **d'une légalisation des drogues dites douces** au niveau national uniquement. Des suggestions et des solutions au niveau européen sont nécessaires pour cela. Nous voulons aider les malades mais éviter à tout prix le tourisme de la drogue avec toutes ses conséquences.(…)

Coalition agreements of August 1999 (Excerpt pp. 73-74)

4. Drogues

La politique du Gouvernement en matière de drogues doit reposer sur quatre piliers : 1e la prévention, 2e la thérapie, 3e la prévention des risques et 4e la répression. Afin de mener une politique cohérente en la matière, le Ministre de la Santé regroupera au sein de son département les différentes compétences.

Le Gouvernement mettra l'accent sur la prévention à l'école. Pour ce qui est de la thérapie, il faudra œuvrer à augmenter le nombre de places disponibles. Dans ce contexte, il est retenu que le Luxembourg devra veiller à ce que des **places de thérapie à l'étranger** soient disponibles. En effet, il n'est pas nécessaire que toutes les thérapies se fassent au Luxembourg, les thérapies à l'étranger ayant souvent l'avantage d'écarter la personne du milieu où elle s'enlisait. Il sera cependant nécessaire de créer au Luxembourg des infrastructures post-thérapeutiques.

Les programmes de méthadone seront développés de même que la **distribution d'héroïne** à des toxicomanes sous contrôle médical et à des fins thérapeutiques. De plus, afin de prévenir les risques, des **infrastructures répondant à des conditions hygiéniques** seront prévues pour les consommateurs de drogues. Le Gouvernement améliora aussi le suivi thérapeutique au Centre pénitentiaire.

La politique à mener en la matière **ne pourra conduire à une dépénalisation des drogues**. Pour ce qui est de la position à prendre au niveau européen, il est retenu que, au cas où la politique européenne irait vers une certaine libéralisation, le Luxembourg ne s'y opposerait pas. Dans ce contexte il est précisé que notre législation actuelle en matière de drogues ne sera pas changée sauf en ce qui concerne les peines pour consommation de drogues douces, qui seront réduites de façon à ce que la consommation de drogues douces ne soit plus punie de peines de prison mais d'amendes. Pour ce qui est des drogues dures, les peines de prison pourront être remplacées par des peines condamnant à une obligation de thérapie.

Le Gouvernement a décidé de procéder contre **le dopage**, en prévoyant des peines pour les trafiquants et les distributeurs.

RELEVE GENERAL DE LA LEGISLATION – 1999 – **MINISTERE DE LA SANTE** SERVICE CENTRAL DE LEGISLATION

5. Médicaments, substances toxiques:

Loi du 14 février 1967 portant approbation de la Convention relative à l'élaboration d'une pharmacopée européenne, en date, à Strasbourg, du 22 juillet 1964 (Mém. A 1967, p. 133).

Loi du 20 février 1968 ayant pour objet le contrôle des pesticides et des produits phytopharmaceutiques (Mém. A 1968, p. 123). Règlement ministériel du 27 janvier 1971 établissant le classement toxicologique des produits phytopharmaceutiques (Mém. A 1971, p. 288), modifié par le règlement ministériel du 21 août 1972 (Mém. A 1972, p. 1377).

Loi du 3 juillet 1972 portant approbation de la Convention unique sur les stupéfiants, faite à New York, le 30 mars 1961 (Mém. A 1972, p. 1256).

Loi du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie (Mém. A 1973, p. 319), modifiée par la loi du 23 février 1977 (Mém. A 1977, p. 352), celle du 7 juillet 1989 (Mém. A 1989, p. 923) et celle du 17 mars 1992. (Texte coordonné: Mém. A 1992, p. 2458).

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. A 1973, p. 1967), modifié par le règlement grand-ducal du 31 janvier 1980 (Mém. A 1980, p. 81).

Règlement grand-ducal du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie (Mém. A 1974, p. 462) modifié par les règlements grand-ducaux des 18 janvier 1996 (Mém. A n° 7 du 05/02/1996, p. 84) et 23 mai 1997 (Mém. A - 41 du 11 juin 1997, p. 1439).

Règlement grand-ducal du 4 mars 1974 concernant certaines substances toxiques (Mém. A 1974, p. 465), complété par le règlement grand-ducal du 6 août 1981 (Mém. A 1981, p. 1344) modifié par le règlement grand-ducal du 9 juillet 1982 (Mém. A 1982, p. 1345). Annexe modifiée par les règlements grand-ducaux des 13 décembre 1985 (Mém. A 1985, p. 1491), 13 juin 1986 (Mém. A 1986, p. 1545), 13 octobre 1988 (Mém. A 1988, p. 1050), 7 décembre 1990 (Mém. A 1990,p.963), 13 août 1992 (Mém. A 1992,p.2154), 22 mars 1994 (Mém. A 1994, p. 576), 31 juillet 1995 (Mém. A 1995, p. 1577) et 9 octobre 1996 (Mém. A n° 77 du 07/11/1996, p. 2220).

Règlement ministériel du 6 mars 1974 établissant le modèle du registre spécial prévu par l'article 5 du règlement grand-ducal du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie (Mém. A 1974, p. 466).

Règlement grand-ducal du 20 mars 1974 concernant certaines substances psychotropes (Mém. A 1974, p. 468), modifié et complété par les règlements grand-ducaux des 9 juillet 1982 (Mém. A 1982, p. 1346), 22 août 1985 (Mém. A 1985, p. 1045), 13 juin 1986 (Mém. A 1986. p. 1546), 7 décembre 1990 (Mém. A 1990,p.962) et 9 octobre 1996 (Mém. A - 77 du 7 novembre 1996, p. 2220).

Règlement grand-ducal du 26 mars 1974 établissant la liste des stupéfiants (Mém. A 1974, p. 470), modifié par le règlement grand-ducal du 8 juillet 1982 (Mém. A 1982, p. 1347), celui du 16 août 1984 (Mém. A 1984. p. 1376), celui du 23 janvier 1987 (Mém. A 1987. p. 60) et celui du 15 septembre 1988 (Mém. A 1988 p.1028) et celui du 7 décembre 1990(Mém. A 1990, p. 963) et celui du 9 janvier 1998 (Mém. A - 4 de 1998, p. 55)

Règlement ministériel du 2 avril 1974 établissant le modèle du bon de commande prévu par l'article 2 du règlement grand-ducal du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie (Mém. A 1974. p. 474).

Règlement ministériel du 2 avril 1974 établissant le modèle du carnet à souches et son mode d'obtention prévu par l'article 7 du règlement grand-ducal du 19 février 1974 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie (Mém. A 1974, p. 475).

Règlement grand-ducal du 24 septembre 1974 concernant les agents pathogènes pour les animaux et les vaccins vivants à usage vétérinaire, et déterminant les exigences minimales pour les principaux sérums et vaccins vétérinaires (Mém. A 1974, p. 1563).

Loi du 4 août 1975 concernant la fabrication et l'importation des médicaments (Mém. A 1975. p. 1051), modifiée par la loi du 11 avril 1983 (Mém. A 1983. p. 706).

Règlement grand-ducal du 12 novembre 1975 portant exécution de la loi du 4 août 1975 concernant la fabrication et l'importation des médicaments (Mém. A 1975. p. 1484), modifié par le règlement grand-ducal du 29 avril 1983 (Mém. A 1983. p. 762), et celui du 22 septembre 1992 (Mém. A 1992,p.2228).

Loi du 25 novembre 1975 concernant la délivrance au public des médicaments (Mém. A 1975, p. 1540), modifiée par celle du 27 juillet 1992 (Mém. A 1992, p. 1658).

Règlement ministériel du 15 mars 1976 relatif a la désignation des spécialités pharmaceutiques qui ne peuvent être librement vendues en pharmacie (Mém. A 1976, p. 158).

Loi du 24 avril 1976 portant approbation du Protocole portant amendement de la Convention unique sur les stupéfiants de 1961, signé à Genève le 25 mars 1972 (Mém. A 1976. p. 394).

Règlement ministériel du 11 juin 1981 déterminant les spécialités pharmaceutiques à usage vétérinaire que les médecins-vétérinaires sont autorisés à détenir en stock (Mém. A 1981, p. 1036).

Règlement grand-ducal du 18 novembre 1981 relatif aux matières pouvant être ajoutées aux médicaments en vue de leur coloration (Mém. A 1981, p. 2114).

Règlement ministériel du 19 mars 1982 déterminant le questionnaire à remplir a l'occasion de l'examen médical en cas de suspicion d'infraction à la législation réprimant la toxicomanie (Mém. A 1982, p. 783).

Règlement grand-ducal du 19 mars 1982 fixant les modalités de l'examen médical et de la prise de sang et/ou d'urine, effectués en cas de présomption d'usage illicite d'un stupéfiant ou d'une substance toxique, soporifique ou psychotrope (Mém. A 1982, p. 782).

Règlement ministériel du 19 mars 1982 déterminant le questionnaire à remplir à l'occasion de la prise de sang et/ou d'urine en cas de suspicion d'infraction à la législation réprimant la toxicomanie (Mém. A 1982, p. 783).

Règlement ministériel du 6 août 1982 établissant le classement toxicologique des produits phytopharmaceutiques (Mém. A 1982, p.1560), modifié par le règlement ministériel du 4 novembre 1983 (Mém. A 1983, p. 2098) et celui du 6 janvier 1987 (Mém. A 1987, p. 54).

Loi du 11 avril 1983 portant réglementation de la mise sur le marché et de la publicité des spécialités pharmaceutiques et des médicaments préfabriqués(Mém. A83 p.758 Rectificatif p. 938) modifiée par la loi du 27 juillet 1992 portant réforme de l'assurance maladie et du secteur de la santé (Mém. A 1992,p.1658).

Règlement grand-ducal du 30 juillet 1983 fixant les droits dus pour la mise sur le marché des spécialités pharmaceutiques et des médicaments préfabriqués (Mém. A 1983, p. 1415).

Règlement grand-ducal du 2 octobre 1985 autorisant la création et l'exploitation d'une banque de données des titulaires d'une autorisation de mise sur le marché de médicaments (Mém. A 1985, p. 1172).

Loi du 18 décembre 1985 relative aux médicaments vétérinaires (Mém. A 1985, p. 1835).

Règlement grand-ducal du 28 janvier 1986 concernant la mise sur le marché des médicaments vétérinaires (Mém. A 1986, p. 736).

Règlement grand-ducal du 19 janvier 1987 concernant le contrôle des produits phytopharmaceutiques (Mém. A 1987, p. 26) et rectificatifs (Mém. A 1989, p. 1445 et Mém. A 1989, p. 1744).

Loi du 11 janvier 1989 réglant la commercialisation des substances chimiques à activité thérapeutique (Mém. A 1989, p. 57).
Règlement grand-ducal du 6 juillet 1990 fixant les modalités de l'examen médical effectué en cas de présomption de trafic illicite d'un stupéfiant ou d'une substance toxique, soporifique ou psychotrope (Mém. A 1990, p. 447).

Règlement ministériel du 14 novembre 1990 déterminant le questionnaire à remplir à l'occasion d'un examen médical en cas de présomption de trafic illicite d'un stupéfiant (Mém. A 1990, p. 877).

Loi du 4 décembre 1990 portant approbation de la Convention sur les substances psychotropes, faite à Vienne le 21 février 1971 (Mém. A 1990, P . 991) .

Loi du 8 avril 1991 portant approbation du Protocole à la Convention relative à l'élaboration d'une pharmacopée européenne, signée à Strasbourg, le 16 novembre 1989 (Mém. A 1991, p. 486).

Règlement grand-ducal du 23 juillet 1991 déterminant les conditions de commercialisation des substances chimiques à activité thérapeutique (Mém. A 1991, p. 1003).

Texte coordonné du 29 octobre 1992 de la loi du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie, telle qu'elle a été modifiée.

Règlement grand-ducal du 15 décembre 1992 relatif à la mise sur le marché des médicaments (Mém. A 1992, p. 3060), modifié par règlement grand-ducal du 11 août 1996 (Mém. A n° 54 du 23/08/1996, p. 1678).

Règlement grand-ducal du 15 janvier 1993 relatif à la mise sur le marché des médicaments vétérinaires (Mém. A 1993, p. 52), modifié par règlement grand-ducal du 11 août 1996 (Mém. A n° 54 du 23/08/1996, p. 1678).

Règlement grand-ducal du 8 mai 1993 relatif au commerce de stupéfiants et de substances psychotropes (Mém. A 1993, p. 661). Règlement grand-ducal du 24 décembre 1993 fixant les droits dus pour la mise sur le marché des médicaments (Mém. A 1993, p. 3148).

Loi du 6 janvier 1995 relative à la distribution en gros des médicaments (Mém. A 1995, p. 20).

Règlement grand-ducal 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 (Mém. A –11 du 10 février 1995, p. 585).

Règlement grand-ducal du 31 juillet 1995 modifiant le règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques (Mém. A – 66 du 16 août 1995, p. 1577).

Règlement grand-ducal du 18 janvier 1996 modifiant le règlement grand-ducal du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie (Mém. A - 7 du 5 février 1996, p. 84).

Loi du 26 avril 1996 portant approbation de la Convention contre le dopage, faite à Strasbourg, le 16 novembre 1989 (Mém. A n° 31 du 10 mai 1996, p. 1032) - Ratification et entrée en vigueur à l'égard du Luxembourg (Mém. A n° 48 du 29 juillet 1996, p. 1392).

Règlement grand-ducal du 7 juin 1996 déterminant les mesures d'application et de sanction du règlement CEE modifié N° 3677/90 du Conseil relatif au commerce de précurseurs de drogues entre la Communauté et les pays tiers (Mém. A n° 40 du 19 juin 1996, p. 1281).

Règlement grand-ducal du 20 juin 1996 relatif aux médicaments homéopathiques (Mém. A n° 42 du 28/06/1996, p. 1296).

Règlement grand-ducal du 11 août 1996 modifiant le règlement grand-ducal du 15 janvier 1993 relatif à la mise sur le marché des médicaments vétérinaires (Mém. A n° 54 du 23/08/1996, p. 1678) ainsi que le règlement grand-ducal du 15 décembre 1992 relatif à la mise sur le marché des médicaments (Mém. A n° 54 du 23/08/1996, p. 1678).

Règlement grand-ducal du 9 octobre 1996 complétant l'annexe du règlement grand-ducal modifié du 14 mars 1974 concernant certaines substances toxiques (Mém. A n° 77 du 07/11/1996, p. 2220).

Règlement grand-ducal du 9 octobre 1996 complétant et modifiant l'annexe du règlement grand-ducal du 20 mars 1974 concernant certaines substances psychotropes (Mém. A - 77 du 7 novembre 1996, p. 2220).

Règlement grand-ducal du 6 février 1997 relatif aux substances visées aux tableaux III et IV de la Convention sur les substances psychotropes, faite à Vienne, le 21 février 1971 (Mém. A - 9 du 19 février 1997, p. 600).

Règlement grand-ducal du 23 mai 1997 modifiant le règlement grand-ducal modifié du 19 février 1974 portant exécution de la loi du 19 février 1973 sur la vente des substances médicamenteuses et la lutte contre la toxicomanie (Mém. A - 41 du 11 juin 1997, p. 1439).

Règlement grand-ducal du 11 octobre 1997 portant interdiction de l'utilisation de certaines substances à effet hormonal ou thyréostatique et des substances Bêta-agonistes dans les spéculations animales (Mém. A - 82 du 23 octobre 1997, p. 2525).

Règlement grand-ducal du 9 janvier 1998 modifiant le règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants (Mém. A - 4 du 29 janvier 1998, p.55).

Loi du 11 août 1998 portant introduction de l'incrimination des organisations criminelles et de l'infraction de blanchiment au code pénal (Mém. A – 73 du 10 septembre 1998, p.1455).

Règlement grand-ducal du 8 mai 1999 modifiant l'annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques (Mém. A - 55 du 19 mai 1999, p.1326).

Règlement grand-ducal du 6 décembre 1999 modifiant le règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques (Mém. A - 146 du 23 décembre 1999, p.2640).

Règlement grand-ducal du 6 décembre 1999 modifiant l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes (Mém. A - 146 du 23 décembre 1999, p.2641).

Règlement grand-ducal du 6 décembre 1999 modifiant le règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants (Mém. A - 146 du 23 décembre 1999, p.2641).