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ADMINISTRATION

# Annual National Report on the Drug Situation 2001

GRAND DUCHY OF LUXEMBOURG

October 2001

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Head of Focal Point

Commissioned by the  
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## *Foreword*

The present report on the drug situation in the Grand Duchy of Luxembourg has been compiled for the European Monitoring Centre for Drugs and Drug Addiction.

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), Prof. Dr Robert Wennig (National Laboratory of Health LNS), Henri Goedertz (AIDS Berödung 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 Ferdy Kasel and Robert Hottua (CHNP-BU-V), Dr Mühe (CHL), Alain Massen (MSF), Tom Schlechter (CNDS-ABRIGADO), Hélène Dellucci and Pascale Straus (NFP – CRP-Santé), Daniel Schroeder (Consultant), Céline Victoire (Administration du Contrôle médical), J.-P. Juchem (Union des Caisses de Maladie), Mady Rouleaux (Directorate of Health), J.-M. Schanck and Guy Rheinart (Ministry of Health).

Luxembourg, October 2001

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*Foreword*

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## REFERENCES

## ANNEX

## GLOSSARY

<b>AST</b>	Service d'Action Socio-Thérapeutique
<b>CNDS</b>	Comité National de Défense Sociale
<b>CePT</b>	Centre de Prévention des Toxicomanies
<b>CPOS</b>	Centre de Psychologie et d'Orientation Scolaire
<b>CRP-HT</b>	Centre de Recherche Public - Henri Tudor
<b>CRP-Santé</b>	Centre de Recherche Public - Santé
<b>CTM</b>	Centre Thérapeutique de Manternach
<b>CHNP</b>	Centre Hospitalier Neuro-Psychiatrique
<b>CPG</b>	Centre Pénitentiaire de Givenich
<b>CPL</b>	Centre Pénitentiaire de Luxembourg
<b>GHD</b>	Groupe Horizontal « Drogues »
<b>GID</b>	Groupe Interministériel « Drogues »
<b>EMCDDA/OEDT</b>	European Monitoring Centre for Drugs and Drug Addiction
<b>EMA</b>	Agence Européenne pour l'Evaluation des Médicaments
<b>EUROPOL</b>	Office Européen de Police
<b>FLTS</b>	Fonds de Lutte contre le Trafic des Stupéfiants
<b>JDH</b>	Fondation Jugend- an Drogenhëllef
<b>LNS</b>	Laboratoire National de Santé
<b>MSF</b>	Médecins Sans Frontières
<b>OEDT/EMCDDA</b>	Observatoire Européen des Drogues et des Toxicomanies
<b>OGD</b>	Observatoire Géopolitique des Drogues
<b>PFN</b>	Point Focal National de l'OEDT
<b>PNUCID</b>	Programme des Nations Unis pour le Contrôle des Drogues
<b>RELIS</b>	Réseau Luxembourgeois d'Information sur les Stupéfiants
<b>SEPT</b>	Semaine Européenne de Prévention des Toxicomanies
<b>SNJ</b>	Service National de la Jeunesse
<b>SPJ</b>	Service des Stupéfiants de la Police Judiciaire
<b>TRANSRELIS</b>	Réseau transfrontalier d'Information sur les Stupéfiants
<b>ZePF</b>	Zentrum für Empirische Pädagogische Forschung – Universität Landau

## Summary

### Annual National Report on the Drug Situation (Edition 2001)

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

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 enables the rapid assessment of new trends and developments.

Its objective is to:

- present comprehensive information on drug issues in the Grand Duchy of Luxembourg
- contribute to drug prevalence estimations 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 supply, demand and risk reduction activities on current drug consume behaviours
- serve as a national data base for research activities.

#### Political, legal and budgetary orientations

Following the parliamentary elections of 1999, the Ministry of Health has been entrusted the **overall drug policy coordination**. The strategic framework of drug demand reduction interventions has been defined by the national drug coordinator mandated by the Minister of Health by means of a **national action plan on drugs and drug addiction** covering the period 2000 to 2004. The latter constitutes the outcome of the bilateral consultation process between the drug coordinators' office and competent field institutions in the light of priorities set by the governmental declaration of 1999. The drug action plan mainly addresses current needs in terms of specialised infrastructures, human and financial resources, collaboration networks and required developments in the field of drug research.

Furthermore, the 2000-2004 action plan is based on the amendments introduced by the **law of 27 April 2001** modifying the basic drug law of 19 February 1973. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of harm reduction and maintenance measures as for instance drug substitution treatment, needle exchange and other state licensed means which could materialise in shooting galleries or medically controlled heroin distribution programmes.

Financial and human resources required for the implementation of the drugs action plan are guaranteed by the Ministry of Health. The overall **budget of the Ministry of Health** allocated to **drug demand reduction measures** has witnessed an increase from 770.000.- € in 1999 to 2.21 million € in 2000, following the centralisation of demand and harm reduction activities by the Ministry of Health and to 2.71 million € in 2001. The provisional budget of 2002 foresees a **supplementary increase of 34.37 per cent**, thus figuring 3,64 million €. The consistent increase in 2002 is mainly due to the implementation of the drugs action plan 2000-2004. In

accordance to national needs and the upcoming work plan of the EMCCDA, a national study on the socio-economical costs of drug use is currently performed by the NFP.

## Law enforcement indicators <sup>1</sup>

### *Seizures of illicit substances at the national level*

Striking variations have been observed as to the **quantity of illicit substances seized** since 1984. The general downward trend as regards seized quantities of heroin and cocaine from 1996 onwards is followed by a steep increase in 2000, due to two major transit seizures.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993 (2000: 969). The number of cocaine and ecstasy like substances' seizures has stabilised and one observes a moderate but continuous increase of amphetamines seizures since 1997. 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), reaching in 2000 the level observed in 1997. The same trend, although proportionally less important, has been observed with respect to the **total number of persons involved in drug seizures**, figuring 1,168 offenders in 1999 and 1,007 in 2000. Summarily, quantities of seizures have been decreasing since 1996, while the number of persons involved shows a significant increase until 1999. The development of distribution micro networks may partly contribute to the current situation. 58 per cent of persons involved in drug seizures are non-natives.

**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 between 1994 onwards whilst seizures, in terms of quantity, have significantly decreased in 1997 and have remained fairly stable over the last 4 years (2000: 316 pills).

In 2000 a remarkable increase of quantities of seized **cannabis** has been observed; the number of cannabis seizures and persons involved followed proportionally an even steeper upward trend. Between 1994 and 2000 the number of cannabis seizures went from 167 to 400. During the same period, the number of offenders involved has marked an increase from 242 to 518.

### *Drug law offenders and prison sentences*

The **number of police records** for presumed offences against the drug law, shows an important increase between 1995 (764) and 2000 (1,340). The **number of drug law offenders** ('*prévenus*' ) has increased from 1,263 in 1995 to 1,758 in 2000. 117 arrests on the same charge have been reported in 2000 (stable since 1998).

The population of drug law offenders counts 85 per cent of males; a proportion that has been varying between 79 and 89 per cent during the past decade. Since 1995, **non-natives** have been representing the majority of drug law offenders (2000: 55%, stable since 1998). Regarding the proportion of **first drug law offenders** (35%), a discontinuous upward trend-line can be observed. The percentage of **minors** (< 18 years) in drug law offenders has increased significantly since 1993 (5,4%) (2000: 8.8%). During the same period the proportion of minors in first drug law offenders went from 14.9 % to 25.3%.

The proportion of **prison sentences** for drug law offences has decreased significantly referred to 1996 data. In 2000, 161 new entries (21 %) (1996: 42.6%) of convicted drug law offenders have been reported by national penal institutions (of a total number of 767 entries in 2000).

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<sup>1</sup> If not specified, data refer to 2000. Figures between brackets refer to 1999 if not specified.

Nevertheless, 55 per cent of problem drug users indexed by RELIS in 1995 reported at least one prison journey during their lifetime; in 2000 the same proportion equals 74 per cent.

## Epidemiological indicators

### Drug use in population

#### *Drug prevalence in school population*

Comparable data from national school surveys, conducted between 1992 and 1999, show increasing lifetime prevalence in young people (16-20 years) for all common illicit substances. Referred to the data from the most representative national school surveys, special emphasis may be put on the disproportional increase of cannabis (16 to 20 years : in 1992 (Matheis 1995) : 10.1% and in 1999 (HBSC 2000) : 38.9%), magic mushrooms (16 to 20 years : in 1992 (Matheis 1995) : 7.1%) and ecstasy prevalences (16 to 20 years : in 1992 (Matheis 1995) : 1.2% and in 1999 (HBSC 2000) : 5.2%). Prevalence of opiates use in youngsters (16 to 20 years : in 1992 (Matheis 1995) : 0.9% and in 1999 (HBSC 2000) : 1.3%) is still showing a low prevalence, which has poorly increased during the referred period. In younger school populations (13-14 and 15-16 years) similar trends are observed, especially with regard to cannabis lifetime use.

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 high risk drug users** indexed by national institutions in 2000 figures 1,024 (1,198) persons (double counting excluded). 637 (757) persons were indexed by **treatment agencies** and 510 (551) by **law enforcement agencies**.

32 per cent (33%) of indexed drug users, of which 63% were non-natives, 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 46 per cent (39%). On average, a problem drug user addresses 1.66 (1.7) drug treatment demands per year. For 3 per cent (4%) of registered cases it has been the **first drug treatment demand** during lifetime (**inter-institutional**).

#### *Socio-demographic and epidemiological characteristics of problem HRC drugs users*

**Gender distribution** has remained fairly balanced since 1994 (2000: 23 % females, 77 % males). The proportion of **non-natives** among the overall national drug population has known a significant increase between 1998 (18%) and 1999 (48%) followed by a stabilisation in 2000 (45%). Since 1994, the **duration of residence** in the G. D. of Luxembourg of non-native problem drug users has constantly increased. The population of non-natives drug users largely consists of Portuguese nationals (2000: 54%, stable); a proportion which is consistently higher than the one observed in the general population. Persons of French and Italian origin respectively count for 17 and 10 percent in non-native problem drug users.

Compared with 1995, the **average age**, applied to the total drug population (28 Y, 1M), has slightly increased, (2000: 28Y, 9M). The proportion of **persons aged 35 and more** has constantly increased since 1996 as well as the **standard deviation** of the observed age distribution meaning that the gap between the youngest and oldest drug users tends to increase. Currently one observes a fairly polarized situation that is an aging population of

long-term drug injectors and a significant decrease in age referred to first treatment demanders and first drug offenders. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders (8.8%), in first drug offenders (25.3%), in the total drug population (3.2%) and to the percentage of students in problem drug users (20%). 82 per cent and 47 per cent of problem users have experienced cannabis and heroin (i.v.) use respectively, while being underage. In 1995, RELIS figures referred to 71 per cent and 23 per cent respectively. Based on RELIS data and several indirect indicators one may estimate the current **prevalence of problem drug users underage** reaching 80 to 100 persons including 40 to 60 injectors.

The average ages of native and non-native problem drug users tend to balance. The **difference in age in proportion to gender** has increased mainly due to the low and decreasing age of female drug users. Generally speaking, the **profile of female users** has known most significant changes during recent years. In comparison with male users, one should mention a lower age (13Y, 3M) at first consume of cigarettes, at first use of illicit drugs (14Y4M) and an earlier start of a physical addiction state reported by female users.

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

**Residential status** of problem drug users has improved for the last 4 years. The proportion of persons reporting stable accommodation has increased from 31 per cent in 1995 to 49 per cent in 2000. At the time of their last indexing, 25 per cent of users lived with their parents or a member of the **family of origin**. **Geographic distribution**, according to electoral districts, suggests that 39.4 per cent (36%) come from the centre region and 41.6 per cent (44.5%) from cities in the South of the country. Eastern cantons figured 5 per cent in 1996 and 9.1 per cent in 2000 and Northern cantons have been showing a stable trend (8-10%) following a significant increase until 1997.

All indicators included, the **employment status** of respondents has declined for the last three years. The **unemployment rate** (2000: 65%) among the drug population has grown in significance since 1997. Data on **revenues** confirm observed trends in occupational status, namely a weakening of financial autonomy (2000: 29%) associated to an **increasing social dependency** (2000: 61%).

Two socio-economic indicators that show a positive evolution refer to **revenues of illegal origin** and the **indebtedness status**. The former went down from 23 to 9 per cent and the latter from 59 to 41 percent from 1995 to 2000.

*Problem drug use prevalence and consume trends*

The multi-methods prevalence study on problem HRC drug use at the national level, published in 2001(Origer 2001), provides the following figures:

	1997	1999	2000
<b>PROBLEM USE : HRC DRUGS</b>			
Average prevalence	2,100	2,350	2,450
Total prevalence rate	5 /1000	5.43 /1000	5.59 /1000
Total prevalence rate - age: 15-54	8.8 /1000	9.58 /1000	9.86 /1000
<b>PROBLEM USE : MAIN DRUG - HEROIN</b>			
Prevalence heroin	1,680	1,975	2,010
Total prevalence rate - heroin	4 /1000	4.57 /1000	4.58 /1000
Total prevalence rate - heroin - age :15-54	7 /1000	8.05 /1000	8.09 /1000
<b>INTRAVENOUS DRUG USE (IDU)</b>			
Prevalence IDU	1,370	1,780	1,715
Total prevalence rate - IDU	3.25 /1000	4.12 /1000	3.91/1000
Total prevalence rate - IDU - age :15-54	5.71 /1000	7.26 /1000	6.90/1000

**Absolute prevalence and prevalence rates of problem HRC (High Risk Consume) drug use** have been showing a growing tendency over the past four years. The increase curve observed between 1999 and 2000 is less pronounced than the one observed during the period 1997 to 1999. The observed figures comply with the stability of **heroin use** and **intravenous drug use** prevalence between 1999 and 2000. Although the total drug use prevalence shows an upward tendency, heroin use does not contribute significantly to the referred progression. Intravenous drug use prevalence has even shown a slight decrease in 2000. Observed tendencies in most of indirect indicators (e.g. overdoses, treatment admissions, drug offences), closely follow the progression curve of the estimated prevalence between 1997 and 2000.

**Opiates** are referred to as **primary drug** by 84 per cent (stable) of indexed users. The significant increase of the **inhalation mode** (also known as 'blowing' or 'chasing the dragon') referred to opiate use in 1998 (36%) (1997: 10%) was followed by a two-years decrease reaching 24% in 2000. **Intravenous heroin use** as primary consume pattern has stabilised (53%). Cocaine and cannabis use are reported as primary drug by 7% of users, respectively. A complete absence of **crack** and **volatile substances** (e.g. solvents) in primary use patterns has to be stressed. **Ecstasy-like substances** are poorly represented, which has to be interpreted with caution since RELIS indexed only current **problem drug users** and not **exclusive recreational users**.

The proportion of **poly-drug use** (2000: 87 %) still on the increase represent the most common consume pattern. 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 4 years. For instance, 25 per cent (22%) of current problem drug users were younger than 14 years at the moment of first cannabis use and 47 per cent (43%) were still underage (< 18 years) as they first injected opiates. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2000

**Problem cannabis use** prevalence in RELIS respondents has shown an upward trend in 2000 (7%). The observed trend is even more significant if exclusively referred to drug treatment demanders (10%). In this context one might refer to recent results from toxicological expertises performed by the National Health Laboratory (LNS) following **traffic accidents**: in 1995, 30,3 percent of expertises reported cannabis use of involved drivers; in 2000 the same proportion figured 48 per cent.

#### *Drug-related morbidity and mortality*

Indicators retained by RELIS stress a slight improvement of the **general health state** of indexed drug users compared with 1994 data. **HBV** and **HIV** prevalence rates<sup>2</sup> are stable. However, one should emphasise that the **HCV** infection rate has been increasing noticeably and reached 40 per cent in 2000.

Since 1995, the proportion of **AIDS diagnostics** in problem drug users has been varying between 1 and 4 per cent. In terms of data validity, one may stress the high percentage of HIV tested users during the last 5 months (males: 81%, females: 85%). A majority of drug injectors (2000: 68%) report not to share used injection material. **HIV infection rate** has stabilised at 4 per cent. National infection rates are consistently lower than the average of those observed in other European Member states (Greece: 0,5 – Spain: 32% - Portugal 48%), (EMCDDA, 2000). According to official figures published by the National Surveillance Committee on AIDS, the average **proportion of injecting drug users in HIV infected persons** between 1984 and 2000 figures 16 per cent. The NFP is currently setting up a research plan (2001-2003) with the objective to estimate HCV and HIV prevalence in recent drug injectors based on medical diagnosis data (saliva tests).

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<sup>2</sup> HIV and hepatitis figures refer to both, injecting on non-injecting drug users

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 (2000: 28%) showing **psychiatric treatment** demands for reasons other than drug detoxification.

The number of **overdose cases** (acute/direct drug deaths), reported by national authorities, has increased steadily since 1984, peaking with 29 cases in 1994. Decrease was observed from 1995 and persisted throughout 1997 (9 cases). Since 1998 a growth tendency has resumed reaching 26 cases in 2000. Results of toxicological analysis performed on overdose victims refer to the presence of **opiate** traces in 84 per cent of cases. In 67 per cent of autopsy cases **heroin** consume was reported; a proportion on the decrease (1999: 90%) for several years balanced by an increase of **methadone** (29%) being the substance which has caused death.

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.

### Profile of the national drug market

A series of reliable information sources suggest 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. Drug supply indicators support **increased opiates availability** on the national market. In 1996, 9 per cent of indexed problem users reported to acquire drugs exclusively abroad; in 2000 the same proportion figured 3 per cent. During the same period the **average street price of heroin** has decreased.

No illicit **drug 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. The intensification of control measures in border countries with regard to synthetic drugs may have as a result that those production units previously established in border countries migrate in order to implement in the Grand Duchy of Luxembourg.

Average **street retail prices** of illicit drugs have been remaining fairly stable during past years, with the exception of cannabis, on the increase (hashish: 7.4 €/gram, marijuana: 6.2 €/gram) and brown heroin, on the decrease (74 €/gram).

In terms of **purity**, samples of 'suspect substances' analysed by the National Laboratory of Health (LNS) in 2000, revealed the following margins of purity of active substance: brown heroin: 2.8 to 54.9 per cent (↗); cocaine: 28.3 to 95.2 per cent (↘); hashish (THC): 2.65 to 11 per cent (↗). In 2000, toxicological analysis of samples sold as ecstasy reported the presence of MDMA in 21 samples (purity: 18.7 to 52.3%) and MDEA in one sample (purity: 6.8%).

### Harm reduction activities

The number of **sterilised syringes distributed** (2000: 189,413 / 1996: 76,259) has been raising 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** (2000: 112,625 (59%) / 1996: 28,646 (38%)) has increased accordingly. Referring to **facilities** included in the needle exchange programme, a majority of drug injectors procure their injection material

from automatic dispensers. All syringes providing facilities and selling points included, pharmacies constitute the main source of provision (37%) reported by intravenous drug users. The most significant increase during recent years has been observed at the level of specialised treatment agencies (19%). The latter (2000: 50% / 1995: 40%) are also increasingly addressed for first treatment demands, which proved detrimental to first treatment demands addressed to general practitioners.

Admission figures from **low threshold agencies** show a constant increase during recent years. Created in 1989, the national **methadone substitution programme** indexed 30 patients in 1993 and 164 patients in 1999. In 2000, the number of treated patients stood at 158.

In addition to the methadone substitution programme financed by the Ministry of Health, an increasing number of problem drug users address the **network of independent general practitioners** either in expectation of programme admission, for detoxification purposes or in order to get ambulatory maintenance care. Data provided by the Union of Health Insurance Funds refer to 844 (1999: 745) patients who did receive substitution treatment in 2000 by means of the prescription of methadone or buprenorphine containing medicaments (MEPHENON ®, METHADICT ® and SUBUTEX ®). In 2000, the number of GPs prescribing the listed drugs reached 145 (1999:125).

One may recall that the above referred to law of 27 April 2001 has set a **legal framework for drug substitution treatment** and other **drug care facilities duly licensed by State**, which may refer to interventions as the creation of **injection rooms** and **controlled distribution of certain narcotics** (e.g. heroin). The future implementation of such facilities has been included in the drugs action plan 2000-2004 of the Ministry of Health.

## **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,
- 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,
- drug treatment impact evaluation.

## **PART I**

# **NATIONAL AND LOCAL POLICIES & LEGAL FRAMEWORK**

# I. Developments in Drug Policy and Responses

## 1.1 Political framework in the drug field

*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 <sup>3</sup>, confirmed this approach putting further emphasis on the diversification of specialised health care, the adaptation of drug legislation and the promotion of harm reduction activities.*

*Following the parliamentary elections of 1999, the Ministry of Health has been entrusted the **overall drug policy coordination**. The strategic framework of drug demand reduction interventions has been defined by the **national drug coordinator** mandated by the Minister of Health by means of an **action plan on drugs and drug addiction covering the period 2000 to 2004**. The latter constitutes the outcome of the bilateral consultation process between the drug coordinators' office and competent field institutions in the light of priorities set by the governmental declaration of 1999. The drug action plan mainly addresses current needs in terms of specialised infrastructures, human and financial resources, collaboration networks and required developments in the field of drug research. Summarily it 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 will be 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 the head of focal point has been appointed National Drug Co-ordinator.*

*Coordination in the field of **drug-related law enforcement** remains a competence of the Ministry of Justice. The role of the **Interministerial Group on Drugs**, currently chaired by the Ministry of Health, has been enhanced in order to guarantee on overall coordination of demand and supply reduction policies.*

## 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.

*Up to 2000, the 1973 drug law has been amended by:*

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<sup>3</sup> ANNEX IV: Déclaration gouvernementale du 12 août 1999,  
<http://www.gouvernement.lu:80/gouv/fr/gouv/progg/declu.html>

- the law of 23 February 1977 (Official gazette: A 1977, p. 352),
- the law of 7 July 1989 (Official gazette: A 1989, p. 923),
- the law of 17 March 1992 (Co-ordinated text: Official gazette: A 1992, p. 2458).
- (law of 11 August 1998 (Official gazette: A-1998, p. 1456.),
- law of 8 August 2000, modifying
  - a) certain disposition of the law of 19 February 1973;
  - b) the law of 26 July 1986 regarding certain execution principles of prison sentences.

Recent **amendments** to the existing drug legislation have been introduced by the **law of 27 April 2001** modifying the basic drug law of 19 February 1973. Besides the **decriminalisation of cannabis use**, **alleviation of penalties for simple drug use**, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of harm reduction and maintenance measures, namely, drug substitution treatment, needle exchange and other state licensed means which could materialise in shooting galleries or medically controlled heroin distribution programmes. Table 1.2 provides a comprehensive overview of amendments introduced by the law of 27 April 2001. In order to increase readability for non-expert readers, legal terminology has been simplified. Those who would like to dispose of the original legal text should consult the following web sites:

<http://www.etat.lu/memorial> or  
[http://eldd.emcdda.org/databases/eldd\\_search.cfm](http://eldd.emcdda.org/databases/eldd_search.cfm).



*Table 1.2 Overview of amendments introduced by the law of 27 April 2001*

Law 1973	Offence(s) / actions/ regulation	Involved substances	Penalties before entry in force of the law of the of 27 April 2001 Imprisonment and/or fine	Current penalties Imprisonment and/or fine
<b>Art. 1. to 2.</b> (n.m. <sup>4</sup> )	Object of regulation Fixation of control abilities and of designation modalities			
<b>Art. 3.</b>	Modification of competences of certain customs' agents			
<b>Art. 4. to 6.</b> (n.m.)	Conditions and modalities of medical examination in case of alleged drug law offence. Penalties in case of medical examination refusal by presumed offender			
<b>Art. 7.</b>	<p><b>A.1.</b> Use and possession for personal use</p> <p><b>A.2.</b> Use <u>in front of</u> minor(s) of age or at workplace (not specially foreseen before by law of 27/04/2001)</p> <p><b>A.3.</b> Use by teacher/educational staff and/or in school (idem)</p>	<p>A.<sup>5</sup></p> <p>A.</p> <p>A.</p> <p>A.</p> <p>B.<sup>6</sup></p>	<p><u>3 months to 3 years</u><sup>7</sup>      25 €</p> <p>to 2,479 €</p> <p><u>5 years to 10 years</u>      <u>1,240 € to</u></p> <p><u>1,239,468 €</u></p> <p>3 months to 3 years      25 €</p> <p>to 2,479 €</p>	<p>8 days to 6 months      <u>248 €</u></p> <p>to 2,479 €</p> <p>1 month to 1 year      248 €</p> <p>to 12,395 €</p> <p>1 month to 1 year      <u>248 €</u></p> <p>to 12,395 €</p>

<sup>4</sup> n.m.: article, indent or paragraph not modified by law of 17/04/2001

<sup>5</sup> Substances A.: nationally controlled substances other than cannabis

	<p><b>B.1.</b> Use and possession for personal use</p> <p><b>B.2.</b> Facilitation of use for third party</p> <p><b>B.3.</b> Use <u>in front</u> of minor(s) of age or in school and at workplace (not specially foreseen before by law of 27/04/2001)</p> <p><b>B.4.</b> Use <u>with</u> minor(s) of age or by medical doctor, pharmacist or other legally authorised provider of referred substance(s)</p> <p><b>B.5.</b> Illicit use by medical doctor, pharmacist or other legally authorised provider of referred substance(s) in prison, school, social services, sportive or social activity places or in immediate vicinity of this places</p>	<p>B.</p> <p>B.</p> <p>B.</p> <p>B.</p> <p>B.</p> <p>B.</p>	<p>3 months to 3 years to 2,479 €      25 €</p> <p><u>3 months to 3 years to 2,479 €</u>      25 €</p> <p><u>1 year to 5 years 1,239,468 €</u>      124 € to</p> <p><u>5 years to 10 years 1,239,468 €</u>      <u>1,240 € to</u></p> <p>3 months to 3 years to 2,479 €      25 €</p> <p><u>3 months to 3 years to 2,479 €</u>      25 €</p> <p><u>5 years to 10 years 1,239,468 €</u>      <u>1,240 € to</u></p> <p><u>1 year to 5 years 1,239,468 €</u>      124 € to</p> <p><u>2 years to 5 years 1,239,468 €</u>      248 € to</p>	<p><u>1 year to 5 years 2,479 € to 247,894 €</u></p> <p>to 2,479 €</p> <p>to 24,790 €</p> <p>8 days to 6 months to 2,479 €      <u>248 €</u></p> <p>8 days to 6 months to 2,479 €      <u>248 €</u></p> <p>8 days to 6 months to 2,479 €      <u>248 €</u></p> <p>6 months to 2 years 24,790 €      496 € to</p> <p><u>6 months to 2 years 24,790 €</u>      <u>496 € to</u></p> <p>year to 5 years 123,947 €      <u>496 € to</u></p>
<b>Art. 8.</b>	<b>1.a.</b> Illicit cultivation, production, manufacture, extraction, preparation, expedition, import, export, sale, offer or	<b>A. and B.</b>	1 year to 5 years 1,239,468 €      124 € to	1 year to 5 years 1,239,468 € <u>496 € to</u>

6 Substances B.: cannabis and derivatives

7 Underlined penalties indicate higher penalties as referred to the amendment of the 27 April 2001. Depending on the case, all penalties or only minimum and maximum penalties are concerned.

distribution	<b>1.b.</b> Transport, expedition, possession or acquisition or intermediate duty (broker), whether paid or unpaid, destined to other people's use	<b>A. and B.</b>	1 year to 5 years 1,239,468 €	124 € to	1 year to 5 years 1,239,468 €	<u>496 €</u> to
	<b>1.c.</b> Use with minor(s)	<b>A and/or B</b>	<u>5 years to 10 years</u> 1,239,468 €	<u>1,240 €</u> to	1 year to 5 years 1,239,468 €	496 € to
	<b>1.d.</b> Facilitation of other people's use (ex. Providing a room)	<b>A and/or B</b>	(art.9. before modification of 17/04/2001) Substance A. and B.			If substance B. 'minors' erases and replaces the term ' use in group or in front of a third party'
	<b>1.e.</b> Propaganda, publicity or provocation actions on account of aimed substances	<b>A. and B.</b>	1 year to 5 years 1,239,468 €	124 € to	1 year to 5 years 1,239,468 €	<u>496 €</u> to
	<b>1.f.</b> Recourse to false, fictitious or complaisance prescriptions. Deliverance of referred substances with full knowledge of the prescription's illicit origin	<b>A. and B.</b>	Substance A. and B.			If substance A. Exception : offers and means duly licensed by the Ministry of Health
	<b>1.g.</b> Prescription or administration without necessity by medical doctor, so as to create, maintain or aggravate a state of drug addiction.	<b>A. and B.</b>	1 year to 5 years 1,239,468 €	124 € to	1 year to 5 years 1,239,468 €	<u>496 €</u> to
	<b>1.h.</b> Illicit use by medical doctor, pharmacist or other legally authorised provider of referred substance(s)	<b>A and/or B</b>				
	<b>1.i.</b> Manufacture, transportation, distribution and possession of material or substances referred to under art.7, knowing it would be used in or for illicit cultivation, production or manufacture of these substances	<b>A. and B.</b>	1 years to 5 years 1,239,468 €	124 € to	1 year to 5 years 1,239,468 €	<u>496 €</u> to
		<b>A. and B.</b>	1 year to 5 years 1,239,468 €	124 € to	1 year to 5 years 1,239,468 €	<u>496 €</u> to
		<b>A. and B.</b>	1 year to 5 years 1,239,468 €	124 € to	1 year to 5 years 1,239,468 €	<u>496 €</u> to

<b>Art. 8.1</b> (n.m.)	Offence according to art. 8 committed in prisons, schools, social services or in the immediate proximity, and in sportive or social activity places	1 year to 5 years 1,239, 468 €	124 € to	1 year to 5 years 1,239,468 €	<u>496 €</u> to	
	2. Legal institution of a drug addiction treatment program by substitution	2 years to 5 years 1,239,468 €	248 € to	2 ans à 5 ans 1,239,468 €	<u>992 €</u> to	
	1. Facilitation (on purpose) of false justification of the origin of assets or incomes related to one of the offences referred to under art. 8a) and 8b)	Not foreseen			Are excluded from sanctions foreseen under 1.g medical doctors allowed to prescribe the substances referred to under art.7 in the framework of a drug addiction treatment by substitution, instituted by the law of 27.05.01	
	2. Participating in or supporting (on purpose) a placement, concealment or conversion operation of the object or product from one of the infractions referred to under art. 8a) and 8b)					
	3. Acquisition, possession or use of the object or product from one of the infractions referred to under art. 8a) and 8b), knowing their illicit source	1 year to 5 years 1,239,468 €	1,240 € to	1 year to 5 years 1,239,468 €	1,240 € to	
	4. Offences aimed at 1) to 3) are also punishable if the primary offence was committed abroad or/and if the author is also the author or the accomplice of the primary offence	1 year to 5 years 1,239,468 €	1,240 € to	1 year to 5 years 1,239,468 €	1,240 € to	
		1 year to 5 years 1,239,468 €	1,240 € to	1 year to 5 years 1,239,468 €	1,240 € to	

<p><b>Art. 9.</b></p> <p>(n.m.)</p>	<p><b>a)</b> Offence referred to under art. 8) committed towards a minor of age</p> <p><b>b)</b> if the use of the substances made subsequently to a proven offence has caused to a third party whether a incurable disease, a permanent personal work incapacity, or an absolute use loss of an organ, or a serious mutilation</p>	<p><b>A and/or B</b></p>	<p>5 years to 10 years 1,240 € to 1,239,468 € if substance A. or B.</p> <p>5 years to 10 years 1,240 € to 1,239,468 €</p>	<p>5 years to 10 years 1,240 € to 1,239,468 € if substance A.</p> <p>5 years to 10 years 1,240 € to 1,239,468 €</p>
<p><b>Art. 10.</b> (n.m.)</p> <p><b>Art. 10.1</b></p>	<p>Offence referred to under art.8 and 8.1 if they are related to the main or secondary activity of an association or an organisation</p> <p>Offences referred to under art. 8 that have caused death</p> <p>Offences referred to under art. 8 have caused death of a minor of age</p> <p>If guilty of offence(s) referred to under art. 7 or 8c and the use of these substances has caused serious health damage, the offender has immediately sought specialised help</p> <p>If guilty of offence(s) referred to under art.9 or 10 indent 2 and the use of these substances has caused serious healthy damage, the offender has immediately sought specialised help</p>	<p><b>A. et B.</b></p> <p><b>A. et B.</b></p> <p><b>A. et B.</b></p> <p><b>A. et B.</b></p>	<p>15 years to 20 years 1,240 € to 1,239,468 €</p> <p><u>hard labour</u> from 15 to 20 years and a fine from 1,240 € to 1,239,468 € <u>hard labour for life</u></p> <p>not foreseen</p> <p>not foreseen</p>	<p>15 years to 20 years 1,240 € to 1,239,468 €</p> <p>15 years to 20 years 1,240 € to 1,239,468 €</p> <p>15 years to 20 years 1,240 € to 1,239,468 €</p> <p>exemption of penalties</p> <p>reduction of penalties</p>
<p><b>Art. 11.</b> (n.m.)</p>	<p>The association or agreement in order to commit offences referred to under art 8a) and b) is punishable by the same penalties as the consumed offence. The same applies to crimes attempts or offences referred to under art. 8 to 10.</p>	<p><b>A. et B.</b></p>		

<b>Art. 12.</b> (n.m.)	In case of recidivism within a time span of 5 years after a conviction accordingly to offence(s) referred to under art. 8 to 11, prison penalties could be doubled (...)	<b>A. et B.</b>		
<b>Art. 13</b>			Abrogated by the law of 11 August 1998	
<b>Art. 14</b> (n.m.)	<b>Indent 2.</b> Offence referred to under art. 7 to 11 by a pharmacist or a person (author or accomplice) practising a medical profession or paramedical profession  <b>Indent 3.</b> Same offences by persons (author or accomplice) with other professional status if the offence has been committed during the exercise of the referred profession	<b>A. et B.</b>  <b>A. et B.</b>	Possibility for the judge to forbid temporarily or definitely the practice of this profession or occupation  Possibility for the judge to forbid temporarily or definitely the practice of this profession  The judge can forbid to the convict the temporary or definite exploitation whether by himself, whether by an interposed person, of any establishment or any place where the offence has been committed; moreover the judge could order the temporary or definite closing of such institutions	Possibility for the judge to forbid temporarily or definitely the practice of this profession or occupation  Possibility for the judge to forbid temporarily or definitely the practice of this profession  The judge can forbid to the convict the temporary or definite exploitation whether by himself, whether by an interposed person, of any establishment or any place where the offence has been committed; moreover the judge could order the temporary or definite closing of such institutions
<b>Art. 15.</b>			Abrogated by the law of 7 July 1989	
<b>Art. 16</b> (n.m.)	Offences referred to under art. 7 to 11	<b>A. et B.</b>	Court interdiction to drive a automobile vehicle or airplane for a duration ranging between 3 months and 15 years	Court interdiction to drive a automobile vehicle or airplane for a duration ranging between 3 months and 15 years
<b>Art. 17</b>	Infractions to interdictions referred to under art. 14, indent 2	<b>A. and B.</b>	3 months to 1 year                      62 €	3 months to 1 year                      62 € to

(n.m.)	and 3		to 1,240 €	1,240 €
<b>Art.18. - 22.</b> (n.m.)	Regulation on seizure modalities Regulation on legal closing modalities of institutions or any place accessible to public	<b>A. and B.</b>		
<b>Art. 23.</b> (n.m.)  (n.m.)	<b>Indent 1.</b> Culprit(s) of offence referred to under art. 7, 8c) or 8h) who underwent detoxification treatment prior to the disclosure the offence(s)  <b>Indent 2.</b> Police record for illicit use of one of the substances aimed at art. 7  <b>New indent 3.</b> Police record for offence referred under art.8 a) and b), if main activity appears to be personal drug <u>use</u>  <b>New indent 4.</b> Offence referred to under art. 7, 8c) or 8h) and the concerned person has completed a detoxification treatment proposed by the Public prosecutor	<b>A. and B.</b>	Interruption of public action  Possibility for the Public prosecutor to suggest that concerned persons should voluntarily submit to detoxification treatment  Not foreseen  Public action not taken	Interruption of public action  Possibility for the Public prosecutor to suggest that recorded persons should voluntarily submit to detoxification treatment  Possibility for the Public prosecutor to suggest that concerned persons should voluntarily submit to detoxification treatment  No public action taken also for offences referred to under art. 8a), b)
<b>Art. 24.</b> (n.m.)	Charge of having used illegal substances and if it is subsequently established that the person is in need of medical treatment	<b>A. and B.</b>	The examining judge could order, at the state prosecutor's or accused person's request, a detoxification treatment	The examining judge could order, at the state prosecutor's or accused person's request, a detoxification treatment
<b>Art.25. - 29</b>	Regulation of detoxification treatment order Regulation of proposed or ordered withdrawal treatment modalities	<b>A. and B.</b>		
<b>Art. 30.</b>	Creation and function modes of a multidisciplinary service			

(n.m.)	within the Ministry of Health			
<b>Art.30.1</b>	Regulation of prescription and deliver of substances referred to under art. 7 by means of a counterfoil book Control modalities and renewal of the counterfoil book	<b>A. and B.</b>	Not foreseen	New article 30.1
<b>Art. 31.</b> (n.m.)	<b>1.a.</b> Guilty of having committed offence(s) referred to under art. 7, 8c) et 8h) and having revealed to the authorities the identity of offenders referred to under art. 8a), b), d), f), g), l), 9, 10 and 11 if author(s) is(are) unknown, the existence of the committed offences	<b>A. and B.</b>	Exemption of penalties	Exemption of penalties
(n.m.)	<b>1.b.</b> Guilty of having committed offence(s) referred to under art. 8a), b), d), e), l) et 10 indent 1 <sup>st</sup> and having revealed to the authorities, prior to any legal pursuit, the identity of offenders referred to under art. 8a), b), d), f), g), l), 9, 10 and 11 if author(s) is(are) unknown, the existence of committed offences	<b>A. and B.</b>	Not foreseen	Exemption of penalties
(n.m.)	<b>1.c.</b> Guilty of being a member of the association or the agreement as laid down in art. 11, and having revealed to the authorities the existence of this group or provided further information on its operations and hierarchy	<b>A. and B.</b>	Exemption of penalties (diff. terminology)	Exemption of penalties
	<b>2.a.</b> Guilty of having committed offence(s) referred to under art. 8a), b), d), e), l) et 10 indent 1 <sup>st</sup> or guilty of participation to an association or an agreement as laid down in art. 11, <u>after</u> the start of legal pursuits could reveal to the authorities the authors' identity who have remained unknown as regards offences(s) listed in art. 8a), b), d), f), g), i), 9, 10 and 11	<b>A. and B.</b>	Reduction of penalties	Reduction of penalties
	<b>2.b.</b> Guilty of having committed offence(s) referred to under art. 9 or 10 indent 2 and having revealed to the authorities	<b>A. and B.</b>	Not foreseen	Reduction of sentences

	the authors' identity that has remained unknown as regards offences(s) listed in art. 8a), b), d), f), g), i), 9, 10 and 11			
<b>Art. 32.</b> (n.m.)	Extradition procedures for non-native criminals (law 13 March 1870)			
<b>Art. 33.</b>	Abrogation of the law of 28 April 1922			



As regards **regulation mechanisms 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:

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

*In the course of 2001, the following substances have been placed under national control by Grand Ducal regulations of:*

**14 January 2001:** Flunitrazepam – maximum prescription period: 7 days)  
modifying the annexe of the Grand Ducal regulation of 4 March 1974

**23 February 2001:** Norephidrin  
modifying annex I of the Grand Ducal regulation of 2 February 1995

*Other relevant laws in the field of drugs and drug addiction are the following <sup>8</sup>:*

- **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.

- **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).

- **Loi du 14 juin 2001** portant

*1. approbation de la Convention du Conseil de l'Europe relative au blanchiment, au dépistage, à la saisie et à la confiscation des produits du crime, faite à Strasbourg, le 8 novembre 1990;*

<sup>8</sup> **ANNEXE V:** Service Central de Législation, (2001) Relevé Général de la Législation 2000, Luxembourg  
<http://www.etat.lu/SCL/> or [http://eldd.emcdda.org/databases/eldd\\_search.cfm](http://eldd.emcdda.org/databases/eldd_search.cfm)

2.modification de certaines dispositions du code pénal;  
3.modification de la loi du 17 mars 1992  
1.portant 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.

## b. Prosecution policy

Legally speaking, police has no discretionary 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 implies 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

*Following the latest amendment of the national drug legislation by the law of 27 April 2001, no project of law has been reported. The Green Party (Ecological Party) presented a proposition of law to the Parliament on 4<sup>th</sup> January 2001, regarding the regulation of **state controlled cannabis production, distribution and selling** by means of a national observatory on cannabis and local selling points.*

Furthermore, a **grand-ducal regulation concerning practical modalities of drug substitution treatment** and the list of allowed substitution drugs is currently elaborated by the Ministry of Health. At present the regulation proposal foresees mandatory state licenses to be granted by the Ministry of Health to medical doctors prescribing a series of controlled substitution drugs as listed in the regulation as well as substitution notification procedures to a special surveillance commission.

### 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 conducted 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** (1989) 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 expressively 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 pharmaceuticals 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 increased need and willingness to access information on drug consume behaviours by a larger public is seen as a direct consequence of this late evolution.

*As regards the future implementation, **injection rooms and heroin distribution programmes** as retained by the drugs action plan 2000-2004, public opinion largely split leaving absolute opponents on the one side and practical oriented non-opponents on the other side. The site where those infrastructures will be implemented will be of great importance as well as the objective and progressive public relation*

*work aiming to inform the general public on possible consequences (pro and cons) of such measures.*

#### **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 and to avoid counter-productive information strategies especially with regard to the emergence of new synthetic drugs.*

*A national and international press review on drugs, jointly compiled by the State's Press Service and the NFP since 1998, has allowed a close follow-up of the media approach towards the drug phenomenon. The written press and radio show a keen interest in the drugs topic especially since the governmental declaration, and the vote of the law of 27 April 2001.*

Most of national media fit to objective information although a few more socially oriented radio stations and newspapers put further emphasis on controversial, yet constructive, analysis of the current situation. The topics most currently covered by national media are prevention activities, cannabis and ecstasy use, national strategies against drug abuse and, *recently, early warning mechanisms following the emergence of new synthetic drugs and measures retained by the national drugs action plan 2000-2004.*

## 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. Few drug prevention activities are subsidised by council districts on an ad hoc basis. Respective ministries or governmental departments, according to their attributions, are co-ordinating the creation, the implementation and the funding of required infrastructures. Governmental departments directly rely on the state budget while NGOs involved in drug treatment or research activities have either signed a financial and quality control agreement called '*convention de collaboration*' with 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 '*coordination 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 comprehensive drug budget allocation analysis since several budgetary subsections include both, drug specific and other activities. The same comment applies to the funding of drug treatment activities that are ensured by specialised agencies and general health care services and to research and training centres. In accordance to national needs and the work plan of the EMCDDA, a national study on socio-economic costs of drug use and action against drugs has been performed by the NFP (Origer and Cloos, in press). The study report is due for the beginning of 2002. The following preliminary data are extracted from the first draft of the referred study.*

*The overall **budget of the Ministry of Health** directly allocated to **drug demand reduction measures** has witnessed an increase from 770.000.- € in 1999 to 2.21 million € in 2000, following the centralisation of demand and harm reduction activities by the Ministry of Health and to 2.71 million € in 2001. The provisional budget of 2002 foresees a **supplementary increase of 34.37 per cent**, thus figuring 3,64 million €.*

*Financial and human resources required for the **implementation of the drugs action plan 2000 - 2004** are guaranteed by the Ministry of Health. The national study on socio-economic costs of drug use and action against drugs will provide detailed figures on the overall national budget allocated to drug demand and supply reduction activities as well as research programmes in accordance to approved methodological standards.*

**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 typically consumed by mono-users till 1988. Multiple problem drug preferentially 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. **Ecstasy-like** substances show an increasing demand even though seizure figures do suggest an inverse and currently stable trend. All indicators on **cannabis use** (problematic and recreational) are on the increase since three years. Whilst preference patterns have persisted over the past four years, significant changes have occurred in the route of administration. The 2000 figures, albeit showing a slight decrease referred to 1999 data, confirm the decisive reduction in **intravenous opiates** consume associated to an amplification of the **inhalation mode** (also known as 'blowing' or 'chasing the dragon'), compared with 1997 and earlier.

**Cannabis** use is still developing in youngsters especially in association with ecstasy consume. The **average age of first consume of cannabis, ecstasy and iv heroin** tends to decrease. In 2000 a remarkable increase of quantities of seized **cannabis** has been observed; the number of cannabis seizures and persons involved followed a proportionally steeper upward trend. Between 1994 and 2000 the number of cannabis seizures went from 167 to 400 as well as the number of offenders involved has marked an increase from 242 to 518.

Compared with 1995, the **average age**, applied to the total drug population (28Y, 1M), has slightly increased, (2000: 28Y,9 M). The proportion of **persons aged 35 and more** has constantly increased since 1996 as well as the **standard deviation** of the observed age distribution meaning that the gap between the youngest and oldest problem drug users tends to increase. Currently one observes a **fairly polarized situation** that is an aging population of long-term drug injectors and a significant decrease in age referred to first treatment demanders or first drug offenders. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders (8.8%), in first drug offenders (25.3%), in the total drug population (3.2%) and to the percentage of students in problem drug users (20%). 82 per cent and 47 per cent of problem users have experienced cannabis and heroin (i.v.) use respectively, while being a minor of age. In 1995, RELIS figures referred to 71 per cent and 23 per cent respectively. Based on RELIS data and several indirect indicators one may estimate the current **prevalence of problem drug users underage** reaching 80 to 100 persons including 40 to 60 injectors.

The average ages of native and non-native problem drug users tend to balance. The **difference in age in proportion to gender** has increased mainly due to the low and decreasing age of female drug users. Generally speaking, the **profile of female users** has known most significant changes during recent years. In comparison with male users, one should mention a lower age (13Y, 3M) at first consume of cigarettes, at first use of illicit drugs (14Y, 4M) and a earlier start of a physical addiction state reported by female users.

The proportion of **poly-drug use** (2000: 87 %), still on the increase, represent the most common consume pattern. 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 4 years. For instance, 25 per cent (22%) of current problem drug users were younger than 14 years at the moment of first cannabis use and 47 per cent (43%) were still underage (< 18 years) as they first injected opiates. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2000.

Drug supply indicators support increased **opiates availability** on the national market. In 1996, 9 per cent of indexed problem users reported to acquire drugs exclusively abroad; in 2000 the same proportion figured 3 per cent. During the same period the **average street price of heroin** has decreased.

**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). **Geographic distribution**, according to electoral districts, suggests that 39.4 per cent (36%) come from the centre region and 41.6 per cent (44.5%) from cities in the South of the country. Eastern cantons figured 5 per cent in 1996 and 9.1 per cent in 2000 and Northern cantons have been showing a stable trend (8-10%) following a significant increase until 1997.

Attention should be paid to low detection figures 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) or PMA (paramethoxyamphetamin).

## 2.2 Drug use in population

### a. General population

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

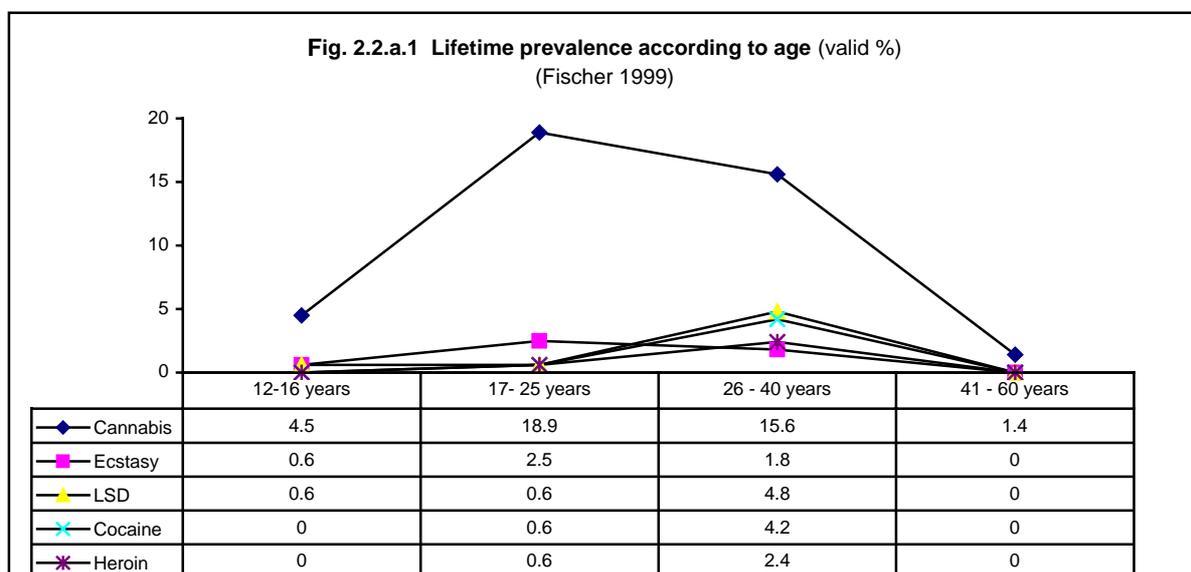
➤ In the beginning of 1995, a pilot project on community based drug prevention has been launched by the CePT. Currently, 13 district councils spread all over the country are involved in the project, which also included a low scale (not representative) study on drug consume in the general population. The results from the CePT study (ref. b.1) are currently the most reliable source providing an exploratory picture of the national drug use prevalence in general population.

<b>REFERENCE b.1.</b>	Fischer U. CH. et Krieger W. (1999) Suchtpräventioun an der Gemeng – Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg.
	EN.: Drug prevention at the communal level
Year of data collection	1998
Single/repeated study	Single study
Context	Drug Prevention - Public Health – Cross sectional
Area covered	7 council districts of the Grand Duchy of Luxembourg
Age range	12-60 years
Data coll. procedure	Anonymous self-administrated questionnaires
Sample size	667 valid cases
Response rate (M, F, T)	33.9%

Substance	LIFETIME PREVALENCE (15-34 years)	LAST 30 DAYS PREVALENCE (15-34)
Cannabis	15.8%	5.6%

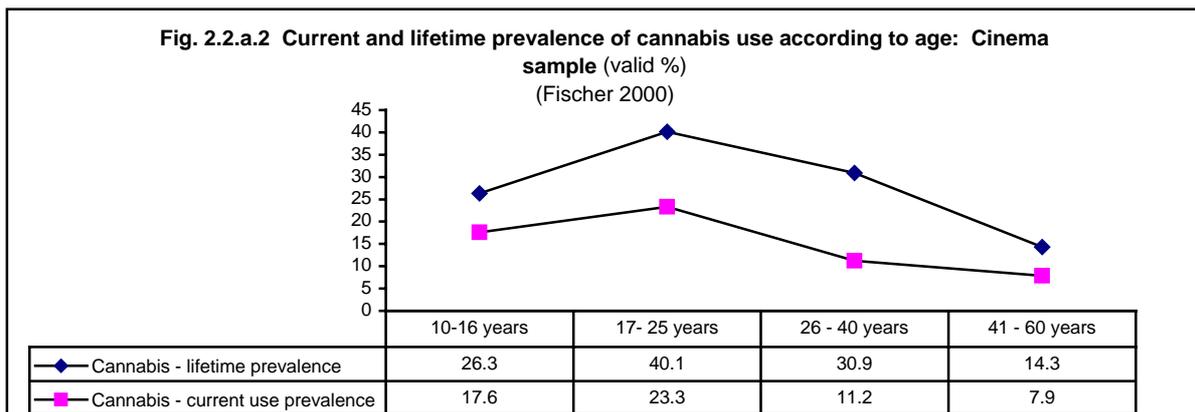
Ecstasy:	1.2%	0%
Heroin	1.9%	0.3%
Cocaine:	0.3%	0.3%
LSD:	1.3%	0.0%
Magic mushrooms	2.6%	1.3%

Source: Fischer, 1999



➤ A second survey, (Fischer, 2000) worth mentioning in the present context has been commissioned by the CePT in 1998 (ref. b.2). Although focusing on cannabis use lifetime and current prevalence, the referred survey included other drugs use and sampled cinema customers in Luxembourg-City (ref. B.2) and the population of 6 council districts (ref. B.3), respectively.

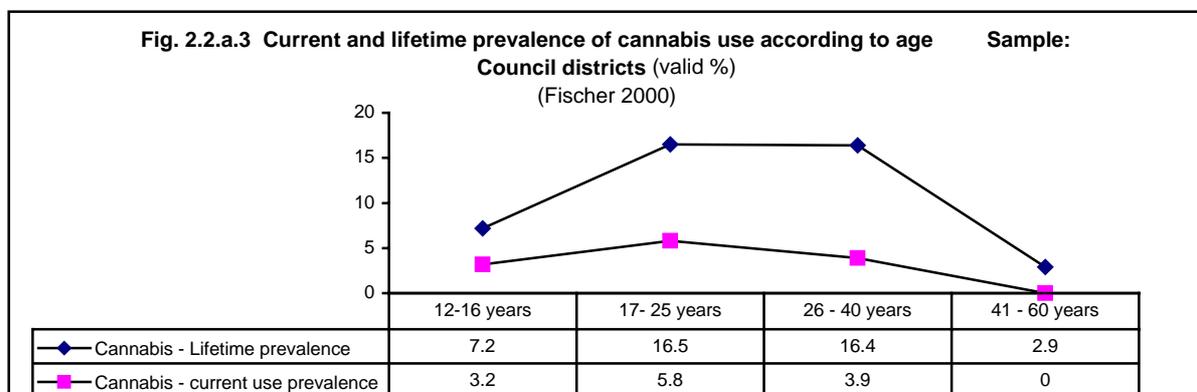
<b>REFERENCE b.2:</b>	Fischer U. CH. (2000) Cannabis in Luxemburg - Eine Analyse der aktuellen Situation, CePT, Luxemburg.
	<b>EN.:</b> Cannabis in Luxembourg
Year of data collection	1998
Single/repeated study	Single study
Context	Drug Prevention - Public Health – Cross sectional
Area covered	Cinemas 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
Remark	Detailed results of both surveys are provided in EMCDDA standard tables



**REFERENCE b.3:** Fischer U. CH. (2000) *Cannabis in Luxemburg - Eine Analyse der aktuellen Situation*, CePT, Luxembourg.

EN.: Cannabis in Luxemburg

Year of data collection 1999  
 Single/repeated study Single study  
 Context Drug Prevention - Public Health – Cross sectional  
 Area covered 6 district councils  
 Age range 12 to 60 years  
 Data coll. procedure Mail questionnaire  
 Sample size 486 valid cases  
 Sampling procedure Random sampling  
 Response rate 27.7%



## 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.

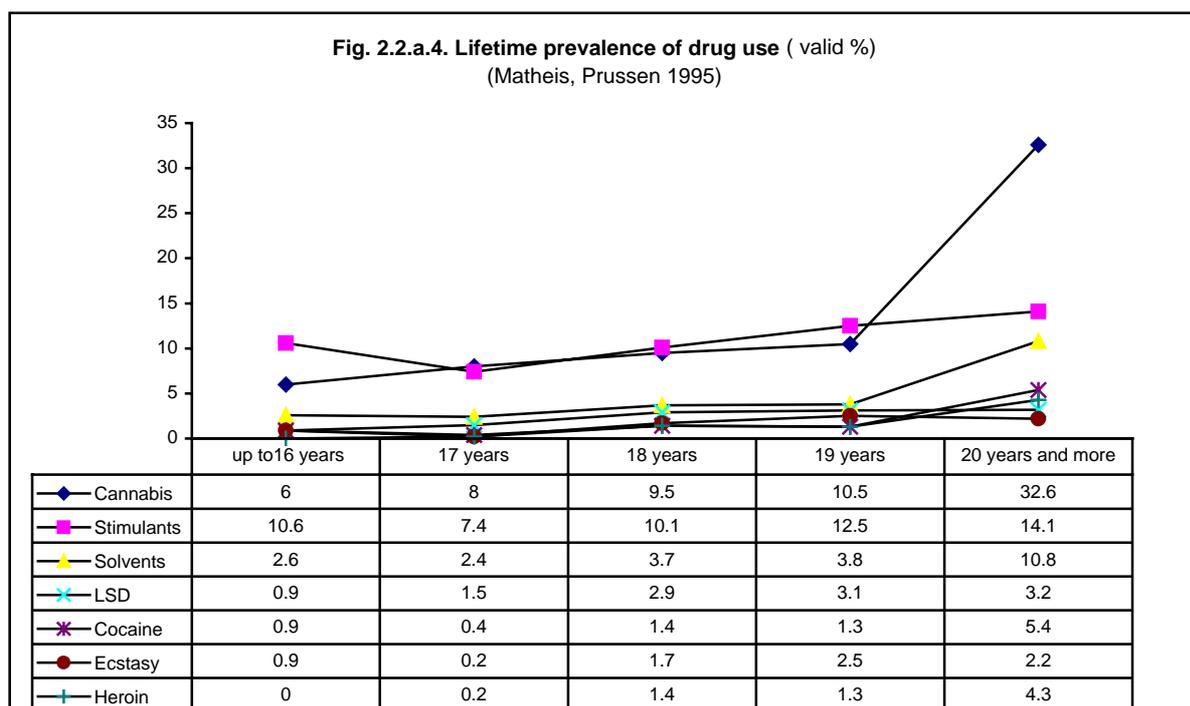
As regards the **first category**, a repeated studies has been conducted in 1983 and 1992)(ref.1) and two single study in 1994 (ref.2) and in 1999 (ref.3), respectively. The 1999 survey (HBSC), which is repeated each 4 years is the most representative school survey ever conducted at the national level. It is based on the WHO cross-national survey on health and health behaviour among young people, last published in 2000.

It has been jointly performed the Ministry of Youth and Education and the Directorate of Health.

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:	<b>Matheis J. et al. (1995) 'Schüler an Drogen', IEES, Luxembourg. EN.: Students and Drugs</b>
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%
	Matheis and Prussen (1985) have conducted a survey on 1983 data relying on the same methodological criteria than the 1995 survey. The referred study will be addressed in the comparative analysis part.



REFERENCE 2:	<b>Dickes P. et al. (1996), La consommation de drogues légales et illégales des élèves des 6ième de l'enseignement secondaire et des 8ième de l'enseignement secondaire technique, CEPS/INSTEAD. Luxembourg. EN.: The use of licit and illicit drugs by students in 6<sup>th</sup> and 8<sup>th</sup> classes of national secondary schools.</b>
Year of data collection	1994
Single/repeated study	Single study
Context	Drug prevention. Commissioned by the National Drug Prevention Centre (CePT)

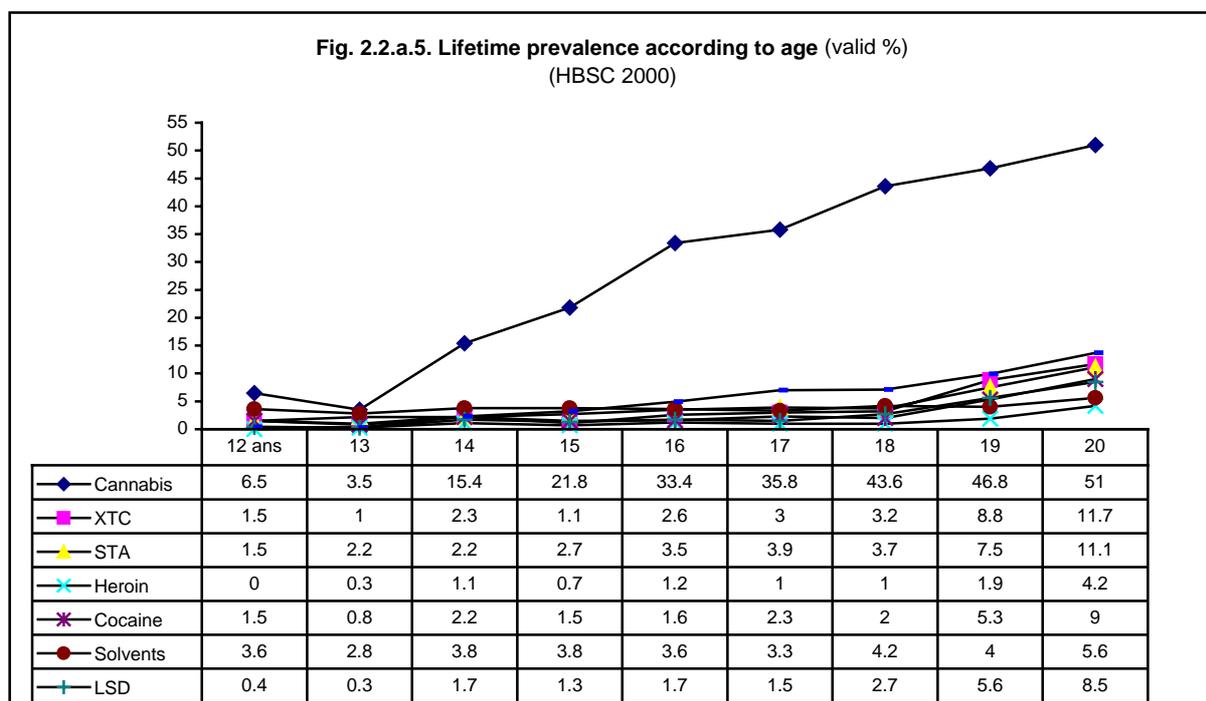
Area covered	City of Luxembourg
Type of school	6th secondary school level and 8th secondary technical school level
Age range	13-16 years
Data coll. procedure	Anonymous self-administrated questionnaires in school classes
Sample size	650
Response rate (M, F, T)	100%

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

Source : Dickes, 1996

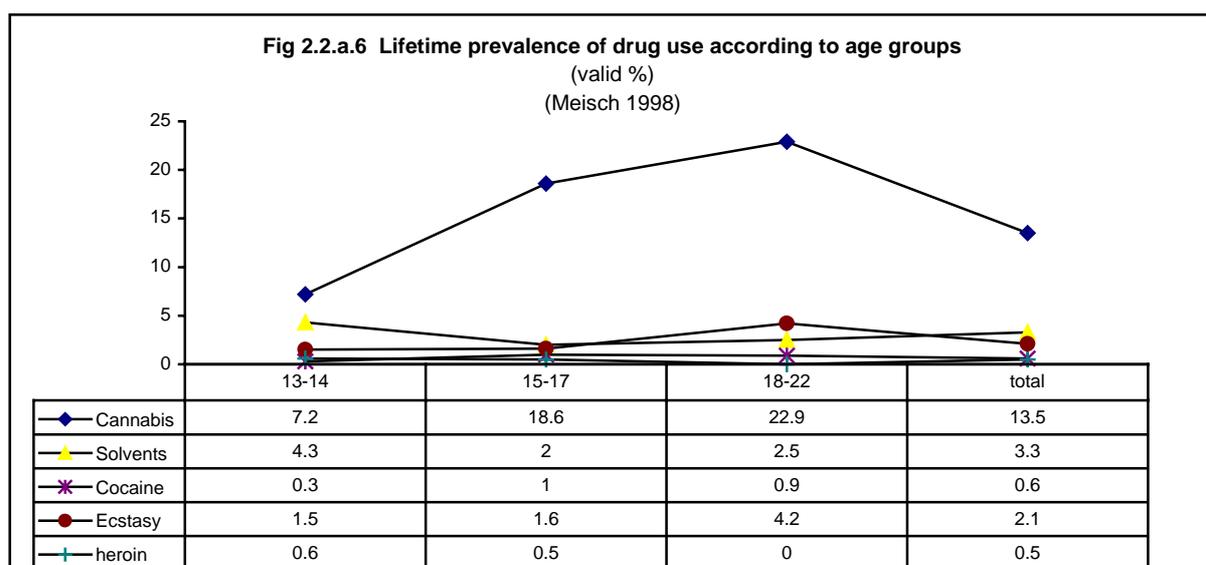
REFERENCE 3: Das Wohlbefinden der Jugend – HBSC Studie (in press), Ministère de l'Education Nationale de la Jeunesse et des Sports, Direction de la Santé, Luxembourg.  
EN.: Health and Health Behaviour of Young People

Year of data collection	1999
Single/repeated study	Repeated study (intended each 4 years)
Context	Health and Health Behaviour among Young People – WHO cross-national study
Area covered	Nation wide, representative
Type of school	Secondary schools
Age range	12-21 years
Data coll. procedure	Anonymous self-administrated questionnaires in school classes
Sample size	7,347
Response rate (M,F,T)	97%



## Surveys: category 2

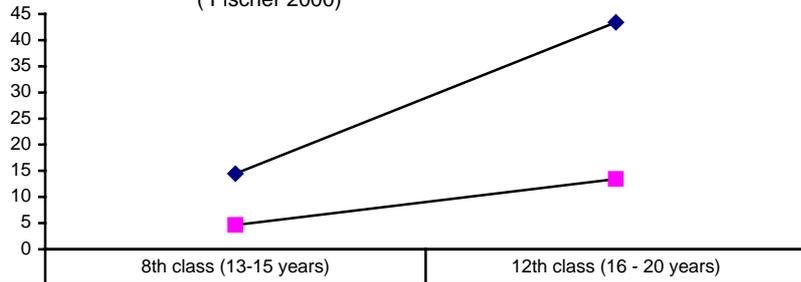
REFERENCE 4:	<b>Meisch, P.</b> (1998), Les drogues de type ecstasy au Grand-Duché de Luxembourg, CePT, Luxembourg. <b>EN:</b> Ecstasy type drugs in the G. D. of Luxembourg
Year of data collection	1997
Single/repeated study	Single
Context	Public Health - primary drug prevention
Area covered	Nation wide
Type of school	2 <sup>nd</sup> and 6 <sup>th</sup> 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:	<b>Fischer U. CH.</b> (2000), Cannabis - Eine Analyse der aktuellen Situation, CePT, Luxembourg. <b>EN.:</b> Cannabis – Rapid assessment of the current national situation.
Year of data collection	1999
Single/repeated study	Single
Context	Cannabis prevalence
Area covered	Nation wide
Type of school	2 <sup>nd</sup> and 6 <sup>th</sup> years of secondary schools
Age range	13-20 years
Data coll. procedure	Self-administrated questionnaires
Sample size	562
Sampling frame	Schools selected on basis of their geographical situation (national representativity), exhaustive student sampling within the selected schools.
Response rate (M, F, T)	100%

**Fig. 2.2.a.7. Current and lifetime prevalence of cannabis use according to school levels**

(valid %)  
( Fischer 2000)



	8th class (13-15 years)	12th class (16 - 20 years)
—◆— Cannabis - Lifetime prevalence	14.5	43.4
—■— Cannabis - current use prevalence	4.64	13.45

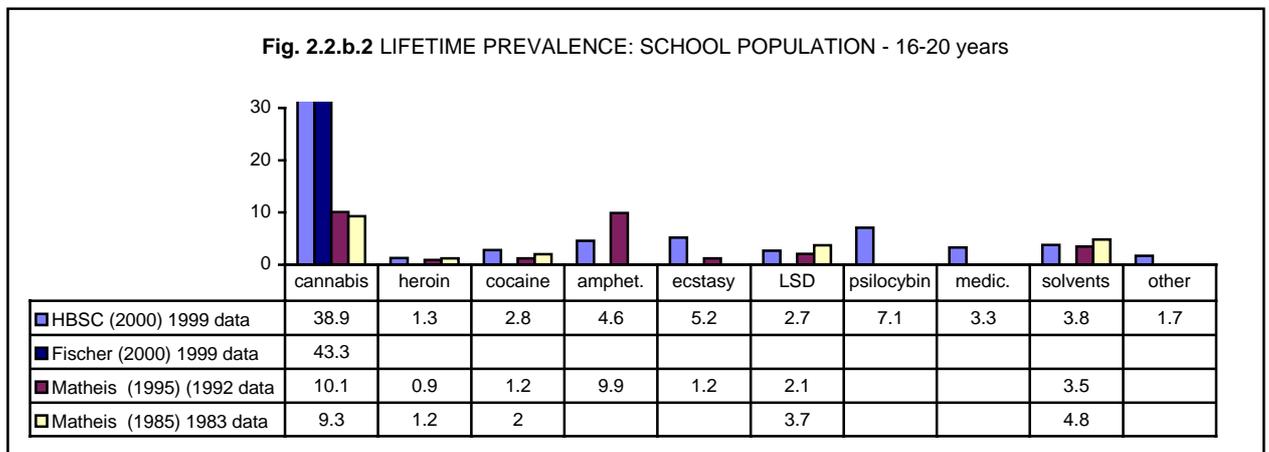
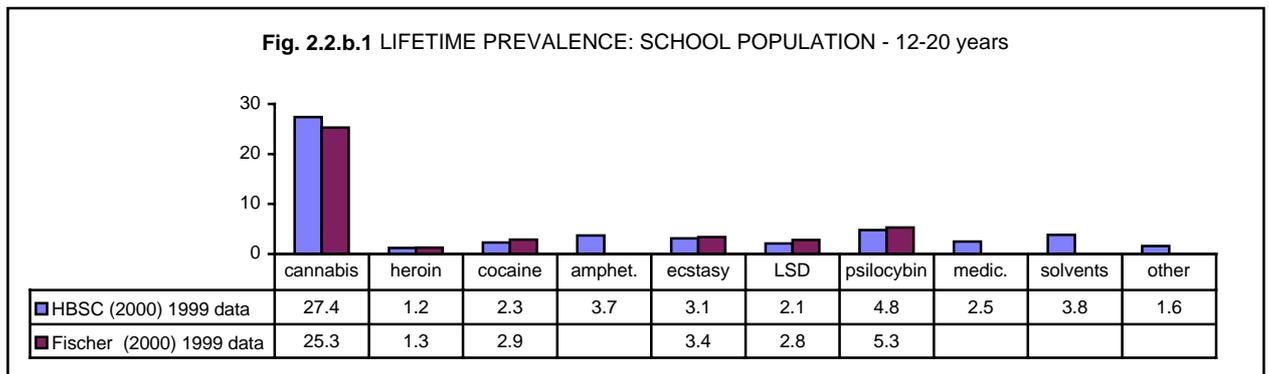
SYNOPSIS OF MAIN COMPARABLE RESULTS AND OBSERVED TRENDS

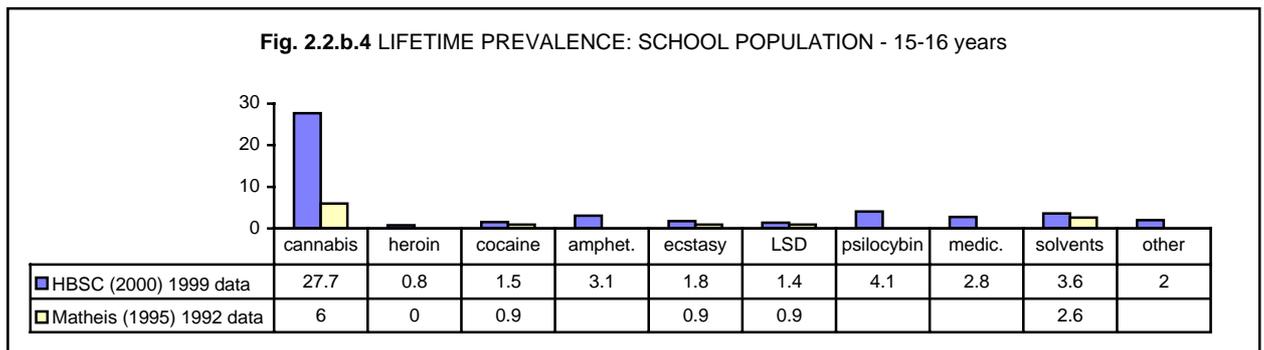
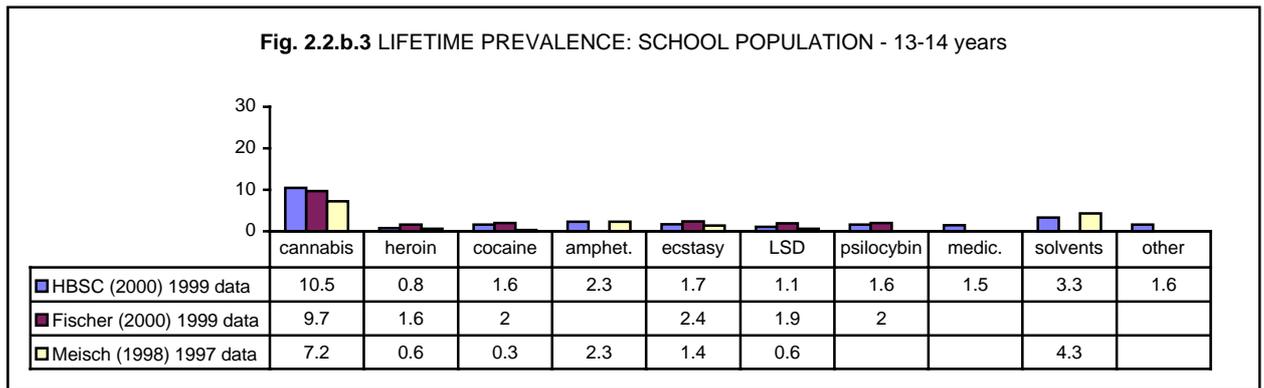
**LIFETIME PREVALENCE: SCHOOL POPULATION:**

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 but a higher prevalence of medicament use.

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

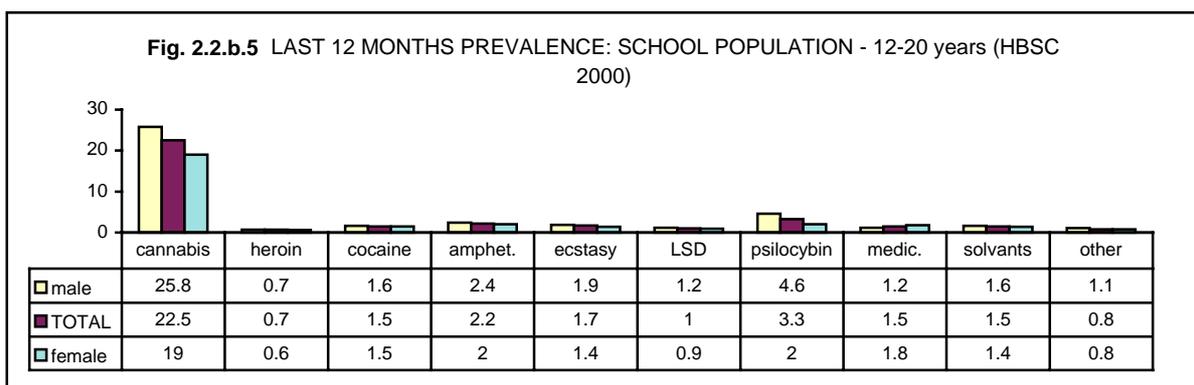
Regarding age group **13-14**, one should emphasise the increase of cannabis (9.7 - 10.5%) and cocaine (1.6 - 2%) lifetime prevalence over the last two years. In age group **15 -16** years, all prevalence rates show increasing figures since 1992 (cannabis: 27.7%, psilocybin: 4.1%). Compared with the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





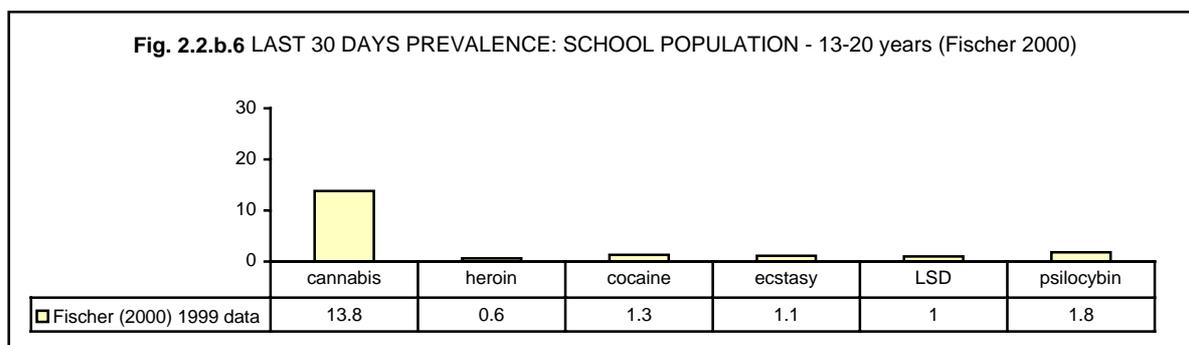
### LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

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



## LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

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



### 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.

#### MAIN RESULTS:

- GPs reported on average 3 different drug treatment demanders 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 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. HIV and HCV status were determined by on site saliva tests. 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 current drug injection 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 (control group);
- IDUs showed lower average age than non drug users;
- a majority of imprisoned IDUs were natives

<b>REFERENCE c.2</b>	<b>Dr. Schlinck J.</b> (1999), Etude épidémiologique des infections à l'HIV et à l'hépatite virale C dans les prisons luxembourgeoises, CPL, Luxembourg.
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**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

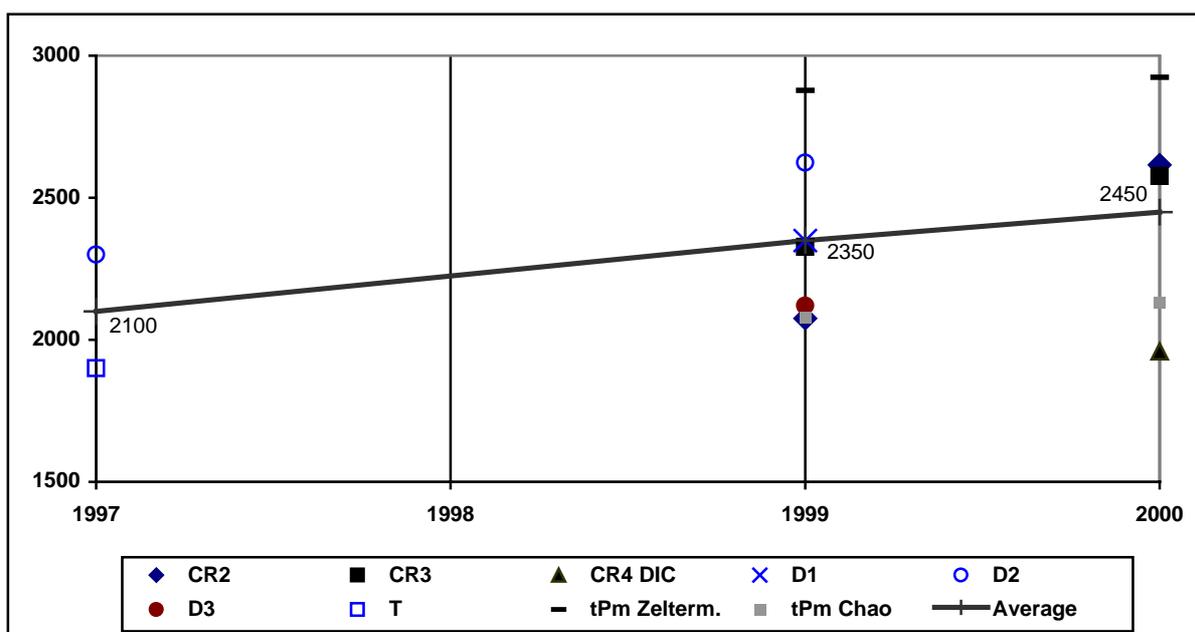
#### Overview of national drug prevalence studies

*A first national drug prevalence study has been conducted in 1997 by the national EMCDDA focal point. The 1997 study relied on a limited number of estimation methods and primarily aimed at the analysis of the national context with a view to the application of a multi-methods approach in coming years. Data presented in the present report have been provided by the latest drug prevalence study (hereinafter referred to “2001 study”) conducted by the focal point between 1999 and 2001 (Origer, 2001) and refers to the years 1999 and 2000. The 2001 study pursued two primary objectives. It is the **first comparative multi-methods drug prevalence study at the national level**. Furthermore the evaluation of estimation methods in the light of national data availability and quality has allowed to define an overall methodology with respect to the follow-up of national drug prevalence and incidence parameters in the future.*

*The research strategy relied on the methodological framework of the Luxembourgish Information System on Drugs and Drug Addiction (RELIS), set up in 1995 by the NFP. RELIS stands for a nationwide multisectorial information network, including specialised drug treatment institutions, general hospitals, counselling centres and competent law enforcement agencies. As such, it provides for the most comprehensive and reliable data on problem drug users indexed by national institutions. In compliance with RELIS case definition, the 2001 study specifically aimed at **the prevalence estimation of problematic use of illicitly acquired high risk drugs (HRC) in the national population aged between 15 and 54 years**. The chosen terminology defines the target population with regard to the observable consequences of drug use, the nature of consumed substances as well as the context (legal or illegal) of their acquisition.*

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

Fig. 2.3.a. Prevalence estimation of problem HRC drug use (1997 – 2000)



Source: Origer, 2001

Tab. 2.3.a. Prevalence and prevalence rates according to selected sub-groups (1997 – 2000)

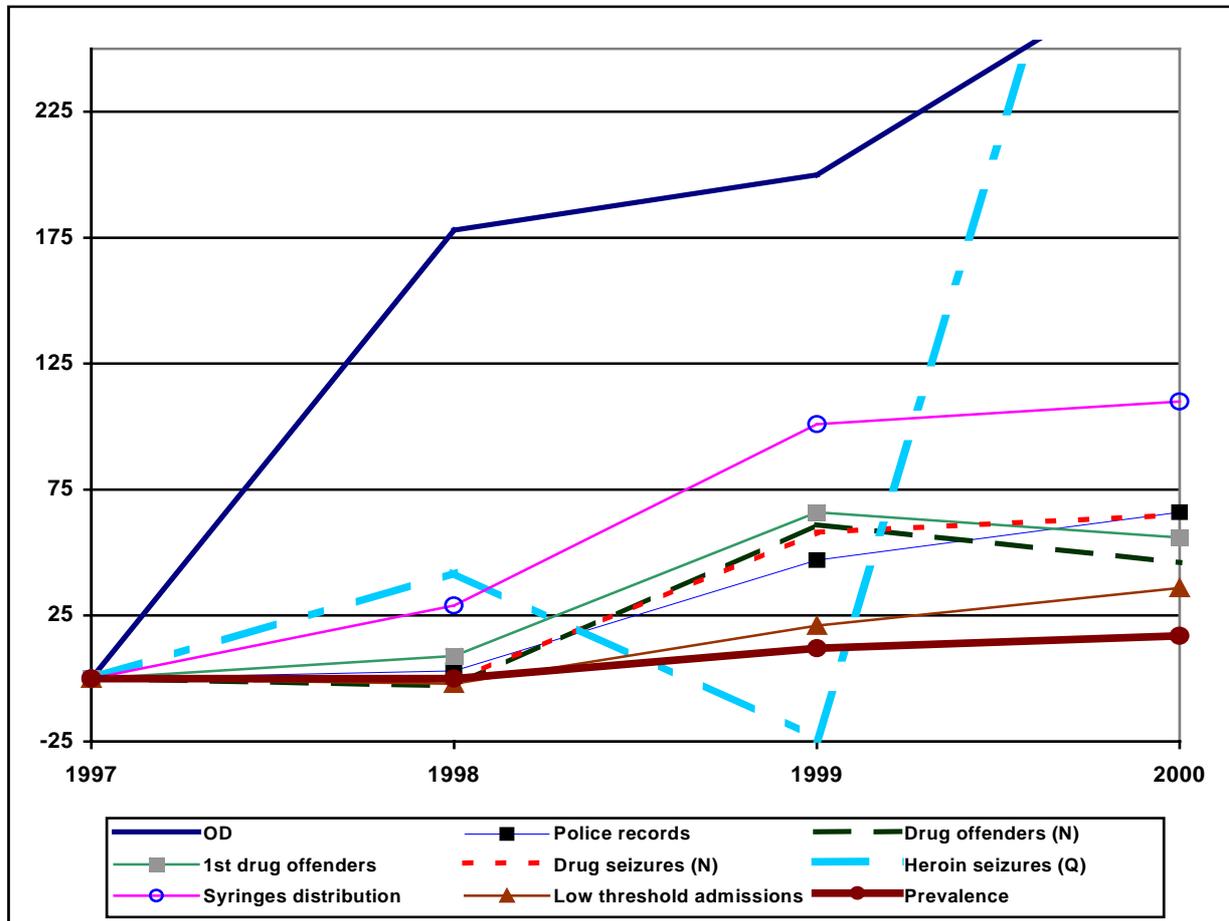
	1997	1999	2000
GENERAL POPULATION			
National population on 1 <sup>st</sup> July	421,000	432,450	438,500
National population aged between 15 and 54 years on 1 <sup>st</sup> July	239,818	245,308	248,440
HRC USERS IN CONTACT WITH THE NATIONAL INSTITUTIONAL NETWORK (low threshold agencies not included)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

Source: Origer, 2001

*Absolute prevalence and prevalence rates of **problem HRC drug use** have shown a growing tendency over the past four years. The increase curve observed between 1999 and 2000 is less pronounced than the one observed during the period 1997 to 1999. The observed figures comply with the stability of **heroin use** and **intravenous drug use** prevalence between 1999 and 2000. Although the overall drug use prevalence shows an upward tendency, heroin use does not contribute significantly to the referred progression. Intravenous drug use prevalence has even shown a slight decrease in 2000.*

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

Fig. 2.3.a.1. Prevalence estimates (problem use of high risk drugs) and evolution of selected indirect indicators



Source: Origer, 2001

The average prevalence of problematic HRC drugs use (2,350) and the related prevalence rate of 5.59/1000 (9.58/1000 in national population aged between 15 and 54), in 1999 are deemed to show good validity according to the non-contradicting estimates obtained by the multi-methods approach and the evolution of indirect indicators such as the number of fatal overdose cases, the number of distributed syringes through the national needle exchange programme, the number of HRC drug law offences and seizures and admission data of low threshold agencies. Prevalence figures calculated for 2000 (N: 2,450, total rate: 5.59/1000, rate 15-54: 9.58/1000) also fit the curve of indirect indicators. Since the 2000 figures have been obtained by a more limited number of estimation methods, observed tendencies should be confirmed by further research based on the evaluation outcome of multi-source methodologies in the light of national specificities.

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. *Due to the specificity of the national drug scene and the geographical dimension of the country, no further local prevalence study has been conducted 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
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)	EMCDDA, (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 (illicitly acquired HRC drugs)

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

*The **number of problem high risk drug users** indexed by national institutions in 2000 figures 1,024 (1,198) persons (double counting excluded). 637 (757) persons were indexed by **treatment agencies** and 510 (551) by **law enforcement agencies**. The number of drug law offenders admitted to prison is the only indicator on decrease over the last 3 years.*

32 per cent (33%) of indexed drug users, of which 63% were non-natives, 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 46 per cent (39%). On average, a problem drug user addresses 1.66 (1.7) drug treatment demands per year. For 5 per cent (4%) of registered cases it has been the **first drug treatment demand** during lifetime (**inter-institutional**).

***Gender distribution** has remained fairly balanced since 1994 (2000: 23 % females, 77 % males). The proportion of **non-natives** among the overall national drug population has known a significant increase between 1998 (18%) and 1999 (48%) followed by a stabilisation in 2000 (45%). Since 1994, the **duration of residence** in the G. D. of Luxembourg of non-native problem drug users has constantly increased. The population of non-natives largely consists of Portuguese nationals (2000: 54%, stable); a proportion that is consistently higher than the one observed in the general population. Persons of French and Italian origin respectively count for 17 and 10 percent in non-native problem drug users.*

*Compared with 1995, the **average age**, applied to the total drug population (28 Y, 1M), has slightly increased, (2000: 28Y, 9M). The proportion of **persons aged 35 and more** has constantly increased since 1996 as well as the **standard deviation** of the observed age distribution meaning that the gap between the youngest and oldest drug users tends to increase. Currently one observes a fairly polarized situation that is an aging population of long-term drug injectors and a significant decrease in age referred to first treatment demanders and first drug offenders. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders (8.8%), in*

first drug offenders (25.3%), in the total drug population (3.2%) and to the percentage of students in problem drug users (20%). 82 per cent and 47 per cent of problem users have experienced cannabis and heroin (i.v.) use respectively, while being underage. In 1995, RELIS figures referred to 71 per cent and 23 per cent respectively. Based on RELIS data and several indirect indicators, one may estimate the current **prevalence of problem drug users underage** reaching 80 to 100 persons including 40 to 60 injectors.

The average ages of native and non-native problem drug users tend to balance. The **difference in age in proportion to gender** has increased mainly due to the low and decreasing age of female drug users. Generally speaking, the **profile of female users** has known most significant changes during recent years. In comparison with male users, one should mention a lower age (13Y, 3M) at first consume of cigarettes, at first use of illicit drugs (14Y4M) and an earlier start of a physical addiction state reported by female users.. **Average age at first use of illicit HRC drugs** has decreased 1 year and 3 months from 1994 to 2000.

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

**Residential status** of problem drug users has improved for the last 4 years. The proportion of persons reporting stable accommodation has increased from 31 per cent in 1995 to 49 per cent in 2000. At the time of their last indexing, 25 per cent of users lived with their parents or a member of the **family of origin**. **Geographic distribution**, according to electoral districts, suggests that 39.4 per cent (36%) come from the centre region and 41.6 per cent (44.5%) from cities in the South of the country. Eastern cantons figured 5 per cent in 1996 and 9.1 per cent in 2000 and Northern cantons have been showing a stable trend (8-10%) following a significant increase until 1997.

All indicators included, the **employment status** of respondents has declined for the last three years. The **unemployment rate** (2000: 65%) among the drug population has grown in significance since 1997. Data on **revenues** confirm observed trends in occupational status, namely a weakening of financial autonomy (2000: 29%) associated to an **increasing social dependency** (2000: 61%).

Two socio-economic indicators that show a positive evolution refer to **revenues of illegal origin** and the **indebtedness status**. The former went down from 23 to 9 per cent and the latter from 59 to 41 percent between 1995 and 2000.

**Opiates** are referred to as **primary drug** by 84 per cent (stable) of indexed users. Cocaine and cannabis use are reported as primary drug by 7% of users, respectively. A complete absence of **crack** and **volatile substances** (e.g. solvents) in primary use has to be stressed. **Ecstasy-like substances** are poorly represented, which has to be interpreted with caution since RELIS indexed only current **problem drug users** and not **exclusive recreational users**.

**Problematic cannabis use** prevalence in RELIS respondents has shown an upward trend in 2000 (7%). The observed trend is even more significant if exclusively referred to drug treatment demanders (10%). In this context one might refer to recent results from toxicological expertises performed by the National Health Laboratory (LNS)

following **traffic accidents**: in 1995, 30,3 per cent of expertises reported cannabis use of involved drivers; in 2000 the same proportion figured 48 per cent.

## b. Risk behaviours and trends

*Intravenous drug use, mainly heroin and heroin/cocaine cocktails (speedball), prevail among indexed drug users although **intravenous heroin use** as primary consume pattern has stabilised (53%). The significant increase of the **inhalation mode** (also known as 'blowing' or 'chasing the dragon') referred to opiate use in 1998 (36%) (1997: 10%) was followed by a two-years decrease reaching 24% in 2000.*

*The proportion of **poly-drug use** (2000: 87 %) still on the increase represent the most common consume pattern. The **average ages** at the moment of **first consume** of the current main drug and illicit drugs in general have shown a slow but constant downward trend resulting in a decrease of 1 year and 3 months from 1994 to 2000. Furthermore, 25 per cent (22%) of current problem drug users were younger than 14 years at the moment of **first cannabis use** and 47 per cent (43%) were still underage (< 18 years) as they **first injected opiates**. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2000*

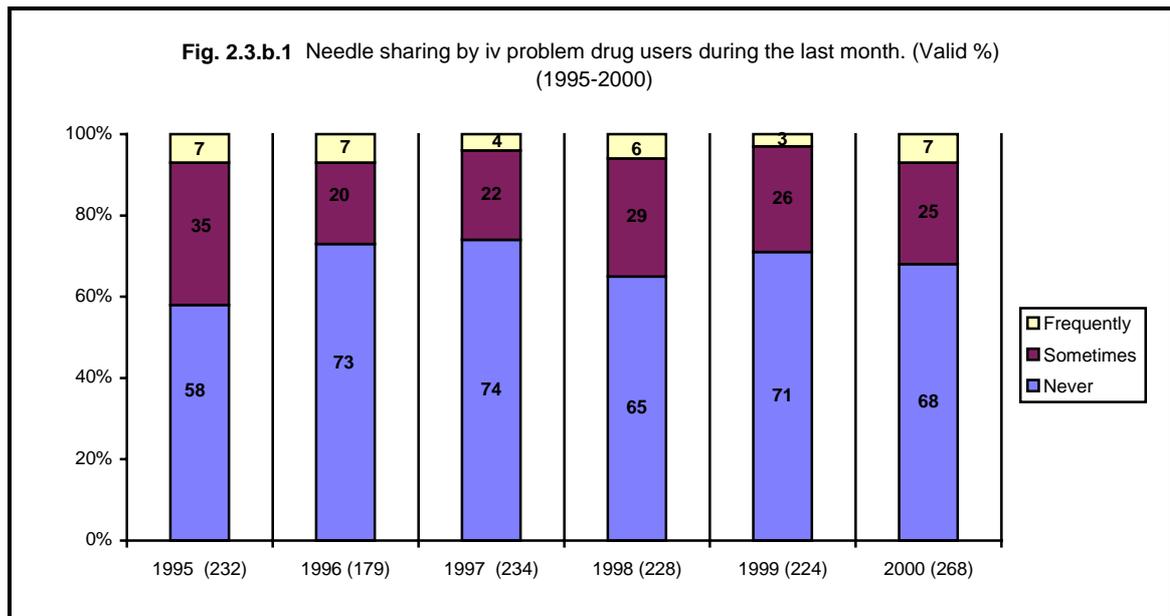
*In 2000, 47% (1998: 38%) of current problem users were still minor of age as they **first injected heroin**; a similar trend is observed with regard to cocaine injecting. The average **duration of intravenous drug use** of RELIS respondents was 9 years and 1 month (1998: 7 years and 4 months). Generally speaking, the **duration of i.v. use** increases while the **average age at the moment of first iv use** (2000: 19 years and 8 months) tends to stabilise.*

*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** (2000: 189,413 / 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** (2000: 112,625 (59%) / 1996: 28.646 (38%)) has increased accordingly. Referring to **facilities** included in the needle exchange programme, a majority of drug injectors procure their injection material from automatic dispensers. All syringe providing facilities and selling points included, pharmacies constitute the main source of provision (37%) reported by intravenous drug users. The growing tendency in syringe distribution on re-collection 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 fairly stable trend over the last 4 years. In 2000, 68% of RELIS respondents reported not to exchange used needles. A stable majority of indexed drug users (37%) 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, conducted by the National Surveillance Committee on AIDS in 1998 (National Surveillance Committee on AIDS 1998).



Source: RELIS 2000

**Saver sex:** The use of condoms during sexual intercourse is a core item of the RELIS 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, 44 to 48% of RELIS respondents have reported condoms use. No notable trend has emerged since the set up of RELIS.

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

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, in terms of statistical probability, female opiate user highly increase 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.

### 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** observed in 2000 (5%) reflects the low rate observed in 1998 (4%). 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 few years. Gender distribution shows **an upward trend in female treatment demanders** (2000: 40% / 1997: 34%). **Age distributions** have 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 (43%) has stabilised, while the same age group has increased (59,5%) for seven years in the South of the country. In other words, the average age of the drug treatment population in the centre tends to stabilise (with however a noticeable increase of demanders aged 40 and more) and the one in the South is definitely ageing. **Treatment demands for problem opiate use** or for multiple-use, including opiates, have slightly decreased (2000: 59% / 1997: 72%) and **cannabis-related demands** show a clear upward trend (2000: 11% / 1997: 1%).*

➤ *Outpatient, underage*

*Specialised drug care agencies for minors only exist in the centre of the country. The **rate of new treatment demanders** has constantly increased since the implementation of the referred agencies. Likewise adult outpatient agencies, gender distribution in minor treatment demanders shows a **rising proportion of female users** (2000: 34% / 1997: 26%). The **average age of clients** has been decreasing up to 1999 and appears to stabilise in 2000. In 1997, the proportion of clients aged 15 years and below has passed from 7% in 1997 to 12.9% in 2000. Cannabis use is increasingly the main reason of demand (78%), followed by heroin, and ecstasy.*

➤ *Inpatient, drug therapy*

*The proportion of **new clients** has remained stable for the last years. The proportion of **female treatment demanders** tends to increase (2000: 25% / 1997: 18%) and the observed mean age still is on the increase (2000: 28Y8M / 1998: 27Y). The referred age distribution reflects an **overall trend** observed in most adult drug treatment demanders, that is an increase of persons **under 20 years**, a decrease of patients aged **between 20 and 34** and an increase of patients **older than 34 years**. A decrease is also observed as to the **proportion of natives** within the inpatient treatment demanders. All treatment demands are related to **opiate abuse**, mainly iv.*

➤ *Inpatient, detoxification*

Drug detoxification units throughout the country show a stable trend regarding admissions and **first treatment demanders** (27% in 2000). **Gender distribution** has remained fairly unchanged and the mean age of clients has been on the decrease for the last four years (2000: 28Y9M / 1997: 28Y2M). **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. The **mean age** of clients (28Y9M) has increased compared with 1997 data (28Y2M) and the proportion of **native substitution treatment demanders** has stabilised (73% in 2000). The **socio-economical** situation of substituted patients is consistently more beneficial than the one observed in other treatment demanders. As already mentioned, the number of patients who do receive substitution treatment by prescription **from independent general practitioners** is on the increase (2000: 844 /1999: 745), meaning that the **overall number of medically substituted problem users** at the national level is still rising.

➤ *Low threshold services*

The **number of contacts** indexed by low threshold agencies has increased dramatically over the last five years (2000: 11,834 / 1996: 6,456). The proportion of **new clients** within low threshold settings has stabilised. The number of **female clients** shows a weak but constant increase, partly linked to the fluctuation in the number of female drug using prostitutes. Data on age distribution are not available. 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 four years, however, one has observed a downward trend passing from 80% in 1997 to 65% in 2000. Likewise the trend observed in all indexed problem drug users, drug treatment demanders have witnessed an increasing preference for heroin in **inhalation mode** as opposed to injection.

**Cocaine use** as main reason of treatment demand shows a fairly low prevalence (5%). **Crack** is newer reported as main problem drug and very rarely (1%) as secondary or occasional drug.

A recent trend has also to be seen in the increasing number of treatment demands related to **cannabis use**. The percentage of the latter has passed from 4% in 1997 to 10% in 2000.

Treatment demands related to **ecstasy use** are rare (1-3%) and have shown a fair stability over the last years. The same comments apply to **STA use**.

## 3.2 Drug-related mortality

### a. Drug-related deaths

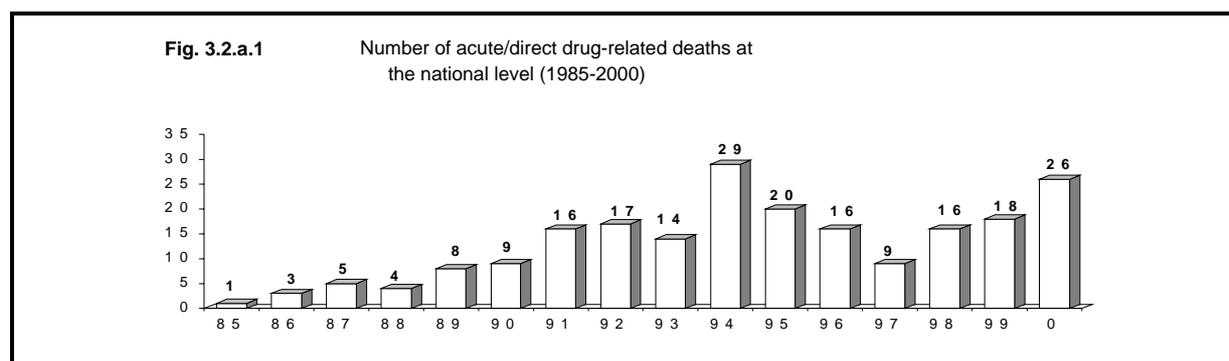
➤ Direct/acute drug-related deaths

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 26 cases in 2000.

The SPJ Special Overdose Register applies the following definition of acute/direct drug-related death:

'Lethal intoxication, voluntary, accidental or of undetermined intent, confirmed by forensic autopsy, and caused directly by abuse of illicit drugs or by any other drug(s) if the victim has been known to be a regular consumer of illicit drugs'. The case (code: suspect death) is documented by forensic autopsy ordered by the Public prosecutor.



Source: Special Overdose Register, SPJ, 2000

Since 1992, results of toxicological analysis performed on overdose victims refer to the presence of opiate traces in all direct drug death cases. In 1999, 90 per cent of autopsy results reported heroin consume; a proportion that has remained stable for the last three years. *Forensic data from 2000 suggest a decrease of heroin-related deaths (76%) and a significant increase of death cases related to substitution drugs' consume, especially methadone. Other substances involved mainly refer to cocaine and other substitution drugs such as Buprenorphine (SUBUTEX).*

**Table 3.2.a.1.** Results from toxicological analyses on suspect deaths cases by the LNS (1992 - 2000)

YEAR	AUTOPSIES (N)	N. of DEATHS HEROIN*	N. of DEATHS OTHER OPIATES *	TOTAL OPIATE DEATHS AUTOPSIES
1992	38	11 of which 4x cocaine associated	2x DHC	13
1993	45	11 of which 1x DHC + tilidine associated 1x cocaine associated	3x DHC 2x DPX	16
1994	49	22 of which 8x DPX associated 1x DHC associated 1x DHC + tilidine	1x DHC 6x DPX of which 1x DHC associated 3x heroin associated	29
1995	41	13 of which 3x DPX associated 1x MTD associated	3x 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	1x tilidine	9
1998	39	16 of which 2x cocaine associated	1x MTD	17
1999	61	17 of which 5x cocaine associated 1x MTD associated 1x tramadol associated	1x Buprenorphine 1x morphine	19
2000	75	14 of which 6x MTD assoc.	6x MTD	21

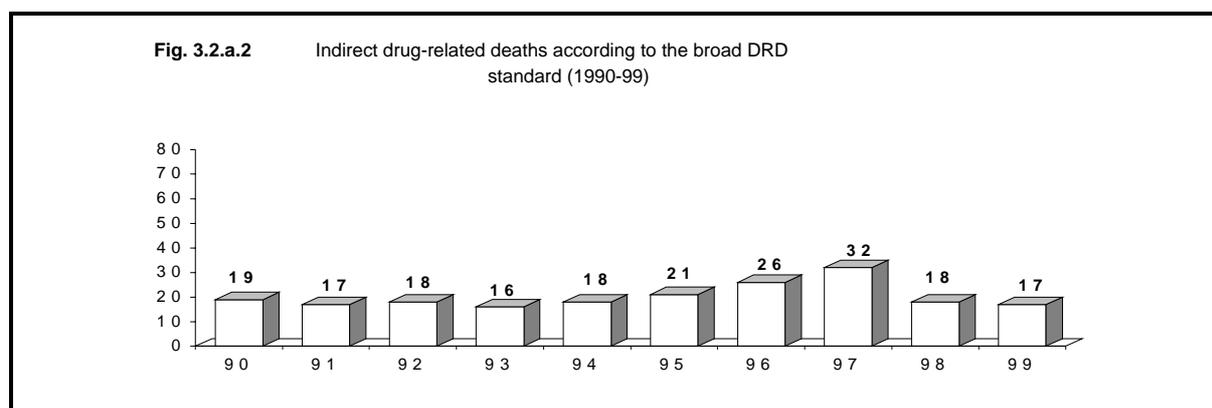
		4x cocaine assoc.	1x codeine	
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(\*) In most cases in association with 'alcohol, benzodiazepines and other medicaments.  
DHC= dihydrocodein, DPX= dextropropoxyphene, MTD= methadone

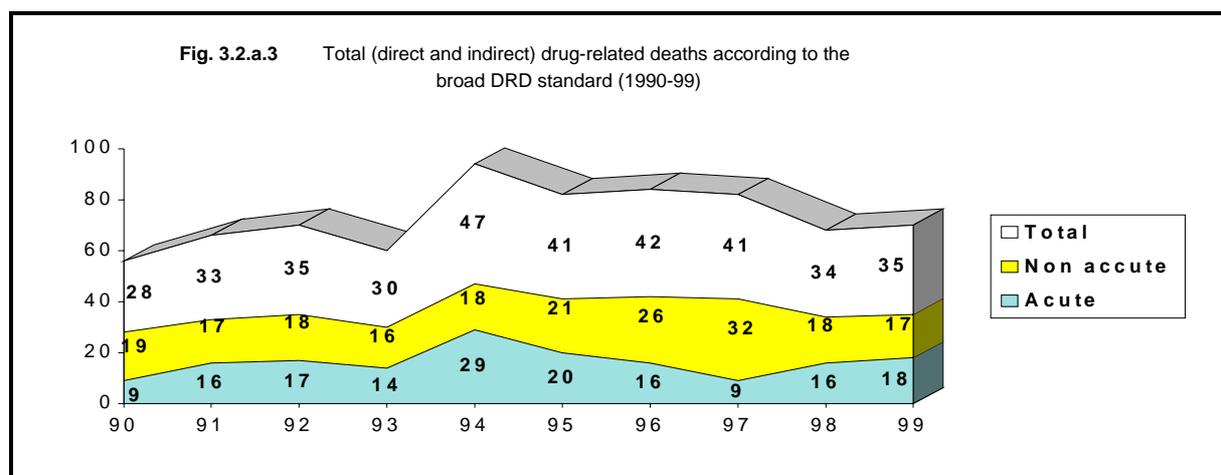
➤ Indirect drug-related deaths

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 2002. 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 recommended **broad DRD (ICD-9/10) standard**. The GMR started to apply ICD-10 coding in 1998.

It is remarkable that, as opposed to acute deaths figures, the number of indirect drug-related deaths has been constantly increasing from 1993 to 1997 and currently tends to decrease. In 1998, the GMR has switched to IC-10 coding. Figures for 2000 are not yet available.



Source: National Death Register. Ministry of Health, 1999



Source: Origer and Dellucci, in press

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 stabilisation from 1995 to 1997 followed however by a slight decrease until 1999. One should bear in mind that in 1998, ICD-10 coding was first applied by the national GMR which may have had an impact on DRD based data processing.*

*Whether the **upward trend in acute drug deaths from 1997 onwards** is due to an increasing drug user prevalence, changing drug market profile and use patterns, remains uncertain at present. One should stress, however, that recent figures (Origer 2001) confirm an increasing prevalence of problem drug users. On the other hand, an increase in non-iv heroin administration mode, observed for the last 3 years, should have reduced associated risk factors. Availability and quality of drugs available on the national market, multiple-drug use, associate morbidity and contexts of drug-related deaths are some of the relevant topics 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

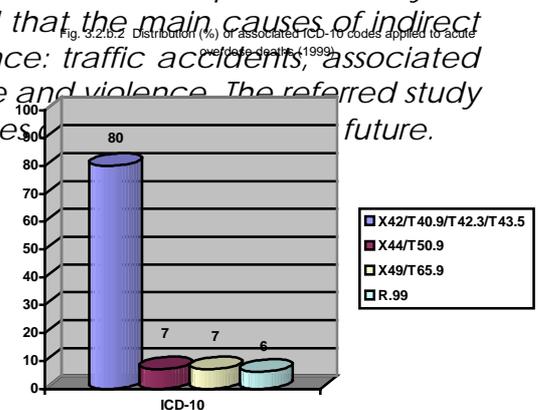
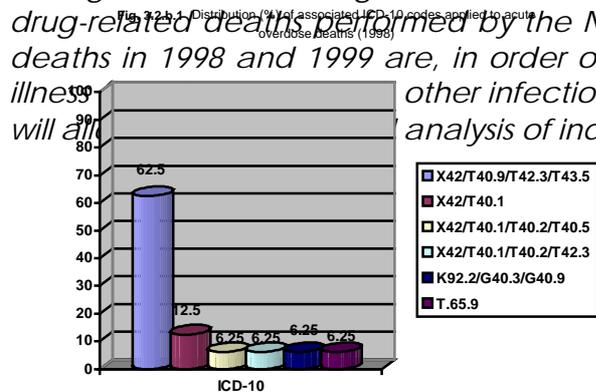
### ➤ Mortality rate

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 indexed acute drug deaths as coded by the GMR by means of the ICD-10 standard in 1999 and in 2000. 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.

*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 other infections), suicide and violence. The referred study analysis of indirect causes will allow a more detailed analysis of indirect causes in the future.*

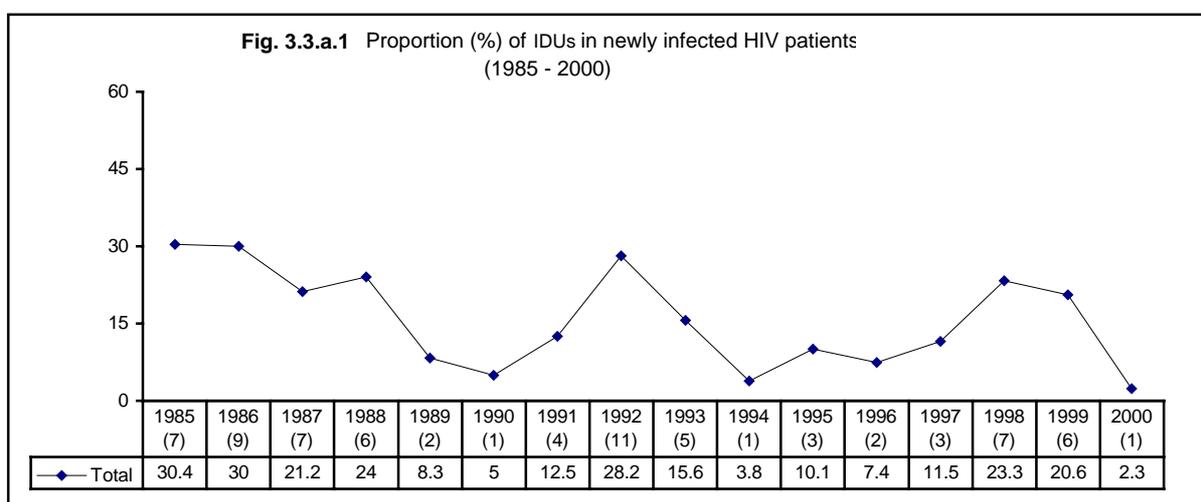


### 3.3 Drug-related infectious diseases

#### 3.3.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, 470 HIV infected persons have been registered at the national level; 75 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 16 per cent since the registration of the first HIV case in Luxembourg in 1984. 75% 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 decreased since 1998 (33%), although the **number of newly indexed HIV infection has increased** from 30 to 44 cases during the same period.



Source: Laboratoire de Retrovirologie – CRP-Santé. 2000

Since 1996, RELIS allows for breakdowns of HIV data by IDU and institutional contact status. In 1997, a significant decrease of **HIV rates in drug users**, and especially in IDUs, occurred. In 1999 and 2000, **HIV rates in current IDUs have stabilised** and the number of HIV infected persons in **drug treatment demanders** went up (4.87%). It may appear unusual that the HIV rate in IDUs is lower than the rate observed in the overall drug treatment population (in 2000). This may be linked to the **observed evolution of administration modes (inhalation vs. injecting)**. Indeed, current heroin inhalers might have been previously injecting and then caught a HIV infection. Those persons are referred to as **current non-injectors** even though they may have been infected while injecting. As the opiates administration modes have stabilised in 1999-2000, one should pay particular attention to the future evolution of HIV infection rates.

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

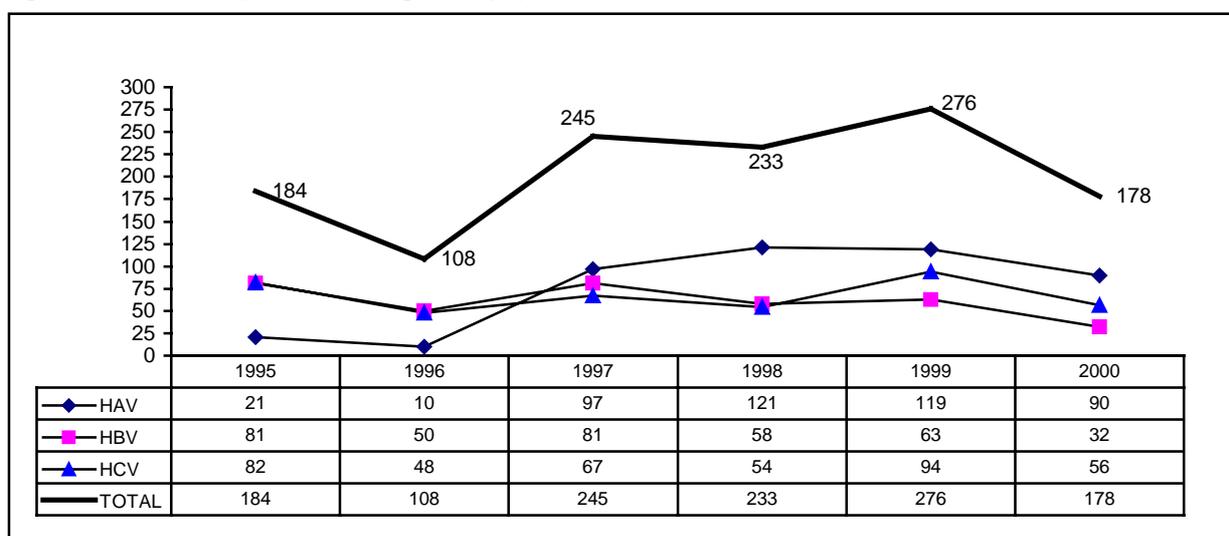
YEAR	1996	1997	1998	1999	2000
HIV rate in problem drug users (RELIS)	4.8	3	2.9	2.9	4.3
HIV rate in drug treatment demanders	6.5	3.8	2.6	3.4	4.8
HIV rate in current IDUs (RELIS)	<b>6.9</b>	<b>3.6</b>	<b>3.5</b>	<b>3.3</b>	<b>3.6</b>
HIV rate in current IDUs treatment demanders	8.6	4.5	3.4	3.9	3.9
HIV rate in current IDUs prisoners	/	/	4.4	/	/

Sources: RELIS 2000

### 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. 3.3.a.2** Notified hepatitis cases in general population (1995-2000)



Source: Division de l'Inspection Sanitaire. Direction de la Santé. 2000

Hepatitis B and C indicators have been included in the RELIS 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 47% in 2000. 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 3.3.a.2** Synopsis of national data on HBV infection rate in drug using populations (valid %)

YEAR	1997	1998	1999	2000
------	------	------	------	------

HBV rate in drug users (RELIS)	29	30	29	25
HBV rate in drug treatment demanders	/	27	30	24

Source: RELIS 2000

**Table 3.3.a.3** Synopsis of national data on HCV infection rate in drug using populations (valid %)

YEAR	1997	1998	1999	2000
HCV rate in drug users (RELIS)	26	25	30	40
HCV rate in drug treatment demanders	/	29	38	47
HCV rate in IDU prisoners	/	37	/	/

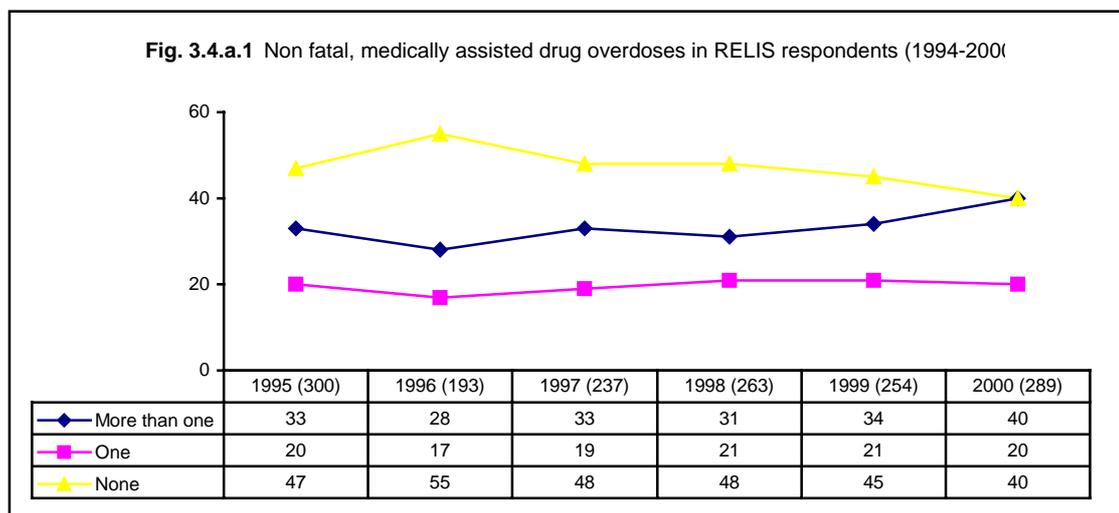
Sources: RELIS 2000

Even though AIDS incidence in problem drug users 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 2000 and HCV prevalence in drug users is constantly increasing. In terms of **future research activities**, the NFP plans to participate in a EMCDDA co-ordinated study aiming at the estimation of HCV and HIV prevalence in recent drug injectors.

### 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)(60%) during lifetime has slowly increased during the last four years.



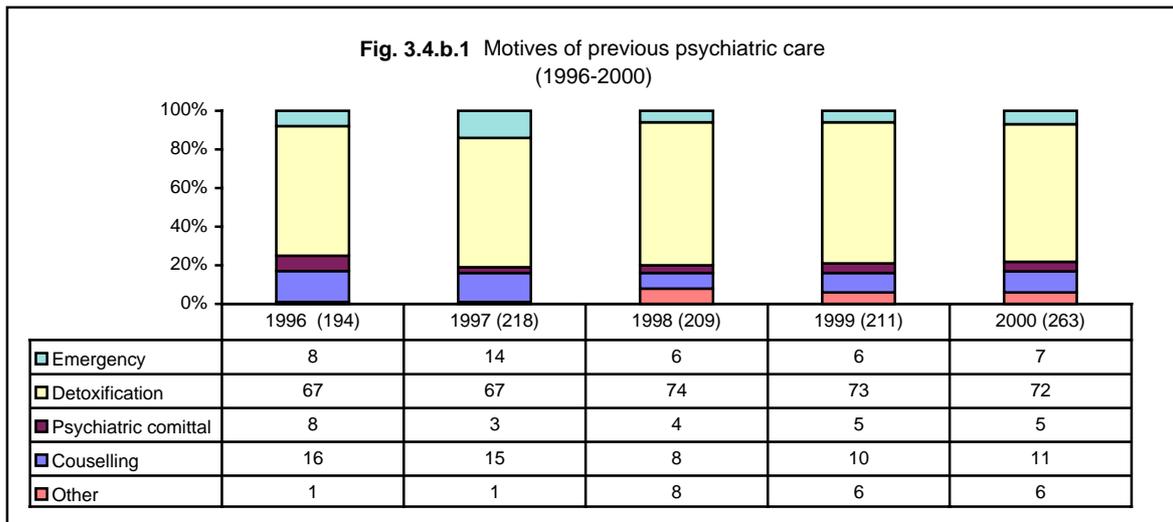
Source: RELIS 2000

#### 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 30% (22%)**. Figure 3.4.b.1 shows the motives of previous psychiatric care demands by RELIS respondents.



Source: RELIS 2000

### c. Other important health consequences

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed users except for HCV prevalence. In 2000, 58 per cent of problem drug users reported a satisfying general health condition against 51 per cent in 1994.

## 4 Social and Legal Correlates and Consequences

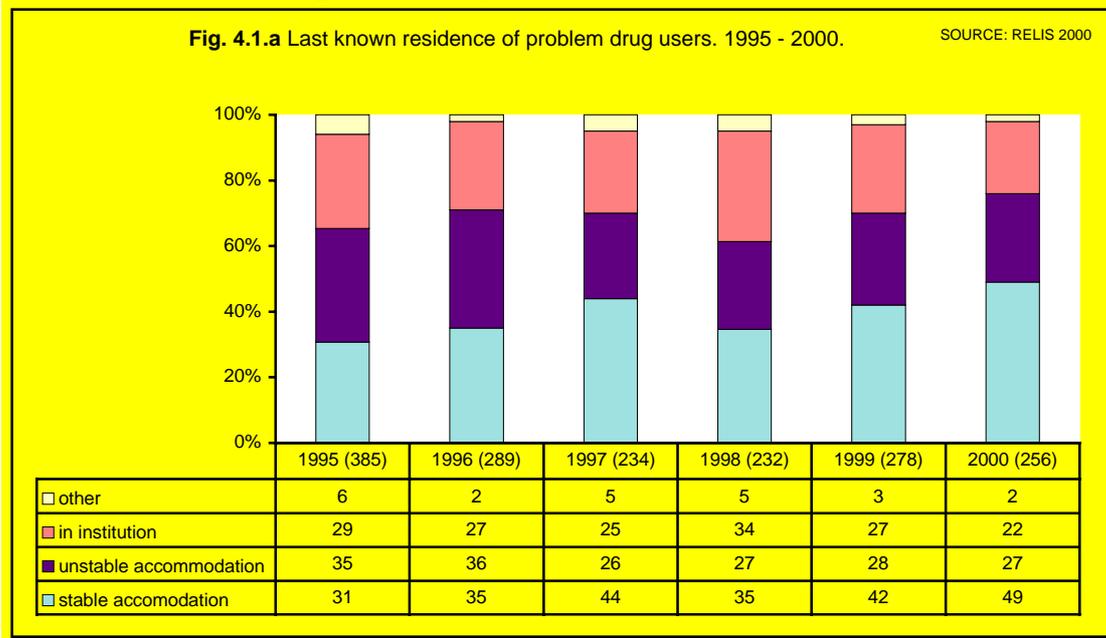
### 4.1 Social problems

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, the significant decrease of age at first use of illicit drugs and recent highly mediatised debates on the modification of the drug legislation has contributed to somehow differentiate a highly undifferentiated view on drug abuse.*

The **geographical size** of the Grand Duchy does often not allow intimacy or anonymity of people who are stated to behave in a socially deviant way. Native drug addicts are often forced to seek treatment abroad in order to avoid public stigmatisation. *The increasing number of problem drug users seeking treatment aboard (102 in 2000) supports this statement.*

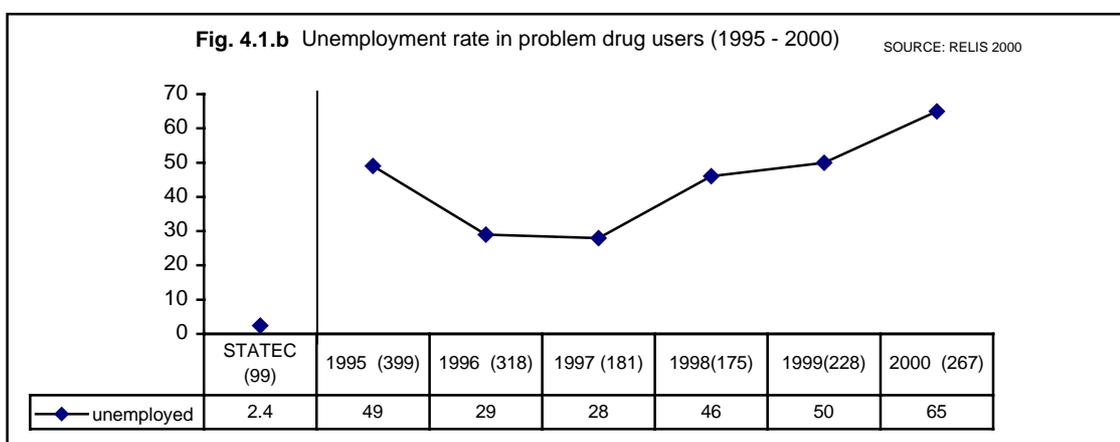
The **educational level** of problem drug users shows a slow but constant improvement, even though the average age at the end of studies remains stable.

**Residential status** of registered drug users has improved for the last 6 years, 49 percent of indexed drug users reported a stable residential situation 72 per cent (63%) of respondents reported current or past drug abuse within their family of origin and 75% have been living with their parents at the time of their first use of illicit drugs.



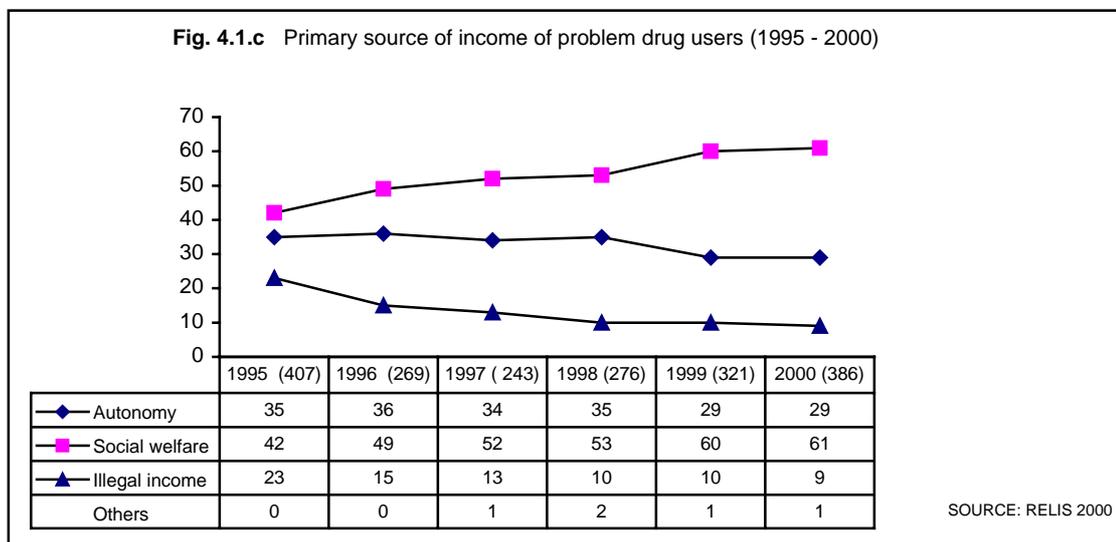
All indicators included, the **employment status** of problem users has declined for the last four years. The unemployment rate in problem drug users has grown in significance since 1997. Furthermore, the percentage of students (2000: 20%) tends to increase. Data on revenues confirm observed trends in 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.



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

*Illegal activities and revenues have seen a downward trend that has stabilised since 1995. The proportion of respondents reporting major depths ( $\geq 2,500$  EURO) (41%) is still decreasing, however, proportionally less than in previous years (1995: 59%).*



## 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.

- 'Détection' (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 from 1998 onwards (2000:1,340). The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 199 followed by a subsequent increase settled at 1,758 drug law offenders. The number of arrests on the same charge has decreased from 154 in 1997 to 117 in 2000 (see table 4.2.a.1).

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 2000. One should emphasize that the Gendarmerie and the Police have merged into a single force in 2000, namely the Grand-Ducal Police.

Table 4.2.a.1 Number of national law enforcement interventions (1995-2000)

Year	DRUG LAW ENFORCEMENT RECORDS						PREVENUS					
	95	96	97	98	99	2000	95	96	97	98	99	2000
S.P.J.	123	117	137	192	343	231	152	141	182	224	434	278
Gendarmerie	198	232	255	265	782		319	322	335	339	916	
Police <sup>9</sup>	199	179	177	243	189	965	371	344	280	386	283	1.200
Customs <sup>10</sup>	244	336	236	125	173	144	421	561	408	221	306	280
<b>Total</b>	<b>764</b>	<b>864</b>	<b>805</b>	<b>825</b>	<b>1,187</b>	<b>1,340</b>	<b>1,263</b>	<b>1,368</b>	<b>1,205</b>	<b>1,170</b>	<b>1,939</b>	<b>1,758</b>

Year	ARRESTS						SEIZURES					
	95	96	97	98	99	2000	95	96	97	98	99	2000
S.P.J.	27	24	25	19	27	22	61	86	78	124	216	154
Gendarmerie	8	12	15	7	15		104	130	125	98	375	
Police	32	27	32	34	32	47	150	130	138	171	151	650
Customs	61	86	82	40	34	48	234	346	246	140	185	165
<b>Total</b>	<b>128</b>	<b>149</b>	<b>154</b>	<b>100</b>	<b>108</b>	<b>117</b>	<b>549</b>	<b>702</b>	<b>587</b>	<b>533</b>	<b>927</b>	<b>969</b>

Source : Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 85% **males**; a proportion that has been varying between 79 and 89% during the past decade. Within the same period, **non-natives** have been representing the majority of drug law offenders (52-63%, except in 1994). Regarding the proportion of **first drug law offenders** (2000: 35%), no trend-line can be observed. The **percentage of minors** (< 18 years) among drug law offenders has increased since 1993 (3%) (2000: 8.8%) (see table 4.2.a.4/5).

Table 4.2.a.2 Socio demographic data on 'prévenus' (1985-2000)

YEAR	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
AGE																
0-14	5	9	5			7	2	6	12	1	12	3	6	7	27	21

<sup>9</sup> The general activity report of the Grand-Duchy of Luxembourg can be downloaded from: <http://www.gouvernement.lu/gouv/fr/doss/rapact2000/index.html>

<sup>10</sup> A summary of the general activity report of the "Anti-Drugs and Sensible Products" division of Customs can be found in annex H. The original report can be downloaded from : <http://www.gouvernement.lu/gouv/fr/doss/rapact2000/index.html>

15-19	121	121	179	212	173	179	293	320	146	169	205	270	257	249	415	413
20-24	234	264	262	569	461	383	520	527	242	403	456	447	369	321	519	497
25-29	100	119	110	220	232	278	275	371	255	309	256	304	269	220	448	354
30-34	65	49	71	67	58	124	98	159	104	186	167	191	151	187	269	208
35-39	10	17	22	29	21	27	34	52	49	65	98	80	73	76	131	113
≥40	11	17	28	19	30	43	35	46	29	21	33	42	45	78	84	108
unknown	9	27	11	21	25	30	19	50	53	20	36	31	35	32	46	44
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	1,758
Male	431	503	574	970	887	851	1045	1248	674	938	1035	1138	1009	958	1658	1415
Female	122	120	114	166	113	220	213	256	183	209	186	173	174	193	248	241
gender unknown	2	0	0	1	0	0	18	27	33	27	41	57	22	19	33	44

Source: Specialised Drug Department of the Judicial Police 2000.

Table 4.2.a.3 Type of drug law offences broken down by substances involved (1999-2000)

Substance	Offence	1999			2000		
		N	IVDUs	TOTAL	N	IVDUs	TOTAL
Heroin	Use & Traffic	329	157	1.050	193	113	849
	Traffic	75			57		
	Use	646	361		599	370	
Cocaine	Use & Traffic	85	34	204	45	19	87
	Traffic	31			25		
	Use	88	31		17	61	
Cannabis	Use & Traffic	326		995	195		901
	Traffic	43			23		
	Use	626			683		
Amphetamines	Use & Traffic	2		12	9		29
	Traffic	3			5		
	Use	7			15		
Ecstasy (MDMA, etc.)	Use & Traffic	10		25	14		30
	Traffic	2			4		
	Use	13			12		
LSD	Use & Traffic	4		10	8		11
	Traffic	1					
	Use	5			3		
Total number of 'interpellation' motives	Use & Traffic		175	756		132	464
	Traffic			155			114
	Use		384	1.385		431	1329
	Total			2,296			1,907
Total number of 'prévenus'				1,939			1,758

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP 1999- 2000)

Remark: The number of 'prévenus' per substance type is higher than the total number of 'prévenus', since a given person 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 (1992-2000)

	1992	1993	1994	1995	1996	1997	1998	1999	2000
--	------	------	------	------	------	------	------	------	------

<i>First offenders</i>	697	331	382	498	508	389	422	645	608
<i>Nb. of offenders underage</i>	96	48	57	92	102	84	79	155	154
<b>TOTAL ('Prévenus')</b>	<b>1,531</b>	<b>890</b>	<b>1,174</b>	<b>1,263</b>	<b>1,368</b>	<b>1,205</b>	<b>1,170</b>	<b>1,939</b>	<b>1,758</b>

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2000.

**Table 4.2.a.5** Distribution of first offenders (use and use/traffic) and substance involved ad minima (1992-2000)

	1992	1993	1994	1995	1996	1997	1998	1999	2000
<i>Substance involved ad minima</i>									
Heroin	162	91	154	170	121	104	109	157	133
Cocaine	64	15	39	46	34	20	30	60	37
Amphetamines	5	0	15	11	11	12	18	14	9
Type ' Ecstasy '	1	3	9	47	20	26	26	6	11
Illicitly acquired medicaments	1	0	3	0	0	0	1	0	7
Illicitly acquired substitution substances	0	0	1	0	0	0	0	0	0
<b>TOTAL (substances HRC)</b>	<b>233</b>	<b>109</b>	<b>221</b>	<b>274</b>	<b>186</b>	<b>162</b>	<b>184</b>	<b>237</b>	<b>197</b>

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2000.

### Arrests data

**Table 4.2.a.6** Arrests broken down by type of offence and substances involved (1995-2000)

Substance	Offence	1995	1996	1997	1998	1999	2000
Heroin	Use & Traffic	68	51	57	59	48	44
	Traffic/Deal	21	56	53	9	18	10
	Use	24	6	7	17	27	29
	<b>Total</b>	<b>113</b>	<b>113</b>	<b>117</b>	<b>85</b>	<b>93</b>	<b>83</b>
Cocaine	Use & Traffic	20	29	27	16	21	14
	Traffic/Deal	7	27	23	7	9	7
	Use	10	1	6	6	12	5
	<b>Total</b>	<b>37</b>	<b>57</b>	<b>56</b>	<b>29</b>	<b>42</b>	<b>26</b>
Cannabis	Use & Traffic	25	13	18	19	32	19
	Traffic/Deal	1	14	11	3	8	2
	Use	4	5	4	8	3	11
	<b>Total</b>	<b>30</b>	<b>32</b>	<b>33</b>	<b>30</b>	<b>43</b>	<b>32</b>
Amphetamines	Use & Traffic		2	2	4	1	2
	Traffic/Deal		1				1
	Use	2			4		1
	<b>Total</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>8</b>	<b>1</b>	<b>4</b>
Ecstasy (MDMA, etc.)	Use & Traffic	3	3	3	1	3	3
	Traffic/Deal	1	4	3			1
	Use	1					1
	<b>Total</b>	<b>5</b>	<b>7</b>	<b>6</b>	<b>1</b>	<b>3</b>	<b>5</b>
LSD	Use & Traffic		1	1		1	1
	Traffic/Deal		1				
	Use						
	<b>Total</b>		<b>2</b>	<b>1</b>		<b>1</b>	<b>1</b>
Total number of <i>arrest motives</i>	Use & Traffic	116	99	108	99	106	83
	Traffic/Deal	30	104	90	19	35	21
	Use	41	12	17	35	42	47

	Total	187	215	215	153	183	151
Total number of arrests notwithstanding arrest motives		128	149	154	100	108	117

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2000.

## b. Court data

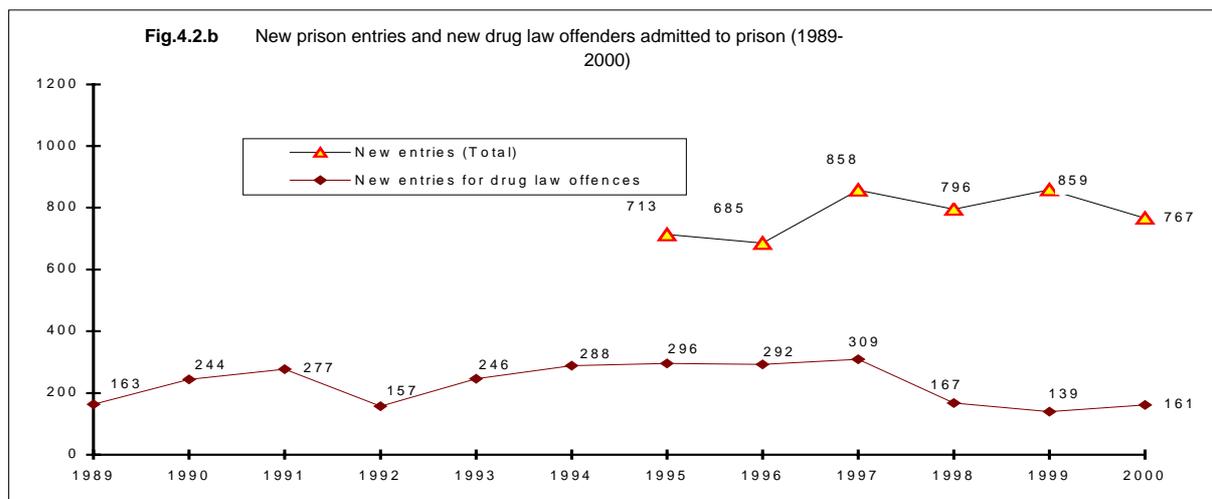
### Prison data

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 until 1997, followed by a fair stabilisation. In 1999, 161 new entries (21 %) (1997: 36%) in national penal institutions referred to the ' DELIT- STUP ' (Drug law offence) codes have been reported (of a total number of entries in 1999: 767).*

Table 4.2.b.1 Prison entries for drug offences (1989 – 2000)

YEAR	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
New prison entries (Total)							713	685	858	796	859	767
New entries of drug law offenders	163	244	277	157	246	288	296 41.5%	292 42.6%	309 36%	167 21%	139 16%	161 21%

Source: Central Prison Administration 2000.



Source: Central Prison Administration 2000.

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

## c. Drug-related crime

The RELIS database provides the following figures for 2000:

- 92% (↗) of drug users indexed<sup>11</sup> by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime. 79% (↗) of the latter show multiple law enforcement contacts.

<sup>11</sup> Persons who have been indexed by the RELIS network during a reporting year.

- the proportion of 'interpellations' for other reasons than presumed offences against the dug law (e.g. **petty crime**) has been decreasing since 1997 (38%), (200:15%) The extension of substitution treatment and the intensification of socio-economic reintegration measures appear to have contributed to the currently observed situation.
- 74% (↗) of indexed addicts have already served at least one **prison sentence** during lifetime. 58% of the latter have been in prison once and 42 % report more than one prison 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 overall budget of the Ministry of Health directly allocated to actions against drugs and drug addiction (A) shows an increase from 2.28 million € in 1999 to 2.94 million € in 2000, following the centralisation of demand reduction activities by the Ministry of Health. The budget of 2001 foresees a supplementary increase of 49 per cent, figuring, 3.52 million €.

The budget of the Ministry of Health specifically **allocated to drug demand reduction activities (A1)** has witnessed an increase from 770,000. - € in 1999 to 2.21 million € in 2000, following the centralisation of demand and harm reduction activities by the Ministry of Health and to 2.71 million € in 2001. The provisional budget of 2001 foresees a **supplementary increase of 34.37 per cent**, thus figuring 3,64 million €. The consistent increase in 2002 is mainly due to the implementation of the drugs action plan 2000-2004.

A national study on the overall socio-economic cost of drug use is currently performed by the NFP (Origer and Cloos in press). Results are due in the beginning of 2002. Meanwhile, given that the coordination and the financing of all national drug demand reduction activities have been centralised within the Ministry of Health in 2000, table 4.3 provides a valuable insight of the overall budgetary progression from 2000 to 2002.

**Table 4.3** Budgetary breakdown of drug-related activities financed by the Ministry of Health (1999 – 2002)

Budget line	Breakdown 1999	Breakdown 2000	Voted budget 2001	Provisional budget 2002
<b>A Overall drug budget</b> Section 14.0	2.28 million €	2.94 million € Progression rate: 29.09%	3,52 million € Progression rate: 19.64%	/
<b>A1 Demand reduction activities only</b> Section 14.1.33.013	770,000.- €	2.21 million €	2.71 million €. Progression rate: 11.27%	3.64 million €. Progression rate: 34,37%

Source: Origer and Cloos, in press

## 5 Drug Markets

### 5.1 Availability and supply

Several 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 restricted local networks. 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.

## 5.2 Seizures

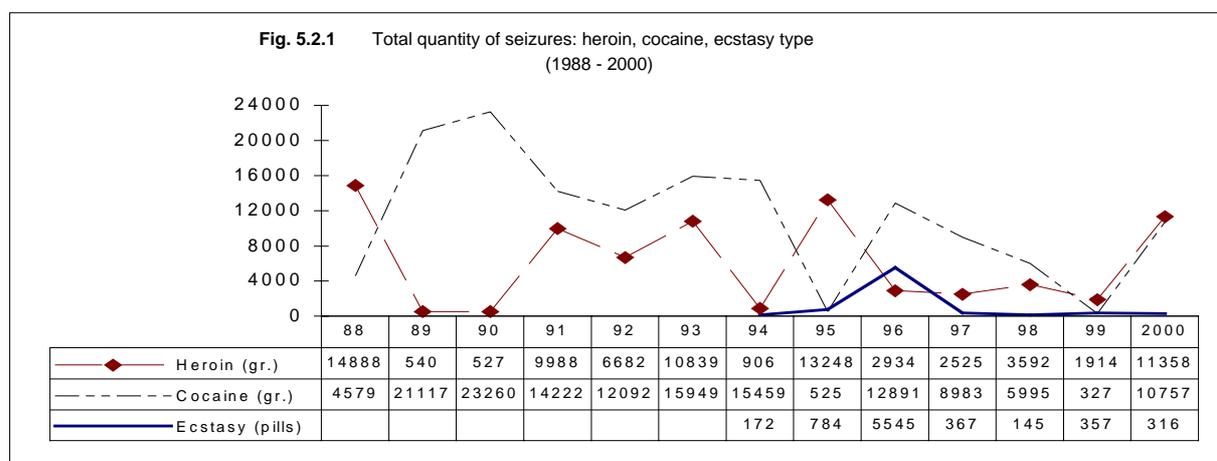
*Striking variations have been observed as to the **quantity of illicit substances seized** since 1984. The general downward trend as regards seized quantities of heroin and cocaine from 1996 onwards was followed by a steep increase in 2000, due to two major transit seizures.*

*Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993 (2000: 969). The number of cocaine and ecstasy like substances' seizures has stabilised and one observes a moderate but continuous increase of amphetamines seizures since 1997. 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) and in 2000 reaches the level observed in 1997. The same trend, although proportionally less important, has been observed with respect to the **total number of persons involved in drug seizures**, figuring 1,168 offenders in 1999 and 1,007 in 2000. Summarily, quantities of seizures have been decreasing since 1996, while the number of persons involved shows a significant increase until 1999. The development of distribution micro networks may partly contribute to the current situation. 58 per cent of persons involved in drug seizures are non-natives.*

***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 between 1994 onwards whilst seizures, in terms of quantity, have significantly decreased in 1997 and have remained fairly stable over the last 4 years (2000: 316 pills).*

*In 2000 a remarkable increase of quantities of seized **cannabis** has been observed; **the number of cannabis seizures and persons** involved followed a proportionally steeper upward trend. Between 1994 and 2000, the number of cannabis seizures*

went from 167 to 400 as well as the number of offenders involved has marked an increase from 242 to 518.



Source: Specialised Drug Department of the Judicial Police 2000.

**Table 5.2.1** Number and quantities of drug seizures – TOTAL (Police & Customs) 1996-2000

Substance	Unit	1996		1997		1998		1999		2000	
		N	Quantity	N	Quantity	N	Quantity	N	Quantity	N	Quantity
Cannabis (total)	kg	281	30.879	191	35.655	237	6.930	375	5.202	406	9.557
Hashish	kg	103	16.460	57	0.868	44	1.974	115	1.270	89	1.174
Marihuana	kg	178	14.419	133	34.787	190	4.956	255	3.932	311	8.383
Plants	units	6	14 + (15 gr)	1	5	3	222	5	93	6	133
Heroin	kg	284	2.934	237	2.525	189	3.592	306	1.914	256	11.358
Cocaine	kg	63	12.891	54	8.983	22	5.995	56	0.327	51	10.757
of which crack	kg	0	0	0	0	0	0	0	0	0	0
Amphetamines	gr	11	2,1	0	0	5	66	5	16	9	157
	pills	1	6 gr.	3	9 gr						
Ecstasy type	pills	26	5,5450	12	367	22	145	10	357	15	318
	gr	1	0.003								
LSD	doses	15	122	3	4	0	0	1	1	1	21
Psilocybin	gr	0		1	57.6	2	295	4	24.76	5	122
Methadone	ml	5	16 doses	4	940	9	955	2	180	2	98
				1	840						
MEPHENON	pills	6	112	8	115	2	70	5	169	0	0

Number of offenders involved in heroin seizures		347	362	215	570	354
Total number of offenders involved in seizures		778	802	590	1,168	1,013

Source: Specialised Drug Department of the Judicial Police 2000.

Table 5.2.2 Number and quantities of drug seizures – Customs only 1996-2000 (included in total table 5.2.1)

Substance	Unit	1996		1997		1998		1999		2000	
		N	Quantity								
Cannabis (total)	kg	164	5.526	96	3.165	64	3.398	110	2.681		2.735
Hashish	kg	97	2.275	38	0.648	20	1.587	41	0.910		1.094
Marihuana	kg	67	3.251	58	2.517	44	1.811	69	1.771		1.641
Plants	units	0		0		0		0			
Heroin	kg	157	0.879	152	1.055	73	0.680	86	0.750		1.826
Cocaine of which crack	kg	39	5.399	44	3.043	10	1.525	27	0.111		10.523
		0	0	0	0	0	0	0	0	0	0
Amphetamines	gr	6	19.7	1	0.5	3	21.5	2	2		35.5
	pills										
Ecstasy type	pills	22	549	6	16	7	49	1	201		31
	gr										
LSD	doses	11	113	0		0		1	1	0	0
Psilocybin	gr	0		0		4	16.5	9	125.5	0	0
Methadone	flask	0		1	9	1	1	0		0	0
	mg										
Mephenon	pills	0		0		1	1	2	71	0	0

Source: Specialised Drug Department of the Judicial Police 1999. Customs administration 2000.

### 5.3 Price/purity

Average **street retail prices** of illicit drugs have been remaining fairly stable during past years, with the exception of cannabis, on the increase (hashish: 7.4 €/gram, marijuana: 6.2 €/gram) and brown heroin, on the decrease (74 € /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	5 - 6	5 - 6	5 - 6	5 - 6	5 - 6			7.4	6.7	7.9	7.4
Hashish				2.5 - 3	2.5 - 3			6.2	6	6.7	6.2
Marijuana											
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, samples of 'suspect substances' analysed by the National Laboratory of Health (LNS) in 2000, revealed the following margins of purity of active substance: brown heroin: 2.8 to 54.9 per cent (↗); cocaine: 28.3 to 95.2 per cent (↘); hashish (THC): 2.65 to 11 per cent (↗). In 2000, toxicological analysis of samples sold as ecstasy reported the presence of MDMA in 21 samples (purity: 18.7 to 52.3%) and MDEA in one sample (purity: 6.8%).*

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

	1994	1995	1996	1997	1998	1999			2000		
	Purity (%)	Pur. (%)			Pur. (%)						
						MIN.	MAX.	MOYEN	MIN.	MAX.	MOYEN
Cannabis Hashish Marijuana						2	5.13	3.46	2.65	11,7	8.03
Cocaine	60-90	60-90	60-90	60-90	60-85	45.8	88.76	70.66	28.3	92.2	60.25
Heroin (brown)			15-23	20-25	17-25	7.2	27.7	12.17	2.8	54.9	17.59
Ecstasy (MDMA) (MDEA)									18.7	52.3	35.5 6.8

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2000.

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

For cannabis, purity refers to percentage of THC.

For ecstasy-type substances, purity refers to percentage of MDMA-HCL in relation to total mass.

## 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).

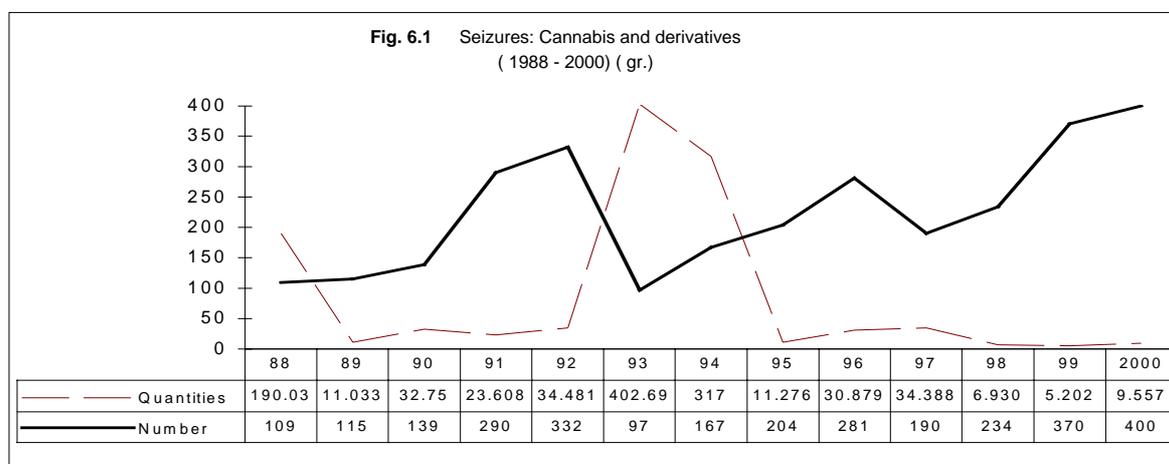
*Cannabis use in indexed problem drug users witnesses a notable increase as main (primary) and secondary drug. The average ages at the time of first consume of the current main drug and illicit drugs in general have shown a slow but constant downward trend for the last 4 years. For instance, 25 per cent (↗) of current problem drug users (2000) 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. (1995-2000)**

Preferential substance	Primary drug						PREF. 2						PREF. 3					
	95	96	97	98	99	00	95	96	97	98	99	00	95	96	97	98	99	00
CANNABIS AND DERIVATIVES	5	5	4	3	3	7	20	16	14	29	24	26	22	33	29	41	40	31
N	405	283	237	574	677	731	362	241	229	397	440	530	235	193	198	255	280	360

Source: RELIS

*Seizure data do confirm a rising prevalence trend as to the seized quantities and the number of seizures since 1993. The latter trend is observed in youngsters of the general population as well as in indexed problem drug users*



Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2000.

### ➤ Synthetic drugs

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

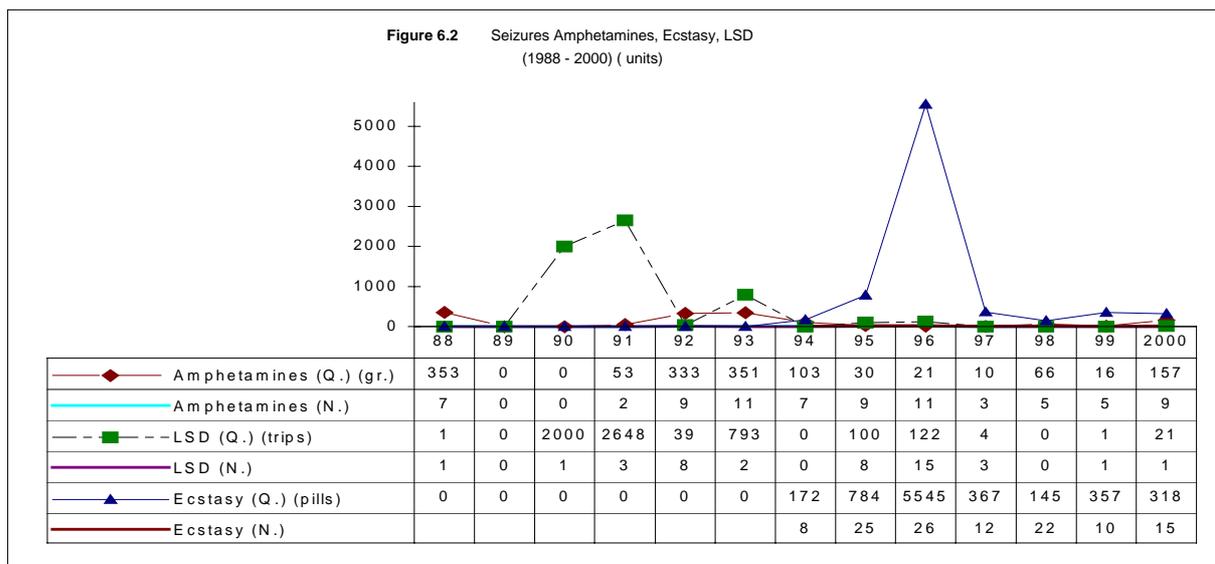
*Synthetic drugs figure poorly as main drug of **problem drug users**. As regards secondary drug prevalence, no significant trend is currently observed.*

**Table 6.2** Preferential drug consume of problem drug users – Synthetic drugs. Valid percentages. (1995-2000)

Preferential substance	Primary drug						PREF. 2						PREF. 3					
	95	96	97	98	99	2000	95	96	97	98	99	2000	95	96	97	98	99	2000
LSD				1			3	3	3	4	1	1	3	8	5	5	5	3
ECSTASY-TYPE	1	2	1	6	2	1	4	6	6	7	4	4	5	8	11	10	10	6
AMPHETAMINES			1	2	1		4	3		3	1	2	4	2	6	6	3	5
N	405	283	237	574	677	731	362	241	229	397	440	530	235	193	198	255	280	360

Source: RELIS

*Seizure data do partly confirm prevalence trends in particular referred to low LSD and ecstasy like substances' figures. The number of amphetamines seizures shows an increase compared with 1994 data.*



Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2000.

## ➤ 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 %).

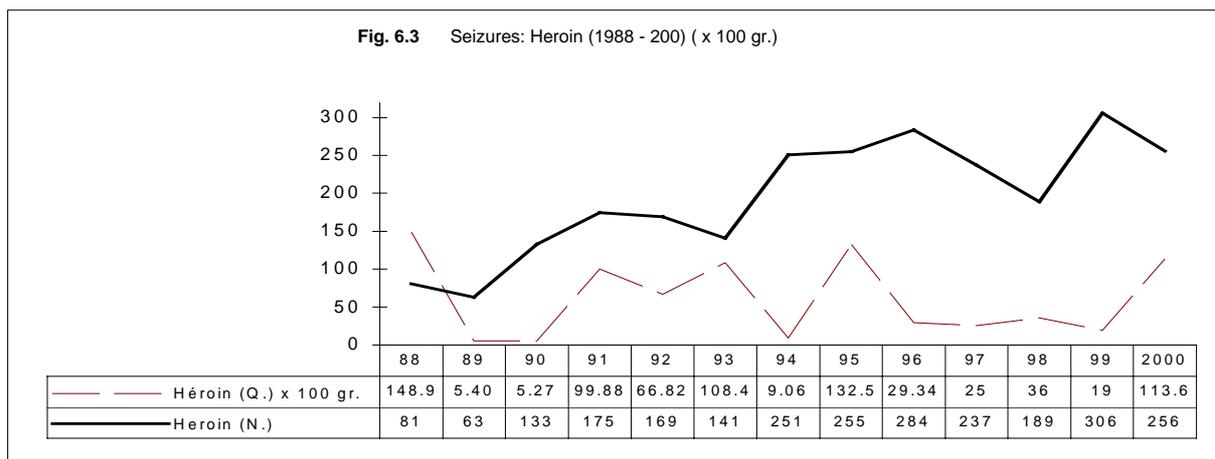
**Opiates** are referred to as **primary drug** by 84 per cent (stable) of indexed problem users. The significant increase of the **inhalation mode** (also known as 'blowing' or 'chasing the dragon') referred to opiate use in 1998 (36%) (1997: 10%) was followed by a two-years decrease reaching 24% in 2000. **Intravenous heroin use** as primary consume pattern has stabilised (53%). 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 4 years. For instance, 47 per cent (1999: 43%) of current problem drug users (2000) were still underage (< 18 years) as they have first injected opiates.

**Table 6.3** Preferential drug consume of problem drug users - Opiates. Valid percentages. (1995-2000)

Preferential substance	Primary drug						PREF. 2						PREF. 3					
	95	96	97	98	99	2000	95	96	97	98	99	2000	95	96	97	98	99	2000
HEROIN / OPIATES (i.v.)	64	58	70	41	51	53	10	11	10	7	7	6	8	5		3	4	5
HEROIN / OPIATES (other route)	17	17	10	36	33	24	17	10	8	4	9	5	3	5	9	3	4	3
Other opiates		3	1	3	1	7	3		7	5	6	10		1		1	1	2
N	405	283	237	574	677	731	362	241	229	397	440	530	235	193	198	255	280	360

Source: RELIS

**Seizure data** show a long-term 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 heroin availability at the street level.



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 %)

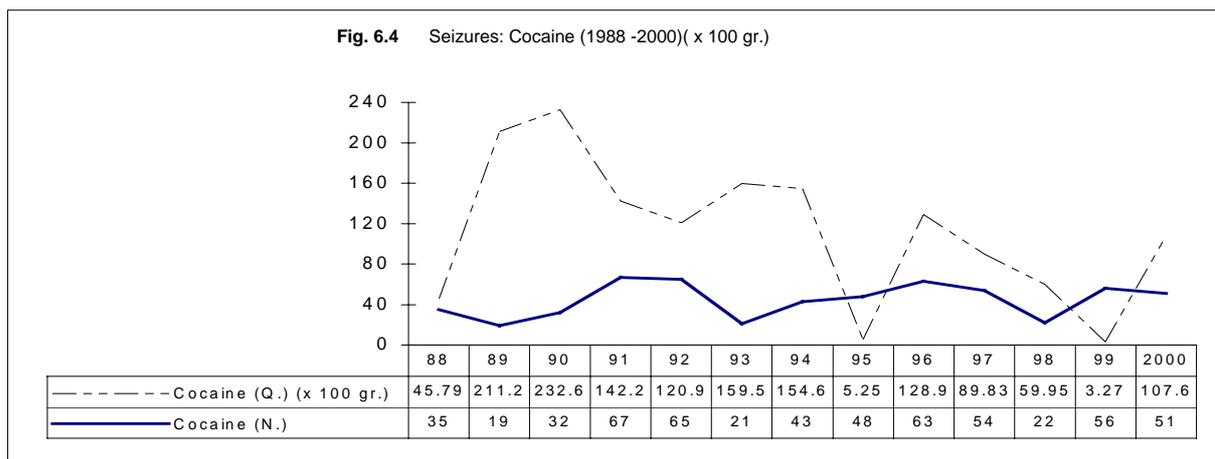
*i.v. and non i.v use of cocaine as main drug by **problem drug users** show fairly stable figures. As far as secondary use is concerned, an apparent increase observed in 1999 seems not to be confirmed by 2000 data. Crack use is insignificant at each preference level.*

**Table 6.4** Preferential drug consume of problem drug users - Cocaine. Valid percentages. (1995-2000)

Preferential substance	Primary drug						PREF. 2						PREF. 3					
	95	96	97	98	99	2000	95	96	97	98	99	2000	95	96	97	98	99	2000
COCAINE (i.v.)	3	5	2	4	4	3	8	12	9	18	16	17	6	3	4	7	5	7
COCAINE (other route)	5	8	9	3	5	4	17	24	22	15	21	15	6	6	5	7	5	7
<b>N</b>	<b>405</b>	<b>283</b>	<b>237</b>	<b>574</b>	<b>677</b>	<b>731</b>	<b>362</b>	<b>241</b>	<b>229</b>	<b>397</b>	<b>440</b>	<b>530</b>	<b>235</b>	<b>193</b>	<b>198</b>	<b>255</b>	<b>280</b>	<b>360</b>

Source: RELIS 2000

**Seizure data** on cocaine show an overall yet disrupted decrease from the beginning of the nineties onwards. The increase of seized cocaine in 2000 is mainly due to an important transit seizure. The number of cocaine seizures has been stable over the last 6 years (except in 1998). No seizure of crack has been reported thus far by national authorities.



Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2000.

## ➤ Multiple use

RELIS data from 2000 have shown that up to 87 per cent (1999: 82%) of drug treatment demanders are **multiple-drug users**. The referred rate has shown great stability since the beginning of drug monitoring and shows a sensible increase in 2000. Data on recorded drug law offenders confirm referred figures. 80% of drug law offenders have been reported multiple-drug users in 2000. 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 (1995) 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% – 1995: 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. The use of hypnotics and sedatives in youngsters has also witnessed an increase during the last 8 years.

## 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 data. Since RELIS is the only national drug monitoring system on problem drug users, consistent cross-validation procedures cannot 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 and independent surveys and studies on drug prevalence and patterns of use. It has been said that problematic drug use **prevalence figures** have been validated in the light of a series of indirect indicators (see 2.3) Drug use in general population and youngsters have been assessed by different studies. Although, RELIS addresses a different clientele, data from youth and school settings generally confirm trends as regards prevalence and new use patterns.

**Infectious disease** rates in problem drug users have been compared to the results of a highly representative study within prison published in 1999 (Schlinck 1999). **Law enforcement indicators**, which quality has been largely improved by means of close collaboration between the SPJ and the NFP, are consistent with the **treatment demand indicators**. One may recall that likewise the drug prevalence figures, the **number of police records** for presumed offences against the drug law, shows an important increase between 1995 (764) and 2000 (1,340). The **number of drug law offenders** ('prévenus') has increased from 1,263 in 1995 to 1,758 in 2000. 117 arrests on the same charge have been reported in 2000 (stable since 1998). 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 **drug-related deaths** and on **number of drug seizures**. Quantity of drug seizures is actually the only indicator, which does not confirm data from other sources.

## 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. A fairly difficult task 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, researchers 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 laid down the revision of the national drug legislation. 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 drug action plan on drugs (2000-2004). The drugs action plan heavily relies on RELIS data, on proposal provided by field agencies and on systematic needs assessment.

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 until 1999 and current high level stabilisation,**

*The number of problem high risk drug users indexed by national institutions in 2000 figures 1,024 (1,198) persons (double counting excluded). 637 (757) persons were indexed by **treatment agencies** and 510 (551) by **law enforcement agencies**.*

*32 per cent (33%) of indexed drug users, of which 63% were non-natives, have been in contact with a given RELIS institution (**intra-institutional**) for the first time in 1999. Expressed in terms of drug treatment demands (health care institutions only), the same rate, on the increase since 1997, equals to 46 per cent (39%). On average, a problem drug user addresses 1.66 (1.7) drug treatment demands per year. For 3 per cent (4%) of registered cases, it has been the **first drug treatment demand** during lifetime (**inter-institutional**).*

*(Overall increase of prevalence, creation and diversification of treatment offers previously not existent, etc.)*

- **high and moderately increasing problem drug use prevalence,**

**Absolute prevalence and prevalence rates of problem HRC drug use** have shown a growing tendency over the past four years. The increase curve observed between 1999 and 2000 is less pronounced than the one observed during the period 1997 to 1999. Observed figures comply with the stability of **heroin use** and **intravenous drug use** prevalence between 1999 and 2000. Although the total drug use prevalence shows an upward tendency, heroin use does not contribute significantly to the referred progression. Intravenous drug use prevalence has even shown a slight decrease in 2000. Observed tendencies in most of indirect indicators (e.g. overdoses, treatment admissions, drug offences), closely follow the progression curve of the estimated prevalence between 1997 and 2000.

*(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 (especially cannabis use),**  
*(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 producer (alcopops, banalisation of performance enhancing drinks (e.g. Red Bull), etc.)*

- **decrease of iv opiate use vs. increase of other administration modes,**

The proportion of **poly-drug use** (2000: 87 % still on the increase) represent the most common drug consume pattern. 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 4 years. For instance, 25 per cent (22%) of current problem drug users were younger than 14 years at the moment of first cannabis use and 47 per cent (43%) were still underage (< 18 years) as they first injected opiates. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2000.

*(Impact of infectious disease prevention campaigns, increased availability of brown heroin, new generation of increasingly younger hard drug users, etc.)*

- *increase of problem cannabis use*

*Problematic cannabis use prevalence in RELIS respondents has shown an upward trend in 2000 (7%). The observed trend is even more significant if exclusively referred to drug treatment demanders (10%). In this context, one might refer to recent results from toxicological expertises performed by the National Health Laboratory (LNS) following **traffic accidents**: in 1995, 30,3 percent of expertises reported cannabis use of involved drivers; in 2000 the same proportion figured 48 per cent.*

*In 2000 a remarkable increase of quantities of seized **cannabis** has been observed; the number of cannabis seizures and persons involved followed a proportionally steeper upward trend. Between 1994 and 2000, the number of cannabis seizures went up from 167 to 400; the number of offenders involved has also marked an increase from 242 to 518.*

- *socio-demographic changes in problem drug users as for instance ageing, nationality, gender distribution, occupational and social status,*

*Compared with 1995, the **average age**, applied to the total drug population (28 Y, 1M), has slightly increased, (2000: 28Y, 9M). The proportion of **persons aged 35 and more** has constantly increased since 1996 as well as the **standard deviation** of the observed age distribution meaning that the gap between the youngest and oldest problem drug users tends to increase. Currently one observes a fairly polarized situation that is an aging population of long-term drug injectors and a significant decrease in age referred to first treatment demanders or first drug offenders. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders (8.8%) and in first drug offenders (25.3%), in the total drug population (3.2%) and in the percentage of students in problem drug users (20%). 82 per cent and 47 per cent of problem users have experienced cannabis and heroin (i.v.) respectively, while being a minor of age. In 1995, RELIS figures referred to 71 per cent and 23 per cent respectively. Based on RELIS data and several indirect indicators, one may estimate the current **national prevalence of problem drug users underage** reaching 80 to 100 persons including 40 to 60 injectors.*

The average ages of native and non-native problem drug users tend to balance. The **difference in age in proportion to gender** has increased mainly due to the low and still decreasing age of female drug users. Generally speaking, the **profile of female users** has known the most significant changes during recent years. In comparison with male users, one should mention a lower age (13Y, 3M) at first consume of cigarettes, at first use of illicit drugs (14Y4M) and an earlier start of a physical addiction state reported by female users.

All indicators included, the **employment status** of respondents has declined for the last three years. The **unemployment rate** (2000: 65%) among the drug population has grown in significance since 1997. Data on **revenues** confirm observed trends in occupational status, namely a weakening of financial autonomy (2000: 29%) associated to an **increasing social dependency** (2000: 61%).

Two socio-economic indicators that show a positive evolution referred to **revenues of illegal origin** and the **indebtedness status**. The former went down from 23 to 9 per cent and the latter from 59 to 41 percent from 1995 to 2000.

*(Diversification of available (synthetic) drugs multiplying alternatives to iv opiate use, need of foreign workers especially in the primary sector, generation clash in Portuguese families (acquired language skills), gaps in socio-cultural integration initiatives for immigrants at the national 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),**

Indicators retained by RELIS stress a slight improvement of the **general health state** of indexed drug users compared with 1994 data. **HBV** and **HIV** prevalence rates<sup>12</sup> are stable. However, one should emphasise that the **HCV** infection rate has increased noticeably during last years and reached 40 per cent in 2000.

Since 1995, the proportion of **AIDS diagnostics** in problem drug users has been varying between 1 and 4 per cent. In terms of data validity, one may stress the high percentage of problem drug users having been tested for HIV during the last 5 months (males: 81%, females: 85%). A majority of drug injectors (2000: 68%) report not to share used injection material. **HIV infection rate** has stabilised at 4 per cent. National infection rates are consistently lower than the average of those observed in Member states of the European Union (Greece: 0,5 – Spain: 32% - Portugal 48%), (EMCDDA, 2000). According to official figures published by the National Surveillance Committee on AIDS, the average **proportion of injecting drug users in HIV infected persons** between 1984 and 2000 figures 16 per cent. The NFP is currently setting up a research plan (2001-2003) with the objective to estimate HCV and HIV prevalence in recent drug injectors based on medical diagnosis data (saliva sample tests).

(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 former 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 laws and their pragmatic enforcement lack of information of the legal status of LRC drugs, etc.)

- **geographical spread of problem drug use towards rural settings,**

Although drug use has spread geographically during the last few years, the main problematic drug scene increasingly settles in Luxembourg City, presumably for reasons of availability of drugs and care facilities

(Development in drug distribution strategies, rural isolation, etc.)

- **risk behaviour of problem and recreational drug users,**

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 (2000: 28%) showing **psychiatric treatment** demands for reasons other than drug detoxification.

The number of **overdose cases** (acute/direct drug deaths), reported by national authorities, has increased steadily since 1984, peaking with 29 cases in 1994. Decrease was observed from 1995 and persisted throughout 1997 (9 cases). Since 1998 a growth tendency has resumed reaching 26 cases in 2000. Results of toxicological analysis performed on overdose victims refer to the presence of **opiate** traces in 84 per cent of cases. In 67 per cent of autopsy cases **heroin** consume was reported; a proportion on the decrease (1999: 90%) for several years balanced by an increase of **methadone** (29%) as being the substance which has caused death.

(Social components as for instance the promotion of a fast and intensive way of life by media and the devalorisation of introspective life competencies, etc.)

- **increasing prevalence and changing profiles of drug-related deaths victims**

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<sup>12</sup> HIV and hepatitis figures refer to both, injecting on non-injecting drug users

*(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, both foreseen by the new drug law (27/04/2001), 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. Revised convention contracts 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 terms of reference of the convention since it allows for data quality insurance in the long run. In 2000, two further field partners (general hospital and AIDS counselling centre) have joined the RELIS network. *Currently, the major low threshold agencies situated in Luxembourg City provides the NFP with representative client data by means of a condensed RELIS protocol.*

*A major achievement during year 2000 has to be seen in the 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 death 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 the validation process of current trends. Furthermore the **automated use of RELIS data in the framework of the recent drug prevalence study** (Origer 2001) especially referred to the application of capture-recapture and several multiplier methods is considered to be a major step towards a time and cost effective overall drug monitoring system.*

GPs 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 referred to first drug treatment demands. 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*

- *Evaluation of implemented TDI standard (in progress);*
- *Annual follow-up of drug prevalence figures by means of validated estimation methods (see recent multi-method drug prevalence study (Origer 2001));*
- *General population survey on illicit drug use;*
- *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);*
- *Access to court data;*
- *Increase of data sources in the framework of the early warning system on synthetic drugs.*

## **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 (IGD)** 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 this work group, as for instance the set-up of a national drug prevention centre (CePT) have been concretised.

*The **National Prevention Centre on Drug Addiction (CePT)**, which has started its activities in 1996, covers illicit drug prevention as well as other types of addiction fields. Legally speaking the CePT is a foundation that has been financed by the Ministry of Education until 1999. In 2000 the referred budget line has been transferred to the Ministry of Health in the framework of the above mentioned centralisation process. The management board of the CePT is composed of delegates of the main ministries involved in the drug and addiction field, which promotes an effective information and interest sharing strategy. In reference to the financial management, the CePT enjoys a certain degree of independence with regard to the conceptualisation of prevention campaigns.*

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

*The overall coordination of treatment and low threshold interventions is within the competence of the **AST (Directorate of Health)** and the **national drug coordinator's office**. Together, both actors have coordination and financial control missions. Furthermore, they are responsible for the conceptualisation and the implementation of activities included in **the drugs action plan 2000 – 2004** (see 1.1).*

### 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 seen as a cornerstone 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 continuous 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 the 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" (joint initiatives of border regions of France, Germany, Belgium and Luxembourg) 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 an example of good practice of a 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.*

*A **booklet presenting all national agencies and institutions involved in the drug and drug addiction field** has been compiled by the CePT and is periodically updated by the NFP. The document has known a broad diffusion within general and specialised public. Special attention has been paid to **GPs** since a former study of the NFP (Origer, 1998) has shown that GPs are poorly informed on specialised national drug treatment facilities and demand data on national on trans-border referral sources.*

*Edited by the Luxembourg drug coordinator's office, the **Mondorf Group** has published a comprehensive and updateable **information file**, containing relevant information on drug treatment facilities, drug legislation and innovative prevention and research projects referred to in respective national member-regions of the Mondorf Group. The original file as well as periodic updates are distributed within a broad network of approximately 500 persons or institutions. The referred strategy has filled an obvious information gap in relation to the intense migration of treatment demanders within the concerned border regions. Special topics as for instance drug penalties and substitution treatment regulations are also addressed in order to provide a clear picture of the current situation to both, drug users and field actors.*

*In addition to the intensification of needs oriented information diffusion, the NFP has recently redesigned its proper **Internet homepage** to be found under: <http://www.relis.lu>*

*In the course of 2001, the main national treatment and prevention agencies have launched their first Internet sites, namely: CePT: <http://www.cept.lu>*

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

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

### Specific events during 2000

**January 2000 (6):** Presentation of the TRANSRELIS study by the Mondorf Group.

**January 2000 (25):** Political round table on the legalisation of cannabis organised by the national ecological party.

**February 2000 (2):** Round table on national drug policies organised by Agora (platform for a humanistic drug policy).

**March 2000 (21):** Workgroup on drug policies in Belgium organised by the federal government of Belgium.

**March 2000:** Street performance week including drug related activities.

**April 2000 (17. -21.):** International adventure week for youngsters applying adventure pedagogical tools in the field of drug prevention jointly organised by the Mondorf Group, the CePT and the SNJ.

**May 2000 (30):** Presentation by the CePT and the ZePF of results of an exploratory study, financed by the FLTS, on cannabis use in Luxembourg by the CePT and the ZePF which has been financed by the FLTS.

**July 2000 (15):** Conference on drug policies in BENELUX member states in presence of the Belgium member of Parliament Mr. Patrick Moriau, members of the national Parliament and the national drug coordinator, organised by the Young Socialists section.

**July 2000 (21&22.):** Continuous training session on drug prevention by means of adventure pedagogical methodologies jointly organised by the CePT and the SNJ.

**September 2000 (18):** Inauguration of a low threshold facility (KONTAKT 25) in Luxembourg City included in the drug action plan 2000-2004 and managed by JDH.

**September 2000:** Publication of an information brochure on alcohol and illicit drugs at the workplace by the CePT.

**October 2000 (18):** Conference organised by MSF on the influence of drug addiction on human relationships.

**October 2000 (19):** Conference on hypnotherapeutic concepts applied to drug treatment organised by MSF.

**October 2000 (27):** 20<sup>th</sup> anniversary of the national drug addicts' parents' organisation (EDK).

**January 2001 (4):** Introduction to the Parliament of a law proposition on the regulation of production, distribution and selling of cannabis by a green member of Parliament.

*March 2001: Presentation and diffusion of the information file on drug policies, treatment facilities and prevention projects in the member regions of the Mondorf Group.*

*April 2001 (27): Parliamentary vote of the law of 27 April 2001 amending the modified basic drug law of 19 February 1973.*

## 9 Interventions Areas

*The present chapter provides a summary of recent drug demand reduction measures undertaken at the national level. More detailed information and examples of good practice can be found in the EDDRA database of the EMCDDA under: <http://www.reitox.emcdda.org:8008/eddra/>*

### 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/and the Division of Preventive Medicine (Directorate of Health) generally reach parents through 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 that are supposed to detect, at the very early stage, problems or behaviours in relation to substance abuse.

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

*In 2000, CePT has started a project called ' d'Schoul op der Sich' (**School on quest**) (see EDDRA). The project includes interested educational institutions on a voluntary basis and aims 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 in terms of complementary service providing at the level of crisis intervention. The project is called "**Solution finding in case of drug abuse in school**". 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 aware that drug prevention only has a chance to work if drug use is not reducibly approached as a symptom but as an 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-oriented clubs. The latter are, however, fairly difficult to list exhaustively.

Since its creation in 1995, the CePT, has initiated a series of 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 institution 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 professionals.*

*The annual "adventure weeks" do fit in a broader programme named "Adventure pedagogy and primary addiction prevention". The project has been initiated and promoted by the Mondorf Group (Transborder ministerial Group created in 1992 (Moselle region (France), Saarland and Rheinland-Pfalz (Germany), the German speaking Community of Belgium and Luxemburg). The project aims at addiction prevention and reducing substance abuse by means of adventure pedagogy oriented activities related to primary prevention measures. The program further aims at the reduction of risk factors and the enhancement of protection factors, by focussing more on the youngsters and their environment, rather than on drugs and addiction. Participant groups are composed of youngsters with and without previous contact with law enforcement forces for drug related offences. The objective of this experience is to support young people in acquiring general life competences allowing them to decide autonomously and in an objective way on the possible consequences of risk behaviour such as drug consume.*

*Prevention professionals thus faced an evaluation perspective, which provided the opportunity to explore different education skills and learn new strategies in emerging situations. Addiction prevention professionals conducted the internal evaluation. The global evaluation of the project showed a general satisfaction of the participants, revealing a positive evaluation of the organisation, the group heterogeneity (girls/boys; youngsters said "problematic" / youngsters said "normal") as well as on the level of the group atmosphere. Communication quality between professionals and youngsters was assessed as non-satisfactory. Referred causes concerned group size (40 pers.) and linguistic barriers (German and French). The evaluators recommended*

*an increase of resources applied to the preparation, as well as more intensive educational framing of participants.*

*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 administered in form of pills). Following a first evaluation phase the game kit has been renamed 'Ecstasy' and applied to different youth settings and distributed and integrated in appropriate school courses (see. EDDRA).*

*EXTASIA is a parlour game for youngsters, developed in trans-border cooperation between the CePT and the region of Saarland (Germany). This communication tool should provide the necessary information and help the youngsters to develop decision skills and alternatives to drug use. The Extasia game exists in two versions: a short version of 45 minutes and a long one of 90 minutes. The Extasia parlour game includes three fields: - check up (information) - statement (sharing and finding strong lines) - action (group experience). It is easy to handle and to integrate in youngster, school or leisure settings.*

*The general objective is mainly preventive. It should provide reliable information on drugs, boost discussion and experience sharing as well as the individual elaboration of alternatives to drug use. The evaluation performed over a period of 9 months on several groups who did experienced Extasia, showed a global satisfaction indicator of 3.24 on a scale between 1 (very positive) to 6. The global notes show a preference for the part "actions", followed by "statement" and finally "check up". Furthermore, participants suggested more than one answer per question and to include questions about legal drugs, especially alcohol. For the part called "statement", the evaluations showed that the retained game items had a strong incitement impact on discussion. Among other suggestions, role-playing was frequently referred to.*

#### **9.1.4 Community programmes**

*In general terms health prevention activities are fairly centralised. Drug demand reduction is no exception to the rule. Local and regional communities do rarely dispose of a comprehensive drug prevention strategy. Commonly, a given national agency initiates projects, defines the general intervention framework and seeks active collaboration with community authorities in order to meet local needs. The observed situation is mainly due to geographical parameters of the Grand Duchy.*

In the beginning of 1995, a pilot project on **community-based drug prevention** has been launched by CePT (see EDDRA). The main idea was to focus prevention activities on the very environment and daily life experiences of young people. Various demand reduction activities have been undertaken, either developed by CePT, SNJ and several youth centres, or initiated by the respective District Councils. *13 district councils 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 primary aim of the project is to improve communication skills on drugs, to increase participants' abilities in handling conflicts, stress and frustration (age range:

12 to 65 years) and to set up autonomous groups to continue implementing local prevention measures. In each participating municipality, prevention groups were composed of local volunteers who were asked to organise local drug-prevention activities related to their specific needs. The methodology used was based on a holistic and community approach. The evaluation of the project, which has been conducted by the University of Koblenz-Landau (ZePF), was based on a micro-level and macro-level indicators applied to target and control groups. An improvement in communication and in the knowledge of the risks associated with drugs was noted. Changes in drug consumption, the behaviour of drug users and drug patterns were not immediately apparent. The second part of the project aims at setting up a platform for a European information exchange in the referred field. The multilingual publication of the project was distributed across Europe. 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, which is expected to develop its proper dynamic over the time. 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.*

*As regards **treatment and low threshold interventions**, all involved agencies are financed by state or by social security reimbursement and implemented in the major cities of the country.*

### 9.1.5 Telephone help lines

*Several specialised and non-specialised telephone help-lines exist at the national level. The first national 24 hours telephone **drug help line "SUCHT-TELEFON 49 60 99"**, financially supported by the European Commission, has been inaugurated by the CePT on the 1<sup>st</sup> of October 1995.*

*The anonymous and confidential help line is available 7 days/week and 24 hours a day and aims at the general public in order to provide information on drug-related topics and to meet its demands by means of non-directive conversational techniques. Operators volunteer an received training during 6 months on conversational and listening techniques, the national assistance and health care network as well as on several addiction and drug topics.*

The CePT is a member of the 'Fondation Européenne des Services d'Aide Téléphonique Drogues - FESAT'. Activity 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 of volunteers and that at present time; calls are not free of charge. *Evaluation of the programme is carried out by means of an annual assessment.*

**Table 9.1.5.1** Client core statistics of national drug help line (1997-2000)

<b>CLIENTS CORE STATISTICS</b>	<b>1999</b>	<b>1998</b>	<b>1997</b>	<b>2000</b>	
<b>Number of calls:</b>	626	717	653	831	
<b>Gender of callers:</b> male	36%	50%	40%	37%	
female		64%	50%	60%	63%
<b>Self implied demander status:</b>	76%	83%	75%	85%	

Involved substances for drug-related calls:					
Alcohol:		42.6%	50.5%	45%	47%
Pharmaceutics:	29.3%	40.6%	38%	42%	
Heroin:	10.6%	10.9%	14%	8%	
Cannabis:	11.1%	9%	6.5%	7%	
Cocaine		2.7%			
Crack	0.5%				
Tobacco:		1,7%	1%		2%
Ecstasy like:	0.5%	2.8%	0.5%	1%	
Age distribution					
≤ 15	0.5%	0.8%	0.7%	0.5%	
16-19	2.6%	2%	2%	1.8%	
20-24	4.1%	2%	5%	2%	
25-30	10.9%	7.2%	4%	7.8%	
31-40	26.4%	40.6%	24%	14.2%	
41-50	42.6%	34.8%	52%	49%	
> 50	12.9%	12.6%	4%	9.7%	

Source: CePT 2000

### 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 financed by 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 conducted. 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** and drug use at the workplace (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 2000, the CePT and the Division of Preventive Medicine have launched three mass media campaigns on illicit drugs. The first has been addressing **alcohol use by youngsters**, the second **on drug use at the workplace** and the third, 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 by means of a multi-annual budget line. Cost sharing is envisaged for instance by means of cinemas' participation in the diffusion of prevention trailers.*

Jointly the NFP and the national drug coordinators' office put major efforts in active PR strategies towards specialised journalists. **Direct interaction with involved or specialised media actors is preferred to broad diffusion to editing teams of newspaper, TV and broadcasting companies.** In 2001 special emphasis has been put on Portuguese media since the **Portuguese speaking community** is currently a priority target in terms of information providing and prevention efforts.

### 9.1.7 Internet

The use of new information technologies as for instance Internet in the field of drug demand reduction has significantly developed over the last two years. Prior to 2000 only few field agencies had access to Internet or operated a proper home page. The NFP maintains an Internet homepage since 1996, which mainly provides research and monitoring data. The **NFP's homepage** (<http://www.relis.lu>) have been redesigned in 2001 and currently includes a document server providing downloadable versions (.pdf) of research reports and annual reports on the national drug situation. This strategy has allowed to reduce costs in terms of hard copy diffusion and has highly increased the accessibility of NFP publications.

In the framework of the recent cannabis action-research, CePT has used Internet facilities as interface for information diffusion and provided an online questionnaire for a small-scale population survey on cannabis. CePT has launched a proper home site (<http://www.cept.lu>) in 2000. The use of Internet by treatment institutions and law enforcement agencies aiming at the promotion, dissemination or information sharing is presently developing (see 8.2).

**The use of internet or intranet facilities in the framework of RELIS data transmission from field agencies towards the NFP has been discussed but not implemented due to security reasons and scarce IT resources of some of the RELIS partners.**

## 9.2 Reduction of drug-related harm

Prior to the latest amendment of the basic drug law of 19 February 1973, harm reduction activities have been developed as a necessary reaction to a rapidly increasing hard drug population in absence of any legal framework regulating their implementation. This situation has changed with the **law of 27 April 2001**.

The **2000-2004 action plan** is founded on the amendments introduced by the law of 27 April 2001 modifying the basic drug law of 19 February 1973. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a **legal framework for a series of harm reduction and maintenance measures** as for instance drug substitution treatment (previously only tolerated), needle exchange and other **state licensed means** which legally speaking could materialise for instance in shooting galleries or medically controlled heroin distribution.

The original text of the law of 27 April 2001 can be downloaded from:  
<http://www.etat.lu/memorial> or

[http://eldd.emcdda.org/databases/eldd\\_search.cfm](http://eldd.emcdda.org/databases/eldd_search.cfm). Table 1.2 provides an comprehensive overview of amendments introduced by the law of 27 April 2001.

### 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 groups and low threshold interventions, to HIV and hepatitis testing, condoms delivering and advice provision to treatment reluctant drug users. *For the last three years one has noticed a decrease in outreach activity since the open drug scenes in the South of the country tend to reduce in number of consumers while the open scene in Luxembourg City are growing 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 (as foreseen by the drugs action plan 2000-2004).*

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 National Committee for Social Welfare (CNDS). 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, two educators and one psychologist 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. Most of client statistics suggest an **increase of the problematic drug users' scene**. In 1996 the average number of demanders per day was 30 rising up to 51 in 2000. The number of female demanders is also increasing which confirms the overall trend observed in different drug treatment settings.*

		1996	1997	1998	1999	2000
Days of presence within the scene		238	248	248	251	232
Total number of contacts		6,456	8,734	8,525	10,602	11,834↗
Average number of demanding persons per day		30	35	34.4	42,2	51↗
First recourse		364	388	+/- 216	215	276↗
Number of new clients per day		1.5	1.6	0.87	0.84	1.2
Number of distributed syringes		22,729	46,993	42,621	55,436	42,924
Number of collected used syringes		20,090	43,987	37,587	48,747	38,534
Return rate of used syringes		88.4%	93,6%	82.2%	88%	89.77%
Proportion of clients aged 18 to 35 years		83.7%	77.51%	80.64%	86.59%	73.45%
Proportion of women with at least 1 child				48.82%	47.17%	42.7%↘
Gender distribution	male	72.16%	72.4%	71.7%	70%	69.38%
	female	27.48%	27.6%	28.3%	30%	31.62%↗
Nationality	natives	64.74%	70.68%	71.52%	68.84%	68.38%
	non-natives	35.26%	29.32%	29.48%	31.16%	31.62%
Drug-related care demands		87.4%	87.14%	87.43%	87.44%	85.5%
Proportion of prostitutes in female clients		46.70%	52.42%	50%	50.63%	46.35%
Previous prison sentences	none	41.85%	49.79%	49.49%	50.52%	47.7%
	1	26.39%	23.02%	22.69%	23.61%	22.03%
	more than 1	31.75%	27.17%	27.80%	25.87%	30.27%

Source: CNDS 2000

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.

	1996	1997	1998	1999	2000
Total number of contacts	804	1,050	1,818	1,676	1,249↘
First recourse	171	113	181	126	114
Number of distributed syringes	854	1,701	3,068	4,948	3,728
Number of collected used syringes	360	990	1,400	3,150	2,160
Return rate of used syringes	42%	58%	46%	64%	58%

Source: Fondation JDH. 2000

*In the framework of the national drug action plan 2000 - 2004, 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 oriented and did include law enforcement actors during its conceptualisation phase. An adequate location as well as the required staff have been provided by the Ministry of Health. The main idea of the project is to integrate*

and consolidate the current activities of ABRIGADO by creating a centralised and drug specialised structure in Luxembourg City offering low threshold services, accommodation facilities and presumably injection rooms in the long run (legally implementable since the law of 27 April 2000). Since the building retained for the project has to be consistently transformed, the emergency centre should start its activity in 2003.

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. In addition to free of charge needle provision by specialised drug and AIDS agencies, *Automatic syringes dispensers and collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy. Technical improvements as well as changes with respect to dispensers' locations have lead to a clearly increased user rate since 1994. Regarding the quantity of distributed syringes table 9.2.3.a shows an **increase of 148 per cent during the period 1996 to 2000**. Return rates are also on the increase (except for automatic dispensers). The needle exchange program has been legalised by the law of 27 April 2001.*

	Distributed syringes					Collected used syringes				
	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000
JDH, Esch s/ Alzette - Streetwork - Counselling centre	122 854	47 1,701	58 3,068	159 4,948	3,728	360 (42%)	990 (58%)	1,400 (46%)	3,150 (64%)	2,160 (58%)
JDH, Luxembourg	6,801	9,339	16,800	28,000	34,532	5,000 (74%)	6,340 (68%)	7,660 (46%)	17,700 (62,5%)	26,560 (77%)
Oppen Dir, (Réseau PSY)	2,829	2,263	3,849	8,772	8,157	1,696 (60%)	1,556 (69%)	2,439 (63%)	7,479 (88%)	7,225 (88,5%)
ABRIGADO	22,729	46,993	42,621	55,436	42,924	20,090 (88%)	43,987 (94%)	37,587 (88%)	48,747 (88%)	38,534 (89,5%)
Automatic dispensers	42,924	24,507	43,347	55,671	63,111	1,500 (3,5%)	600 (2,5%)	1,800 (4%)	1,300 (2%)	2,100 (3,3%)
DROP-IN	/	/	/	21,372	36,961	/	/	/	20,388 (95,4%)	36,046 (97,5%)
TOTAL	76,259	84,850	109,743	174,558	189,413	28,646 (38%)	53,473 (63%)	58,886 (46%)	98,764 (57%)	112,625 (59%)

Source: RELIS

*In 2000, 66,800 (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 (e.g. 2000: 27% / 1998: 19%). Facing an increasing rate of drug users within its clients, AIDSBERODUNG has joined the RELIS network in 2001.*

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

*According to EMCDDA's key indicators and with a view to increase national added value, the NFP has set up an **action-research plan** (2001-2003) with the objective to estimate HCV and HIV prevalence in recent drug injectors based on medical diagnosis data (saliva testing) and to implement required health care infrastructures. The provisional budget of the project is estimated at 25.000.- EUR. The NFP has introduced a financing demand to the FLTS and awaits an answer for December 2001.*

## **9.3 Treatments**

### **9.3.1 Treatment and health care at the 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 restructuring 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**. Worth noticing is the fact that the **national drug coordinator** represent the Ministry of Health within the platforms of associations involved in the drug and AIDS sector. This situation promotes a intense information sharing process, particularly important for instance during the conceptualisation of the drugs action plan 2000 – 2004.*

All referred institutions work in close collaboration and have to be viewed as an **interdependent therapeutic chain** even though there are no formal agreements between them.

Law regulates **continuous training** to be provided to staff members of conventioned institutions. Each staff member has the right to participate 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 co-ordination platform.

With regard to **evaluation procedures**, one might stress that the methadone programme is evaluated on basis of a specially design software (see 12.). Conventioned drug agencies are evaluated by means of the **RELIS drug monitoring** system since it provides data on treatment careers and multiple treatment demands.

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 2000. **Intra-institutional multiple counts** are excluded meaning that all treatment demander indexed by a given agency is only indexed once by the referred agency during a reporting year. **Inter-institutional multiple counts** are not excluded since a given treatment demander may have contacted several national agencies during a given year. More detailed admission data, including low threshold agencies are produced in respective sub-chapters.

**Table 9.3.1.1** Clients admission statistics of drug treatment institutions (inter-institutional multiple counting included) (1994-2000)

INSTITUTION	NUMBER OF ADMISSIONS (A) AND/ OR CONSULTATIONS (C) AND/OR CONTACTS (CO)								NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)						
	94	95	96	97	98	99	2000	94	95	96	97	98	99	2000	
<b>SPECIALISED OUTPATIENT TREATMENT</b>															
JDH LUXEMBOURG (C)	166	1523	1086	773	829	961	924	284	339	308	244	270	299	300	
JDH CONSULT. PRISON (C)	2				260	401	476					43	61	75	
JDH ESCH/ALZETTE (C)		1120	949	883	974	1.676	1.249	130	178	175	166	209	213	165	
JDH EITELBRÜCK (C)	754					32	n.a.						24	n.a.	
PROGRAMME METHADONE								51	90	128	158	186	164	158	
MSF-SOLIDARITE-JEUNES (A)				n.a.	35	70	91					27	46	99	
CENTRE EMMANUEL (C)	2	4	7	17	15	34	42	2	4	7	15	10	21	39	
<b>SPECIALISED INPATIENT TREATMENT</b>															
CT MANTERNACH (A)	48	48	58	62	39	47	43	48	44	55	55	56	59	56	
WEESSEKAER								n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	
<b>INPATIENT - DETOXIFICATION</b>															
CHNP-BU - V (A)	249	277	251	226	251	272	247	148	166	157	150	158	179	161	

CHL								≈ 70	80	≈ 70	50	≈ 50	54	56
CLINIQUE STE. THERESE								n.a.	n.a.	n.a.	n.a.	n.a.	17	32
HVEA								≈ 90	107	37	37	28	50	53
CLINIQUE ST. LOUIS								n.a.	n.a.	13	15	15	7	14
<b>LOW THRESHOLD AGENCIES</b>														
ABRIGADO – SZENE KONTAKT (CO)			6,45 6	8,734	8,525	10,60 2	11,834							
<b>DRUG TREATMENT ABROAD</b>								≈ 50	81	55	57	71	91	102
<b>TOTAL Number of drug treatment demanders</b>														
(Multiple counts not excluded)								713	902	885	872	1,006	1,049	1,113
(Multiple counts excluded)								n.a.	n.a.	n.a.	n.a.	n.a.	757	637

Table 9.3.1.2 summarises in-treatment statistics and law enforcement contacts of HRC problem drug users excluding inter- and intra-institutional multiple counts as determined for the first time by the RELIS database in the framework of the national drug prevalence study 1997 - 2000 (Origer 2001). Although, **inter-institutional multiple counting** controlled data on drug-related institutional contacts are only available since 1999, a **current stabilisation** seems to occur following a steep increase observed between 1998 and 1999. This trend has been confirmed by the recent national drug prevalence study (Origer 2001).

Table 9.3.1.2 Distribution of HRC drug users according to type of institutional contact (multiple counts excluded)

TYPE OF TREATMENT	Indexed HRC users	
	1999	2000
<b>A. Specialised treatment</b>	757	637
A.1 Inpatient:	218	178
A.2 Outpatient:	624	557
<b>B. Problem drug users law offenders (SPJ)</b>	551	510
<b>TOTAL NUMBER OF HRC DRUG USERS INDEXED BY THE NATIONAL INSTITUTIONAL NETWORK (double counts excluded)</b>	1,198	1,024

Source: Origer, 2001

### Detoxification inpatient institution

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

<i>Table 9.3.1.3 Clients core statistics BU-V CHNP 1997-99</i>					
		1997	1998	1999	2000
<b>Number of admissions</b>		226	251	272	247
<b>Number of first admissions</b>			70	62	66
<b>Number of patients</b> <i>(multiple counts excluded)</i>			158	155	161↗
<b>Gender distribution</b>	Male	72%	80,5%	70	76
	Female	28%	19,5%	30	24
<b>Age distribution</b> 1997: m=28 Y 2 M 1998: m=28 Y 1 M 1999: m=27 Y 5 M↘	< 15	1%	0.20%	0%	1%
	15-19	1%	4.80%	8%	4%
	20-24	31%	24%	23%	22%
	25-29	25%	32%	32%	31%
	30-34	26%	21%	25%	24%
	35-39	13%	16%	9%	13%
	≥ 40	3%	2%	3%	5%↗
<b>Duration of treatment</b>	Mean	13.47	14,37	12.83 days	14.24
	Minimum	days	days	1 day	days
	Maximum	1 day	1 day	63 days	1 day
	Standard deviation	88 days	71 days	10.15 days	49 days
		11.85	11.99		10.15
		days	days		days
<b>Post detoxification referral</b>	Home or family	42%	23%	25%	12%↘
	Return to drug scene	29%	46%	31%	35%
	Return to drug scene or home	11%	12%	20%	23%
	Inpatient therapeutic treatment	10%	10%	6%	16%
	Treatment abroad	5%	3%	4%	4%
	Institution / 'Foyer'	2%	1%	2%	0%
	Transfer intra-CHNP	1%	5%	3%	1%
	Other				

Source: CHNP - RELIS 2000

## 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 antennas 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 Drogenh llef 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

<i>Table 9.3.1.4.a Clients core statistics - JDH Luxembourg-City 1997-2000</i>					
		1997	1998	1999	2000
<b>Number of treatment demanders</b>		244	270	299	300
<b>Number of first demanders</b>		120	130	180	196 ↗
<b>Gender distribution</b>	male	68%	70%	70%	62%
	female	32%	30%	30%	38% ↗
<b>Number of counselling sessions</b>	individual	534	654	628	655
	couple / family	167	175	241	199
<b>External counselling sessions (Prison / hospitals)</b>		72	77	92	70
<b>Age distribution</b>	< 20	4%	10%	11%	12.5% ↗
	20-24	21%	20.5%	24.5%	18%
	25-29	25%	23.5%	23%	23%
	30-34	23%	22%	17.5%	15.5% ↘
	35-39	14%	9%	8.5%	9%
	≥ 40	12%	13.5%	13%	19% ↗
	age unknown	1%	1.5%	2.5%	3%
<b>Demand motive</b>	opiate abuse / multiple use	72%	71%	69%	59% ↘
	drug addiction of relative	13%	12%	10.5%	20.5%
	psychosocial or psychiatric problems	7%	9%	9%	3.5%
	after care	2%	2%	1.5%	1%
	alcohol abuse	2%	0.5%	0.5%	2%
	cannabis	1%	3.5%	3.5%	11%
	amphetamines/cocaine/LSD/	1%	1%	2.5%	1.5%
		1%	0.5	0.5%	0%

	ecstasy general information request other (Medicaments, bulimia, etc.)	1%	1.5	3%	3%
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Source: Fondation JDH. 2000

		1998	1999	2000
Number of clients (prisoners)		43	61	75
Number of counselling sessions		260	401	476
Proportion of clients showing no previous contact with JDH		63%	36%	35%
Gender distribution	male	17%	8%	13%
	female	83%	92%	87%
Age distribution	15-19		3%	0%
	20-24	28%	14%	21.5%
	25-29	35%	52%	36%
	> 30	37%	31%	42.5%
Main substance involved	heroin	44%	31%	91%
	multiple use	42%	44%	
	cocaine and heroin	5%	18%	
	other	9%	7%	9%

Source: Fondation JDH 2000

### *Jugend- and Drogenh llef Foundation (JDH) Esch-sur-Alzette (south)*

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

		1997	1998	1999	2000
Number of treatment demanders		166	183	169	165
Number of first treatment demanders <i>Number of clients not previously admitted by another JDH regional service</i>		59 (36%)	64 (35%) 48 (75%)	54 (32%) 24 (78%)	60 (36%) 68 (80%)
Gender distribution	male female	62% 38%	62% 38%	57% 43%	54.5% 45.5% ↗
Number of counselling sessions (individual and family)		883	974	965	917
Number of external counselling sessions		173	245	148	77 ↘

Age distribution	< 20	6%	7%	5%	8.5% ↗
	20-30	48%	43%	46%	32%
	>30	46%	50%	49%	59.5% ↗

Source: Fondation JDH 1999

### Jugend- and Drogenh llef Foundation (JDH) ETTTELBR CK (north)

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

	1999	2000
Number of demanders	24	n.a.
Number of counselling sessions (individual / family)	32	n.a.

Source: Fondation JDH 2000

### M decins Sans Fronti res (MSF)-Solidarit  Jeunes (Addressing minors presenting drug-related problems)

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

		1997	1998	1999	2000
Number of clients		27	46	99	132 ↗
Number of first clients		n.a.	35	70	91 ↗
Gender distribution	Female	26%	28%	26.3%	34.1% ↗
	Male	74%	72%	73.7%	65.9%
Age distribution	< 15	7%	11%	16.1%	12.6%
	15-18	82%	81%	73.8%	74.2%
	> 18	11%	8%	10.1%	12.9%
Main substance involved	Cannabis	45%	49%	65.7%	78%
	Heroin	33%	22%	21.2%	12.9%
	Solvents	7%	11%	5.1%	1.5%
	Ecstasy	4%	12%	3%	3.8%
	Cocaine		3%	1%	
	LSD	4%	3%	1%	
	Other	7%		3%	3.1%

Source: Solidarit  Jeunes (MSF). 2000

The 'Centre Emmanuel association' is subsidised by the Ministry of Health. The team, composed of former drug addicts, one psychologist and one educator offers former drug addicts and addicts' parents the opportunity to meet on a regular basis. The centre also is the national interface for the Italian treatment communities 'Communita Emmanuel'. 39 admissions have been recorded in 2000.

*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 provides 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. 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.

*The national drug action plan foresees the extension of CTM offers by creating a network of modular therapeutic annexes for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone, etc. These annexes will function in the vicinity of the main centre in order to take advantage of training and social reintegration facilities offered by the CTM.*

Staff members: 12

Therapeutic offer:

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

*Table 9.3.1.8 Clients core statistics Centre Thérapeutique de Manternach - Syrdallschlass (1997-2000)*

		1997	1998	1999	2000
<b>Total number of patients</b> (new patients and patients from previous year still in treatment)		55	55	59	56
<b>Number of admissions</b> (during 1999)			39	47	43
<b>Number of admitted patients</b> (during 1999)		36	37	40	37
<b>Average monthly occupation (patients)</b>				20,1	21.6
<b>Provided therapy days</b>		6,580	8,101	7,348	7,910
<b>Gender distribution</b>	male	82%	87.5%	77.9%	75%
	female	18%	12.5%	22.1%	25%

<b>Age distribution</b>	< 20	6.5%	7.2%	3.4%	8.4%
	20-25	43.5%	35.7%	32.2%	26.8%↓
	26-30	25.8%	23.2%	25.4%	35.7%↑
	> 30	24.2%	33.9%	39%	28.6%
<b>Nationality</b>	Luxembourg	69.4%	66%	64.4%	73.2%↑
	Portugal	9.7%	12.4%	18.6%	8.9%↓
	Italy	6.5%	8.9%	6.8%	5.4%
	Spain		3.6%	3.4%	7.1%
	Germany	4.8%		1.7%	1.8%
	France	4.8%	1.8%	1.7%	1.8%
	Belgium	1.6%	1.8%	1.7%	
	Ex-Yugoslavia	1.6%	1.8%		1.8%
	Morocco		1.8%		
	Stateless	1.6%	1.9%	1.7%	
<b>Civil status</b>	bachelor	82.3%	85.7%	81.3%	87.5%↑
	married	1.6%	3.6%	8.5%	3.5%
	separated	3.2%	1.9%	3.4%	1.8%
	divorced	12.9%	8.8%	6.8%	5.4%↓
	widowed				1.8%

Source: CTM. 2000

### “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 national health insurance scheme

Table 9.3.1.9 Drug treatment abroad covered by health insurance scheme

AGE GROUP	1996	1997	1998	1999	2000	MEN (2000)		WOMEN (2000)	
	N	N	N	N	N	N	%	N	%
< 20 years					3	1	1	2	2
20 to 25 years					33	21	20	12	12
> 25 years					66	52	51	14	14
TOTAL number of treatment demanders	55	57	71	91	102	74	72	28	28
Mean age						29 years		25 years	

Source : Administration du Contrôle Médical : Cures de désintoxication (drogues dures et polytoxicomanie) à l'étranger - Exercices 1996-2000

### 9.3.2 Substitution and maintenance programmes

The currently existing **oral administration substitution 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, low threshold substitution programme', which refers to the network of liberal GPs prescribing substitution drugs as **MEPHENON**® **METHADICT**®, (Methadone in pill form also prescribed in pain therapy or **SUBUTEX**®) (Buprenorphine). The union of national sickness funds provided the number of patients receiving referred*

substitution drugs on prescription as well as the number of prescribing GPs in years 1999 and 2000. One observes a continuous increase of low threshold substitution patients and a stabilisation of the number of patients choosing the official substitution programme, more demanding in terms of therapeutic constraints.

**Table 9.3.2.1** Ambulatory, low threshold prescription of substitution drugs by the national network of liberal GPs

YEAR	1999	2000
Number of indexed patients (double counting controlled)	745	844
Number of prescribing GPs (double counting controlled)	125	145

Source : Union des Caisses de Maladie 2001

Up to the beginning of 2001, there existed no **legal framework** regulating drug substitution treatment. However, the recently voted law of 27 April 2001 modifying the basic drug law of 19 February 1973, introduces a legal framework for substitution and maintenance treatment. A yet to be finalised grand ducal decree will set the practical modalities of substitution. 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 will 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.

The law of 27 April 2001 also foresees a legal framework for a series of harm reduction and maintenance measures, namely, needle exchange programmes and other state licensed means which, legally speaking, could materialise for instance in shooting galleries or medically controlled heroin distribution. In 1997, prior to the vote of the new drug law, the Minister of Health had 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 **national drug action plan foresees its implementation in the course of 2003**.

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

Moreover, the internal rules and the evaluation process of the official substitution programme 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**'<sup>13</sup>, 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 in 1997, 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 initiation 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 inclusion of further substances in the substitution list  
will be regulated by grand ducal decree foreseen by the law of 27 April 2001.*

In addition to the drug prescription and medical care, the official substitution  
programme provides for a wide range of psychosocial **counselling facilities**:

counselling and support,  
information and orientation,  
social assistance,  
job finding activities,  
accommodation finding activities,  
provision of clothes,  
discussion groups,  
self confidence and physical expression groups,

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<sup>13</sup> Under the law of 27 April 2001, the Methadone Commission will be replaced by a ' National  
drug substitution commission' mandated to control all aspects of substitution treatment at the  
national level. The composition of the new commission will be similar to the one of the former  
Methadone commission.

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 1999 and 2000, 186, 164 and 158 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.*

		1997	1998	1999	2000
<b>Number of clients</b>		158	186	164	158
<b>Gender distribution</b>	male	68%	70.5%	64%	66%
	female	32%	29.5%	36%	34%
<b>Nationality</b>	Luxembourg	73%	74%	76%	73%
	Portugal	13%	13%	13%	16% ↗
	Italy	6%	5%	5%	4%
	France	4%	3%	2%	3%
	Belgium	1%	1.5%	1%	
	Cap-Verde	1%	1.5%	2%	1%
	Spain	1%	1%	0.5%	
	Germany		1%	0.5%	3%
	Ex-Yugoslavia	1%			
<b>Age distribution</b>	< 20	n.a.	0.5%		
	20-24	n.a.	10.5%	11%	8%
	25-29	n.a.	29%	25.5%	28%
	30-34	n.a.	33%	32%	29%
	35-39	n.a.	18%	20.5%	23%
	≥ 40	n.a.	9%	11%	12% ↗
<b>Duration of drug dependency</b>	< 3 years	1%	2%	2%	3%
	3-5 years	16%	16%	17%	6%
	6-10 years	42%	46%	45%	31%
	11-15 years	28%	24%	24%	27%
	>15 years	13%	12%	12%	32%
	unknown				1%
<b>Geographical distribution</b>	South	47%	44.5%	48%	45%
	Luxembourg City	30%	29%	24%	32%
	(surroundings)	16%	22%	23%	20%
	North	6%	4%	5%	3%
	East	1%	0.5%		
	West				
<b>Motives of treatment release</b>	Abandonment	n.a.	54%	62.5%	68% ↗
	End of agreed treatment period	n.a.	22%	16%	13%
	Referral to residential treatment	n.a.	15%	9%	10%
	Prison	n.a.	3.5%	7%	3%
	Death	n.a.	3.5%		
	Exclusion		2%	5.5%	3%
	Transfer				

Source: Fondation JDH 2000

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 database. In 2000 a second evaluation by an external expert occurred on basis of data provided by the referred evaluation software.

The **main conclusions of the evaluation exercise** (Dellucci 2001) show the following trends (1993 – 2000):

- increase of female substitution treatment demanders
- a large majority of treatment demanders spend 1 to 2 years in substitution treatment. Since 1999 one observes an increase of the proportion of ancient treatment demanders
- Portuguese citizens increasingly represent the main group of non-native substitution treatment demanders
- increasing proportion of treatment demanders from the North of the country confirmed by RELIS data on the overall problematic drug users population
- improvement of residential status of substitution patients compared with the overall problematic drug users population
- increasing proportion of patients relying on social welfare funds.

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.

## 9.4 After-care and re-integration

Prior to the national drug action plan (2000-2004), 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 (10-20 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 2001-2002. The provision of a sufficient number of housing facilities and the implementation of modular supervised residential annexes are the cornerstones of future re-integration strategies.*

*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. Furthermore, synergies between the Ministry of Health and the Ministry of Employment have been set up in the framework of the **EU programme: EQUAL 2000-2006**.*

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 successfully terminated the therapeutic programme at CTM. The centre has a maximum capacity of 6 residents who are offered accommodation and the opportunity 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 2000: 9 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

### Police Prevention Activities

*Police forces take an active part in primary drug prevention. A close collaboration between law enforcement agencies and specialised drug prevention services (e.g. CePT) allows for a smooth interrelation of demand and supply reduction logics, both aiming at the same final objective, that is the overall reduction of drug consume. A recent example of this collaboration is the editing of a comprehensive information brochure on the current drug legislation as modified by the law of 27 April 2001. Furthermore, police agents ensure information courses within secondary schools as well as prevention-oriented discussions with parents of drug law offending children. Delegates of Police departments do also participate in specific work group with drug care agencies. Support is provided bi-directionally since law enforcement agents do attend special training sessions provided by specialised drug prevention agencies.*

### Drug law offences and referral to specialised drug services

*Alternatives to drug-related offence sentences do exist and are addressed under subchapter 9.6. Alternative drug treatment (to criminal sentence) may be provided by all recognised national drug care facilities. **The Multidisciplinary Committee** chaired by a member of the Directorate of Health do report on treatment progress of drug law offenders under the therapeutic injunction regime to the prosecution authority.*

The above referred to **MSF Youth Solidarity** project intervenes in case a minor of age has been entering in conflict with law enforcement forces with respect to a drug-related offence. In this respect MSF Youth Solidarity team may be considered as a crisis situation manager, offering their services to drug offenders referred by judicial and penal institutions. The MSF intervention team, in direct collaboration with Youth magistrates and competent law enforcement actors, proposes a large variety of services with the primary aim to prevent minor aged drug offenders to enter in the criminal justice system. Interventions are based on a holistic approach of the problem, including the involved person him/herself and his/her family. Successful interventions mostly disclose a complex system of psychological, social and family-related dysfunctions in which drug use/abuse merely represents the observable symptom or consequence. MSF is bound to report to prosecution authorities on the progress of treatment. Client statistics have proven an increasing demand for this kind of intervention from both the criminal justice system and the social oriented institutions.

### Interventions 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, 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 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. According to the final concept report, presented to the Minister of Justice in October 2001, the implementation of referred infrastructures in scheduled for mid 2002.

More detailed information on drug use in prison can be found under chapter 13 (key issues).

### Gender – Specific Issues

Very few research or interventions specifically aimed at women and/or children have been undertaken at the national level thus far. RELIS 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 probability of drug-related death after their first contact with law enforcement agencies and a more rapid transition from on setting or recreational drug use to problem drug use, compared to male opiate users.**

*A special workgroup on 'Women and drug use' have been created under the auspices of specialised drug care agencies in 2000.*

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 2000 - 2004, largely based on RELIS 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 (see modular therapeutic annexes) referred to under 9.4 will be geographically and logistically attached to the CTM, which will allow for resources and infrastructure sharing. The first project proposal has not reached the requested funds. A second proposal has been introduced to the Fund Against Drug Trafficking in the beginning 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 Drogenabhängiger Kinder E.D.K) is a long established self-help group. This group, partly financed by the Ministry of Health, 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 'Comunita 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 should 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 cases they have experienced in order not to spoil the image of their enterprise.

*Aware of the present situation the CePT in collaboration with the Directorate of Health has published a **information brochure** on alcohol and illicit drugs abuse at the workplace in 2001.*

*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 Gesundheitsförderung - 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. Compared to the native drug population, Portuguese addicts living 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 their 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, commonly 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 may recall that funding of drug demand reduction activities is centralised at state level. Respective ministries or governmental departments, according to their respective competences, 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 provide 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

*The governmental quality standard certification as foreseen by the law 'ASFT' of 8 October 1998, represent the main tool towards a standardised quality control. However, funding is not directly related to clearly defined evaluation requirements. The quality standard certification commits respective NGOs to undertake necessary evaluation measures of their activities by means, however, they may 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 oriented 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 a computer based evaluation procedure by the national methadone programme as well as the development of the **RELIS drug monitoring system** towards its use as an evaluation tool.*

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

## 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 relies 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 external fund provider for drug-related prevention and research activities. The Fund manages assets and capitals confiscated in the framework of disclosed drug law offences and co-ordinates, among other tasks, the allocation of respective financial resources to selected drug-related prevention or research projects. Several intervention retained by the national drug action plan 2000-2004 are financed by the Fund. Prior to funding decisions made by the Fund, competent ministries are requested to advise 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 interventions in drug demand reduction research activities are increasingly developed at the national level. In 2000 the CePT has published a first annual training directory including training activities ranging from evaluation methodologies to demand reduction action-research strategies. The Department for Scientific and Applied Research may finance training activities following request. Most of national researchers have been trained abroad whether in academic settings or in the framework of continuous (in service) 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 as yet. The 'Cours Universitaire de Luxembourg' offers a limited range of first cycle university courses, which do, however, not specifically address drugs topics. 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). Law guarantees the right of continuous training for people working in the drug sector.*

*The situation has 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.*

*In 2000, the CePT has published an annual training directory for 2001 including seminars and courses for professionals, which covers prevention strategies in schools and community settings as well as therapeutic methods applied in the field of secondary prevention.*

Also, a series of training activities are annually 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 as such rely **on the Ministry of Health's regulation on continuous 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, is ensured by external supervisors. At present, mainly foreign trainers or supervisors ensure these activities.



**PART IV**  
**KEY ISSUES**

## 11 Polydrug Use: Drug set and settings

### *Definition:*

*In terms of epidemiological evidence applied for research purposes and in the framework of the national drug monitoring system, national experts fit to the following definition of multiple drug use: 'The use of more than one drug or type of drug by an individual, often at the same time or sequentially, and usually with the intention of enhancing, potentiating or counteracting the effects of another drug' (ICAA 2001). The term carries the connotation of illicit use, though alcohol, nicotine and caffeine are knowingly the substances most frequently used in combination with others at the national level. The operational national definition includes all controlled psychoactive substances as well as alcohol.*

*In terms of medical diagnosis, the ICD-10 is referred to.*

*Multiple drug use disorder (F19) is one of the 'Mental and behavioural disorders due to psychoactive substance use' in ICD-10, diagnosed only when two or more substances are known to be involved and it is impossible to assess which substance is contributing most to the disorder. The category is also used when the exact identity of some or even all of the substances being used is uncertain or unknown.*

*The French term 'Polytoxicomanie' is often used as a synonym at the national level. The difference between the latter and the concept of polydrug use is that in the case of 'polytoxicomanie' the dependence on two or more drugs is assumed.*

### 11.1 Patterns and user groups – Risk assessment

#### *a. A historical perspective*

#### *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 only 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.*

*'Soft drugs' (Low Risk Consume) such as cannabis and derivatives were typically consumed by mono-users till 1988. Multiple problem drug preferentially 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 90s, the use of LSD has decreased even more significantly. Towards the mid 90s, there has been a progressive increase of amphetamines' use and the*

first reporting of ecstasy-like substances on the national market. Use of ecstasy-type substances has increased significantly especially in younger population involved in the then recent rave movement.

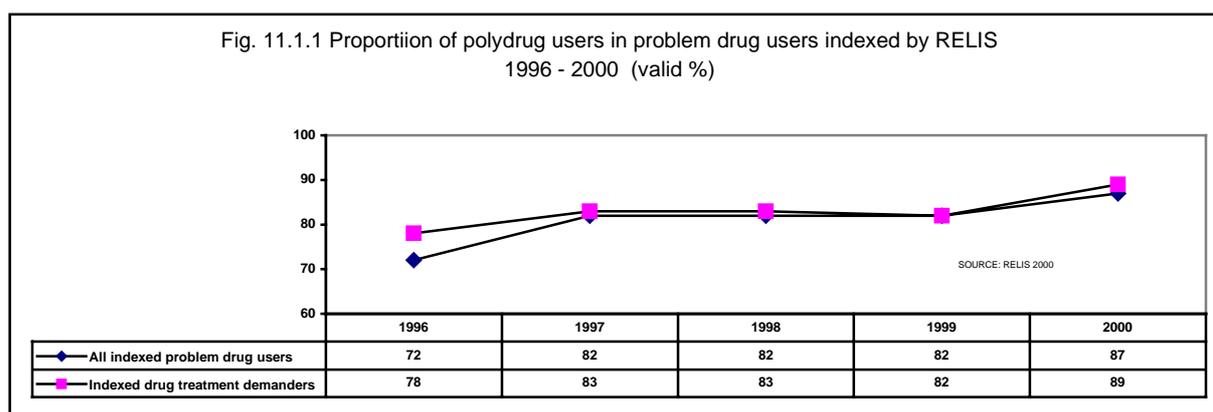
Hitherto, there has been no officially registered seizure of PCP or Crack (freebase) in Luxembourg. The latter substances can, however, be occasionally found on the national market.

### From 1996 until today

During this late period, an increase of **heroin and cocaine** use has been observed. **Ecstasy-like** substances show an increasing demand even though seizure figures do suggest an inverse and currently stable trend. All indicators on **cannabis use** (problematic and recreational) are on the increase since three years. Whilst preference patterns have persisted over the past four years, significant changes have occurred in the route of administration of opiates and cocaine. The 2000 figures, albeit showing a slight decrease referred to 1999 data, confirm the decisive reduction in **intravenous opiates** consume associated to an amplification of the **inhalation mode** (also known as 'blowing' or 'chasing the dragon'), compared with 1997 and earlier. The temporary or permanent switch from intravenous to inhalation mode of opiates highly depend on the availability of the latter, on the financial situation of the user as well as on the impact harm reduction measures might induce.

### b. Patterns and user groups

Polydrug use is currently the most common consume pattern observed in **problem drug users** at the national level. Since 1996, figures provided by the national drug monitoring system RELIS whitens increasing polydrug use rates:



Referring to the **national population of problem drug users indexed by RELIS** in 2000 as polydrug consumers, it clearly appears that preferred drug combinations include opiates, cocaine, cannabis, benzodiazepines and alcohol. The observed polydrug use rates exclusively referred to **drug treatment demanders** follow the same trends although they show slightly higher figures (e.g. 2000: 89%).

*Heroin and cocaine* are preferentially mixed up and injected (speedball) but also use sequentially in order to counterbalance respective effects. Another frequently observed consume pattern consists in the **associated use of heroin and methadone (mephenon pills)** acquired illicitly or by means of multiple prescription by drug users addressing different GPs simultaneously.

More rarely **amphetamines and opiates** are used as "uppers" and "downers" to counteract the highs and lows of drug induced effects, thus causing an addictive cycle of dependence. **Cannabis and benzodiazepines** are consumed in addition to opiates for the same reason or in order to bridge withdrawal effects due to a lack of temporally unavailability of heroin. Alcohol is generally associated to all types of drugs. The combination most frequently reported in case cannabis constitutes the main drug is the concomitant use of ecstasy. **Injection of alcohol or other not typical injection drugs** occurs in very deprived drug scenes. The combination of **alcohol and cocaine** in more exclusive private cocaine scenes occurs in order to boost or to prolong the effect of cocaine.

Table 11.1.1 presents current (last months) preferential drug combination patterns reported by RELIS indexed heroin users in 2000 (alcohol excluded):

*Table 11.1.1 Current (last months) preferential drug combination patterns reported by RELIS indexed heroin users in 2000:*

Combination of substances	Valid % Year 2000
Heroin-cannabis	29%
Heroin-cocaine	28%
Heroin-benzodiazepines	11%
Other combinations or single use of heroin	22%

Source: RELIS 2000

*In recreational or youngster drug scenes* combinations of ecstasy type substances, cannabis and alcohol are frequently observed. Alcohol is used in combination to make the ecstasy or cannabis "high" last longer. Inhalants are rarely used (solely or in combination) by Luxembourgish youngsters.

Figures from recent school surveys seem to suggest that school aged youngsters (12-20 years) do not show a high degree of multiple drug use:

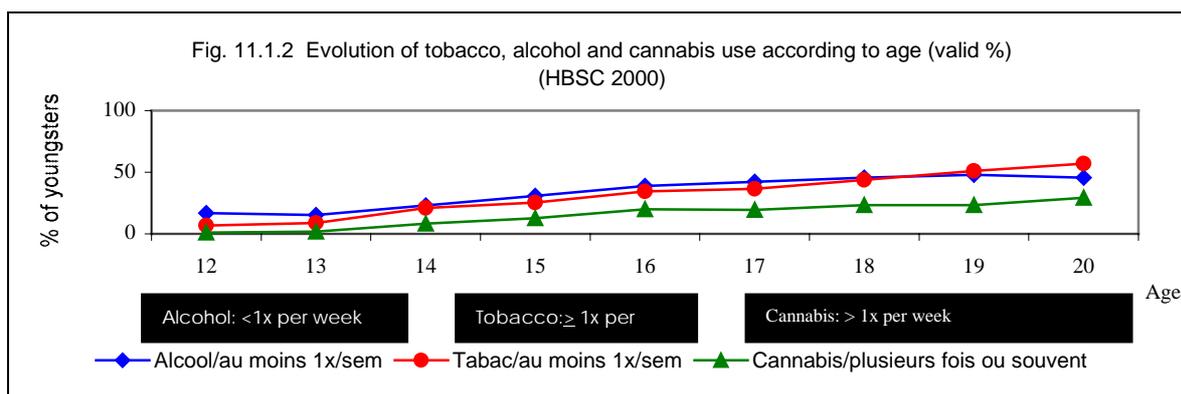
*Table 11.1.2 Number of different illicit drugs used by 12 –22 years old students during current year (medicaments excluded)*

Number of different illicit drugs use during current year	% of total respondents	%male	% female
0	84.2	81.8	86.8
1	13.4	15.3	11.5
2	1.4	1.9	0.9
3	0.4	0.4	0.4
4	0.3	0.4	0.2
5	0.1	0.1	0.1
6	0.05	0.05	0.1
7	0.1	0.1	0.1
8	0	0	0

Source: HBSC 2000

13.4 percent of selected youngsters have used one given drug during the last year, which in most cases refers to cannabis. One observes a higher proportion of males having used 2 drugs during last year. Gender specific differences, however tend to vanish from 3 different drugs onwards.

Figure 11.1.2 shows that the consume profile of cannabis follows a similar evolution than those of alcohol and tobacco but largely differs from consume profiles of other illicit drugs, that know significant lower prevalence rates.



Matheis and al. (1995) have investigated the **correlation between the lifetime use of different licit and illicit drugs** in youngsters aged between 16 and 20 years. The most significant correlations ( $p > 0.05$ ) have been found between illicit drug use on the one hand and tobacco as well as soporific and sedative medicaments on the other hand.

Table 11.1.3 Correlation matrix ( $p > 0.05$ ) of lifetime use of different drugs

	Alcohol	Tobacco	Illicit drugs	Pain killers	Soporifics	Sedatives
Alcohol	1.00	0.25	0.19	0.19	0.10	0.15
Tobacco		1.00	0.38	n.s.	0.15	0.12
Illicit drugs			1.00	n.s.	0.22	0.28
Pain killers				1.00	0.14	0.34
Soporifics					1.00	0.38
Sedatives						1.00

Source: Matheis 1995

## 11.2 Health and social consequences

It has been said that a vast majority of drug treatment demanders are registered as multiple drug users. Moreover, a significant proportion of the latter are addicted to more than one drug. In particular multiple addiction to opiates and benzodiazepines are risky in terms of overdose fatalities, especially since associated benzodiazepines use by opiate addicts are often not reported by treatment demanders. Withdrawal symptoms are hard to endure for users and difficult to manage for health care agents. The associated use of benzodiazepines and opiates often leads to an

*increasing disposition to risk behaviour. Benzodiazepines, often used to prolong opiate effects or to bridge withdrawal symptoms, reduce the level of consciousness and perception benchmarks of danger which can lead to behaviours such as spontaneous switch of administration modes, needle sharing, careless injection procedure or unprotected sexual practice.*

*Few data are available on hospitals admissions or blood borne infections according to the profile of drug users. Often cases are generically coded in terms of multiple drug use (ICD-10) since no detailed information on current drug use has been available.*

With regard to fatal drug overdoses, reliable data from toxicological analysis (excluding alcohol and benzodiazepines) are provided by forensic department of the National Laboratory of Health (LNS). Table 11.2.1 shows that **until 1999** a majority of heroin-induced deaths were not associated to other illicit drugs. If so, drugs most frequently associated to heroin (as main cause) were, in order of importance cocaine, dextropropoxyphene, methadone and dihydrocodein. **In 2000**, for the first time, multiple drug deaths prevailed on single main drug cases. Furthermore, an increasing number of victims showing single or associated methadone blood traces have been reported. Currently multiple drug traces are common in drug autopsies. **Cocaine and methadone** are the drugs most frequently associated to heroin-related deaths. This trend should be monitored closely during the next years. DHC and DPX have not been detected since 1995. Depronal® and Codicontin® are medicament brands most associated to drug deaths.

**Table 11.2.1.** Results from toxicological analysis on suspect deaths cases by the LNS (1992 - 2000)

YEAR	AUTOPSIES (N)	N. of DEATHS HEROIN*	N. of DEATHS OTHER OPIATES *	TOTAL OPIATE DEATHS AUTOPSIES
1992	38	11 of which 4x cocaine associated	2x DHC	13
1993	45	11 of which 1x DHC + tilidine associated 1x cocaine associated	3x DHC 2x DPX	16
1994	49	22 of which 8x DPX associated 1x DHC associated 1x DHC + tilidine	1x DHC 6x DPX of which 1x DHC associated 3x heroin associated	29
1995	41	13 of which 3x DPX associated 1x MTD associated	3x 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	1x tilidine	9
1998	39	16 of which 2x cocaine associated	1x MTD	17
1999	61	17 of which 5x cocaine associated 1x MTD associated 1x tramadol associated	1x Buprenorphine 1x morphine	19
2000	75	14 of which 6x MTD assoc. 4x cocaine assoc.	6x MTD 1x codeine	21

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

### 11.3 Specific approaches to interventions

*It has been said that multiple drug use and polydrug addiction have been developing since the mid eighties and do currently represent the most frequently observed consume pattern in problem drug users. Drug policies and thus prevention and treatment agencies have been developing adequate strategies consequently. In this respect a basic differentiation has to be made between interventions aimed at problem drug users and primary drug prevention campaign addressing younger populations or recreational drug scenes.*

*In terms of treatment and harm reduction facilities for problem drug users, one might stress that provided services are mainly oriented towards multiple drug users since the vast majority of treatment demanders fit to the latter category. Field agents have received training empowering them with adequate knowledge on the effects of specific drugs and consequences of multiple drug use. In other words, there exist no specific drug care agencies exclusively focusing on poly drug users since the national strategy is based on a more holistic approach towards health care provided to problem drug users.*

*Recent changes in legal settings mainly addressed consequences of the latest developments in substitution treatment. **Methadone (Mephenon ® pills)** seems to be increasingly available on the black market. One observes a rather improvised illicit redistribution of Mephenon ® pills mainly by drug users having acquired the latter by means of multiple prescription from different GPs aiming to finance the purchase of heroin for personal use for instance. The yet to be approved regulation on drug substitution treatment foreseen by the law of 27 April 2001 addresses this problem by **enhanced control mechanism** applied to substitution drugs prescription. In addition to a **mandatory prescription licence** granted to medical doctors under certain conditions, the latter have to **notify each drug substitution treatment demander to a central surveillance committee**. The referred committee will have to approve each substitution treatment admission and to maintain a central register on substituted patients. The practical modalities of a **central substitution register** are yet to be defined. Its aim is mainly to prevent multiple prescriptions and to provide licensed medical doctors with information on the current status of addressing drug substitution demanders.*

*As far as **primary drug prevention** in youth and recreational drug user settings are concerned, special emphasise is put on objective and reliable information, on possible effects and consequences of drug use. Recent school surveys (Matheis 1995), (HBSC 2000) suggest that opiate use and multiple drugs consume in youngsters show low prevalence rates. Consequently the latest drug information and prevention campaigns by the CePT have mainly focused on cannabis and ecstasy use. In order to provide a comprehensive insight on those substances detailed information on possible effects and consequences of combined drug use have been included in both campaigns. Evaluation results specifically addressing multiple drug use are currently not available.*

### 11.4 Methodological issues

Basically two questions should be addressed when assessing multiple drug use, namely **to which extend multiple drug use occurs according to different user groups and which types of drugs and combinations of drugs are involved in multiple drug use**. It appears from information provided in the present chapter that the first question has been repeatedly addressed at the national level allowing for an overall assessment of the current situation. Regarding the more complex question on substance-related issues, one might state that the currently available national data are largely based on field evidence and qualitative research settings. The most common consume patterns are known as well as the effects sought by multiple drug use. Most of consume patterns are well established and confirmed by fairly long observation periods. Data on drug-related deaths are documented by highly updated toxicological evidence.

The question to be raised seems to concern the way in which emerging trends in drug consume patterns, be it multiple drug use, changes in administration modes or unknown drug combinations can be detected in the most time effective manner. Early warning procedures as defined under the Joint Action of 16 June 1997 might not meet those requirements since they only include a specific category of synthetic drugs. The proposal to achieve a more **comprehensive early information system on drugs and drug consume patterns** as introduced by the French delegation of the HDG makes sense not only in respect to drug quality control but also in the framework of the assessment of drug use behaviour, which also includes multiple drug use.

The evaluation of the pilot project implemented following the French proposal will allow to assess the feasibility of a comprehensive early information system. Regardless the outcome of the referred project, there seems to be no doubt about the necessity of an enhanced involvement of drug users as primary data providers (**key informants**). Several EU Member States have a fair tradition in this respect, others, and Luxembourg is part of them, do not. Consistent effort especially in terms of **collaboration between Justice departments and Public Health** is required in order to develop the currently existing early warning system on synthetic drugs into a comprehensive early drug information system. Furthermore, legal aspects have to be addressed in order to implement projects such as on-site drug testing and key informants networks at the national level.

Meanwhile great efforts are made to further develop the national drug monitoring system RELIS and to include more institutions such as general hospitals, emergencies services, low threshold agencies and non specialised care agencies in the general framework of drug monitoring.

## 12 Successful Treatment: the effectiveness of interventions

### 12.1 The approaches to treatments and the related concepts of success

#### *a. Concepts and criteria for success*

*Successful treatment appears to be a concept, which is multifactorial, and highly dependant on different treatment settings. Multifactorial in the sense that a given problem drug user might have improved his/her social and health situation and still remains in contact with the institutional network, be it health care or law enforcement agencies. It further relies on different treatment settings since the objectives of low threshold agencies are consistently different from those of residential in-patient therapy centres for instance.*

*The following basic differentiation of in drug care settings in terms of final objectives may be stressed:*

***Low threshold and outreach settings:*** *The primary objective is straightforward, that is the contact making and the retaining of clients within the proposed setting. Transmission of preventive knowledge with a view to risk and harm reduction is one of the major tasks of referred field agents. A further objective is to be seen in the referral of clients to mid and high threshold care facilities.*

***Drug substitution and maintenance programmes:*** *As already mentioned there are currently two substitution treatment settings. The currently existing oral administration substitution programme set up under the co-ordination of the Ministry of Health and JDH and a so-called 'unofficial, low threshold substitution programme', which refers to the network of liberal GPs prescribing substitution drugs as MEPHENON<sup>®</sup>, METHADICT<sup>®</sup> (Methadone in pill form also prescribed in pain therapy) or SUBUTEX<sup>®</sup> (Buprenorphine). For the latter substitution setting no performance indicator is currently available.*

*Regarding the state controlled substitution programme, one might stress that methadone, and buprenorphine are prescribed as part of a long-term treatment with a final abstinence goal. However, there is a high proportion of clients for whom substitution treatment has to be considered rather as a harm reduction or maintenance intervention than an abstinence oriented therapeutic intervention.*

#### ***Outpatient drug counselling agencies***

*The most relevant national outpatient treatment facility is the 'JDH Foundation' offering long and short-term therapies, counselling, crisis intervention, social assistance and further therapeutic referral. Regional antennas of JDH are respectively implemented in Luxembourg City, in the South and in the North of the Grand Duchy. All of the latter are entirely funded by the Ministry of Health. Further agencies provide social care or therapeutic settings that are attended by drug addicts. Drug demand reduction in a general sense constitutes the primary aim of referred facilities. Drug abstinence is considered to be the final outcome of*

treatment, although the stabilisation (or progressive reduction) of drug consume allowing the patient to improve his social and health situation appears to be a more realistic goal and represent the most probable impact in the short term.

### **Inpatient detoxification units**

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 psychosocial support are provided to control withdrawal symptoms in the framework of a 1-2 week detoxification programme. Ideally, detoxified patients are referred to other more therapeutic oriented institutions.

### **Inpatient therapeutic centres**

Two therapeutic communities currently exist in the Grand Duchy. The first is situated in the north of the country and merely provides 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. The therapeutic programme of the CTM is divided in three progressive phases that have been revised in the 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, family 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 a professional training programme. The collaboration with several employers willing to employ ex-drug addicts and the active involvement of social services guarantee a fair panoply of social and professional framing to released patients.

### **b. Political and professional choices and principles**

Instead of considering the 'success' of treatment, national experts and the national drug coordinators office increasingly use a somewhat differentiated terminology, that is: "the impact of interventions" be they denoted positively or negatively. The most valid method to assess the impact of treatment interventions appears to be mid- and long-term cohort studies of different drug users' target groups. These studies are knowingly cost and time intensive and are currently not addressed as a priority at the national level. The national strategy in terms of treatment impact assessment highly relies on the already mentioned 'institutional contact indicator' as applied by the national drug monitoring system RELIS maintained by the NFP. It is the mid-term follow-up of drug careers through the analysis of data provided by a national monitoring system that aims at indexing in the most exhaustive way all institutional contacts, (health care and law enforcement) a given drug users may present over time. 'Vanishing' from the RELIS index does not necessarily mean that the concerned drug user has quit his/her drug consume behaviour nor that a single

intervention has been at the origin of the current situation. It merely suggests that the involved person, if alive, does not present a behaviour that implies a high probability of the occurrence of an institutional contact. Deaths of known drug users are also indexed by RELIS and as such contribute to drug careers assessment.

Experience has shown that considering drug careers longitudinally is more informative than the 'before and after treatment approach' meaning that a typical problem drug user commonly experiences a series of health care and law enforcement contacts before a more permanent change in his/her behaviour occurs.

### 12.2 Evaluation of treatments

In Luxembourg there is a rather limited amount of research in the field of treatment 'success' evaluation, mainly for the reasons stated above. These are budgetary reasons as well as the priority setting on alternative evaluations strategies as for instance the exploitation of RELIS data in order to assess the impact of treatment interventions on institutional drug careers. The RELIS system is fully operational since 1995. Up to now data provided by RELIS have been used in an exploratory way since valid interpretation of changes in drug use behaviour after exposure to treatment interventions does rely on longitudinal data and requires a highly representative, if not exhaustive, data set. A more detailed description of the use of RELIS data in terms of treatment evaluation will be addressed after the presentation of routine performance data provided by treatment settings as previously defined:

**Low threshold and outreach settings:**

Rates of new and previous clients' contacts as well as distributed injection materials are typical performance indicators of such care settings. A further step would be the referral of clients to mid and high threshold care facilities. This evolution pattern is observed in 10 to 20 per cent of clients although the follow-up of effective treatment starts is not documented by the involved field agencies. In this respect, the RELIS system provides information on subsequent treatment contacts.

**Drug substitution and maintenance programmes:**

Clear guidelines for substitution treatment follow-up do exist. Routine performance indicators do concern the evolution of clients' situation while being in treatment as well as the status at the moment of treatment release.

*Table 12.2.1 Treatment release data: National Drug Substitution Programme (JDH) – 1997-2000*

		1997	1998	1999	2000
<b>Motives of treatment release</b>	Abandonment	n.a.	54%	62.5%	68% ↗
	End of agreed treatment period	n.a.	22%	16%	13%
	Referral to in patient treatment	n.a.	15%	9%	10%
	Prison sentence during treatment	n.a.	3.5%	7%	3%
	Death during treatment	n.a.	3.5%		
	Exclusion from programme	n.a.	2%	5.5%	3%
	Transfer to other care facility				3%

Source: Fondation JDH 2000

*In addition to routine performance indicators, a special evaluation software has been developed in 1998 in collaboration with the NFP, which, in the medium term, aims at the integration of substituted patients' data directly in the RELIS database. In 2000 a second evaluation by an external expert occurred on basis of data provided by the referred evaluation software.*

*The main conclusions of the evaluation exercise (Dellucci 2001) show the following trends (1993 – 2000):*

- *increase of the number of female substitution treatment demanders*
- *a large majority of treatment demanders spend 1 to 2 years in substitution treatment. Since 1999 one observes an increase of the proportion of former treatment demanders*
- *Portuguese citizens increasingly represent the main group of non-native substitution treatment demanders*
- *increasing proportion of treatment demanders from the north of the country confirmed by RELIS data on the overall problem drug users population*
- *improvement of residential status of substitution patients compared with the overall problem drug users population*
- *increasing proportion of patients relying on social welfare funds.*

### **Outpatient drug counselling agencies**

*No routine in house data available*

### **Inpatient detoxification units**

*The following table provides an example of performance indicators retained by the main national drugs detoxification centre (CHNP) as provided by the RELIS database:*

		<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
<b>Post detoxification referral</b>	Home or family	42%	23%	25%	12%▼
	Return to drug scene	29%	46%	31%	35%
	Return to drug scene or home	11%	12%	20%	23%
	Inpatient therapeutic treatment	10%	10%	9%	9%
		5%	3%	6%	16%
	Treatment abroad	2%	4%	4%	4%
	Institution / 'Foyer'	2%	1%	2%	0%
	Transfer intra-CHNP	1%	5%	3%	1%
Other					

Source: CHNP - RELIS 2000

### **Inpatient therapeutic centres**

*No routine in house data available*

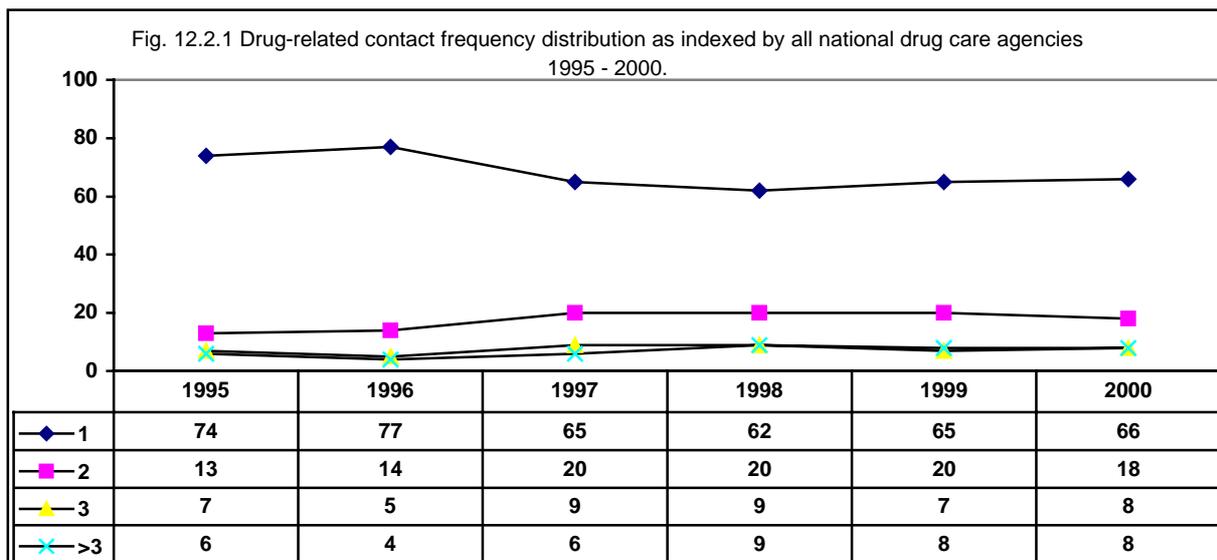
### **RELIS -The institutional contact indicator as a evaluation means of treatment impact**

*A first comprehensive study on the impact of treatment interventions based on data provided by RELIS will be performed by the NFP in the course of 2002. The study will address the evolution of drug careers (institutional contacts with care and law*

enforcement agencies) from 1995 to 2001. The methodological approach might be compared to a national cohort study including problem drug users as indexed by national institutions as previously defined. The cohort is defined by mobile entries and composed of problem drug users showing institutional contact(s) during the observation period. A further advantage of the RELIS monitoring system is its ability to provide **multiple counting controlled data** (by means of an anonymous national identification code) that can be broken down by single treatment institutions. It allows for instance to select a given treatment institution or a group of treatment settings and to follow up post-treatment evolution of patients (whose profile can be extracted from the database) who have been admitted by the referred agencies.

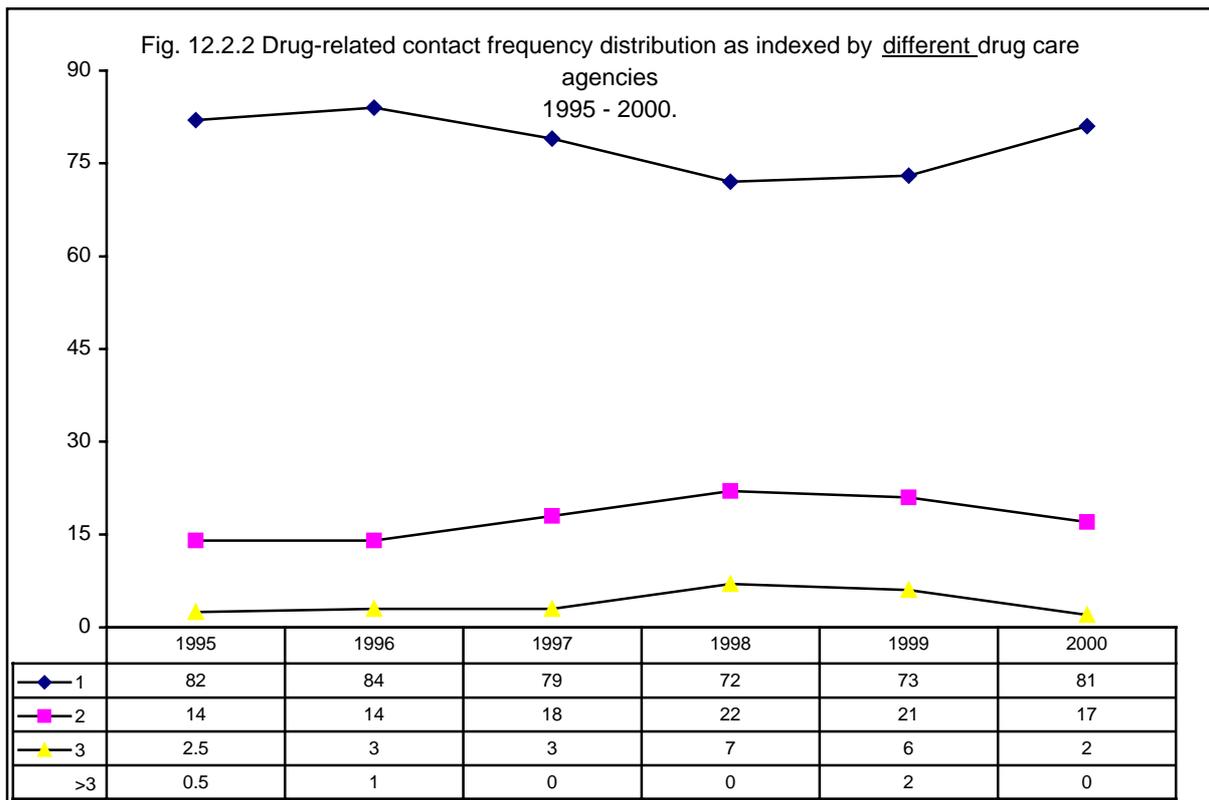
The RELIS system thus provides information on 'institutional circles' specific drug user groups go through, the chronological follow-up as well as the impact of treatment interventions on the further career of the latter. This strategy will not only allow to assess the impact of different treatment settings but also to detect gaps in the treatment system and contribute to the conceptualisation of new interventions approaches.

As already mentioned, the NFP currently only uses a fraction of the potentialities of RELIS in terms of its input for treatment impact assessment. Data produced in the national report on the drugs situation provides only descriptive data on institutional contacts. The following tables provide data on contact frequencies of problem drug



users as indexed at the national level by RELIS.

In the course of 2000, a majority of drug treatment demanders (66%, stable) only addressed a single treatment institution. A marked decrease of contacts is observed from 2 to a maximum of 9 treatment demands per year and per person. On average a problem drug user entered 1.64 times in contact with a national drug care facility during 2000. Since 1995, one observes an increasing number of contacts per drug treatment demander.



*In contrast to the previous chart, the present distribution refers to the number of different institutions (low threshold, substitution, therapy, etc). (inter-institutional double counts excluded) indexed treatment demanders have been in contact with during the year. In 2000 the maximum number of different treatment agencies contacted by RELIS respondents equals to 3. On average 1.21 different agencies have been contacted by drug treatment demanders. Compared with 1995, contact frequencies have remained fairly stable. In general terms, however, drug treatment demanders tend to show more frequent contacts with drug care facilities as compared to 1995.*

*The above referred treatment impact evaluation study will provide more detailed data and include contacts with law enforcement agencies as exhaustively indexed by RELIS since 1996.*

## 12.3 Methodological issues

### *a. Gaps and future needs*

*This brief presentation aimed at providing the reader with an insight of the national concepts and strategies towards the development of treatment impact evaluation. Currently, data directly provided by drug agencies are rather scarce, with the exception of the national substitution programme that has been developing and still improves its evaluation methodology. Even though treatment agencies would provide more elaborated data on immediate treatment outcome, the effective mid-*

and long-term impact of treatment could only be validly assessed over time by considering all possible scenarios a 'currently clean or stabilised known drug users' might encounter after treatment exposure, ranging from subsequent treatment or law enforcement contacts to drug-related death. A **long-term approach** is the cornerstone of all treatment impact assessment.

#### **b. Methodological proposals**

Specific treatment **cohort studies** have not been envisaged thus far since a great deal of efforts has been invested in the development of a **high performing drug monitoring system**. It has been said that the RELIS system has been designed to serve multiple purposes as for instance drug prevalence research and treatment impact assessment. It is obvious that such applications can only be envisaged if the monitoring system provides for both, multiple counting control and multisectorial data. Moreover, in order to obtain valid indicators, the monitoring system should present a high – if not exhaustive – data coverage at the national level. The more exhaustive the data collection is the wider the concepts of behavioural changes and post treatment follow-up can be defined. The NFP has faced the challenge to include all drug-related field agencies in the RELIS network. Even though, there are a limited number of those agencies established on the national territory, problems in terms of motivation, mutual benefits and data protection issues are comparable to those encountered by larger countries. Data protection especially has to be carefully considered since anonymity is less guaranteed in small populations.

Currently all specialised drug care and law enforcement agencies are included in the RELIS network. A first major general hospital (CHL) has joined the monitoring system in 2000. However, two major gaps remain, namely the lack of data from prisons and GPs. Regarding **prison population**, it would be most useful to include data on released drug law offenders, thus allowing for anonymous follow-up of in treatment and mortality rates after prison sentences. The routine data collection of imprisoned drug law offenders or currently drug consuming inmates have been envisaged by the external evaluator in charge of the creation of a conceptual framework for the future implementation of a specialised drug care strategy within national prisons (see key issue: drug users in prison). If approved RELIS could be applied on a routine basis in prison in the beginning of 2002.

**GPs** established in Luxembourg mainly have a freelance status and do not have to report drug-related treatment demands. This also applies to **substitution prescription**. Being aware of the important number (currently over 800) of drug users obtaining drug substitution prescribed by the national network of GPs, the necessary inclusion of GPs within the monitoring systems becomes obvious. In accordance with the law of 27 April 2001 amending the basic drug law of 1973, substitution treatment received legal status. A grand ducal regulation yet to be adopted, foresees state licenses granted under defined conditions to substitution prescribing GPs. The current proposal foresees mandatory reporting of substitution treatment demands to the central authority. Once adopted, this new procedure constitutes an opportunity to improve the follow-up of substituted drug users who undergo substitution treatment by means of prescription provided by the network of GPs.

*The overall national strategy to improve treatment impact evaluation relies on both, the promotion of specific target groups' evaluation and the further development of the national drug monitoring system.*

## 13 Drug Users in Prison

### *Preliminary remarks:*

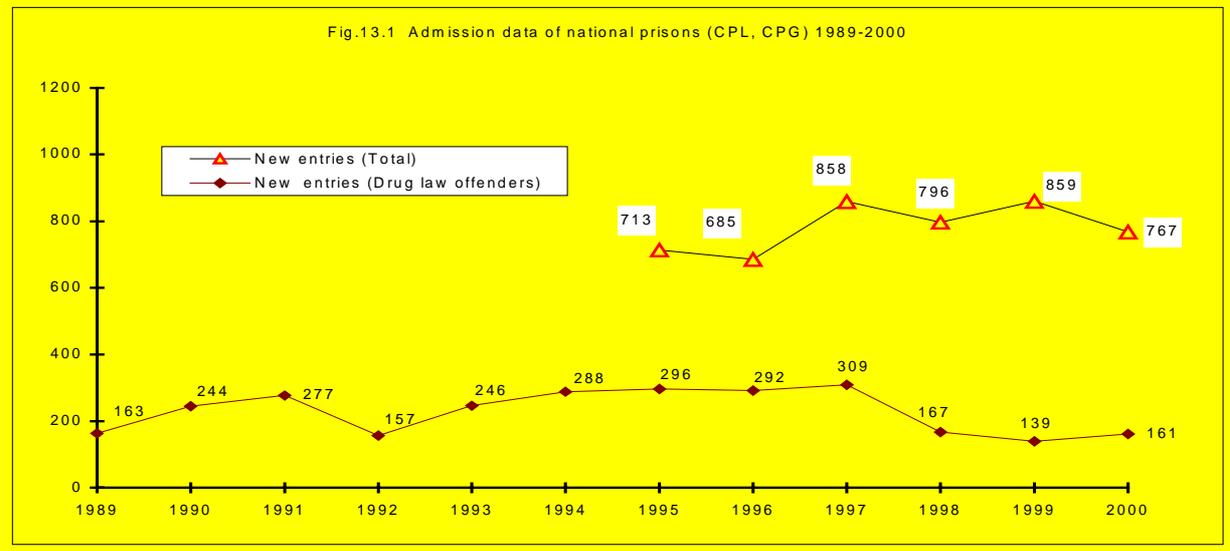
*The law of 27 July 1997 concerning the modification of the penitentiary organisation for the first time regulates the creation of specialised medical units for drug addicts and psychiatric patients within prison. In 1998 the Minister of Justice commissioned the central prison direction to draw-up a respective concept paper. A first proposal has been presented to the Minister of Justice in 1999 and advised by the Minister of Health.*

*In addition, an external expert has worked out a proposal for a pilot project (2000 – 2005) providing a global framework for specialised drug care associated to an in-house drug prevention programme on drugs and infectious diseases (hereinafter referred to as 'global drug care programme'). A project proposal has been presented by the prison direction of CPL to the delegate State Prosecutor. According to the final concept report, presented to the Minister of Justice in October 2001, the implementation of referred infrastructures is scheduled for mid 2002. Joint financing by the Ministry of Justice, the FLTS and the EU (regarding evaluation) is currently under discussion. At the time of the editing of the present report, the final concept paper was not yet available. Therefore, the present chapter will address the current situation observed in national prisons and will provide only fragmentary information on planned activities with regard to the 'global drug care programme'.*

### 13.1 Epidemiological situation

There exist two state prisons at the national level; the CPL situated in the vicinity of Luxembourg City and the CPG implemented in the east of the country. Chart 13.1 provides general admission data (new entries) and number of admissions according

to drug-related convictions in both prisons from 1989 to 2000. On 31 December 2000, the total prison population stood at 400 (CPL: 354 / CPG: 46).



Source : CPL, 2000

**a. Drug use before and within prison**

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

<p>Dr. Schlinck J. (1999), Etude épidémiologique des infections à l’HIV et à l’hépatite virale C dans les prisons luxembourgeoises, CPL, Luxembourg.</p>	
<p>EN: Epidemiological study on HIV and HCV prevalence in prisoners</p>	
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

**MAIN RESULTS:****Drug use in prison**

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

**Risk behaviour**

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

**Miscellaneous**

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

Source: Schlinck, 1999

### ***b. Health status in prison, social and legal consequences among drug users in prison***

*The Schlinck study provides the latest figures on HIV and HCV prevalence in prisoners according to drug use status. Tables 13.1.b.2 and 13.1.b.3 provide a comparative presentation of infection rates of IDU prisoners and RELIS respondents:*

***Table 13.1.b.1 Synopsis of HIV and HCV infection rates in prison population (valid %)(1998)***

Prison population	Infection rate in 1998
<i>HIV rate in total prison population</i>	1.5%
<i>HIV rate in IDU prisoners</i>	4.4%
<i>HCV rate in total prison population</i>	15%
<i>HCV rate in non-IDU prisoners</i>	5%
<i>HCV rate in IDU prisoners</i>	37%

Source: Schlinck J., 1999

***Table 13.1.b.2 Synopsis of national data on HIV infection rates in drug using populations (valid %)***

YEAR	1996	1997	1998	1999	2000
HIV rate in drug users (RELIS)	6.89	3.00	2.87	2.89	4.31
HIV rate in drug treatment demanders (RELIS)	6.67	3.80	2.61	3.37	4.76
HIV rate in IDUs (RELIS)	<b>9.80</b>	<b>3.57</b>	<b>3.52</b>	<b>3.33</b>	<b>3.57</b>
HIV rate in IDUs treatment demanders (RELIS)	8.57	4.48	3.37	3.90	3.87
<b>HIV rate in IDUs prisoners (Schlinck 1999)</b>	/	/	4.4	/	/

Sources: RELIS , 2000 and Schlinck J., 1999

***Table 13.1.b.3 Synopsis of national data on HCV infection rates in drug using populations (valid %)***

YEAR	1997	1998	1999	2000
HCV rate in drug users (RELIS)	22	21	25	40
HCV rate in drug treatment demanders	22	24	29	47
<b>HCV rate in IDU prisoners (Schlinck 1999)</b>	/	<b>37</b>	/	/

*Presently, the Schlinck study represents the most representative study on infectious diseases in the national prison population. In addition HIV, HAV, HBV, HCV and syphilis testing are proposed (on a voluntary basis) to each new prisoner. HAV and HBV vaccinations are also provided to non infected demanding prisoners. Table 13.1.b.4 provides data on infection rates as determined by routine voluntary testing procedures at the moment of prison admission:*

**Table 13.1.b.4** *Infection rates as provided by routine testing procedures applied to new prison entries (valid %)*

Year	1997	1998	1999	2000
<b>Type of infection</b>				
<b>HIV</b>	0.8% (N: 250)	0.8 (N: 250)	0.7% (N: 300)	0% (N: 200)
<b>HAV</b>	41% (N: 212)	50% (N: 252)	61% (N: 282)	62% (N: 185)
<b>HBV</b>	40% (N: 212)	43% (N: 252)	39% (N: 282)	50% (N: 185)
<b>HCV</b>	31% (N: 212)	31% (N: 252)	29% (N: 282)	29% (N: 185)
<b>Syphilis</b>	0.9% (N: 212)	0.4% (N: 252)	1% (N:282)	1% (N: 185)

Source: CPL (1997-2000)

*According to routine testing data within prison, it appears that HIV, HCV and syphilis prevalence in prisoners has remained fairly stable since 1997. HAV and HBV prevalence show notable increases during the same period. Differences between routine data on the total prison population and results of the Schlinck study performed in 1998 are due to different sampling frames.*

**Drug testing:** *urine test are applied randomly or following suspicion expressed by prison wards and staff members. In case prisoners refuse to be tested, they are found guilty by default and endure the same sanctions than positive tested inmates. No mandatory drug testing is performed at prison admission. Sanctions for drugs consume in prison differ according to factors such as recidivism, health situation, etc. In general, the penalty for opiate use in prison is 1 month solitary confinement, which means isolation from other inmates an a 1 hour leave from cell per day. In case of a first drug use offence usually two weeks of reprieve are granted. In case of recidivism, penalties may increase gradually. Medical care to be provided during isolation detention is regulated by law.*

## 13.2 Availability and supply

*Thus far, no research has been done on drug availability and supply in national prisons. Poor information is provided on possible ways drugs may enter prison. According to the CPL prison direction the current price of a 'pill' (usually MEPHENON® or benzodiazepines) or a single dose of illicitly acquired heroin within prison walls approaches 25 Euro, if not paid by other means (e.g. barter) or services (e.g. prostitution).*

*Furthermore, one may quote an extract of a letter of 15 July 1999 addressed by the CPL direction to the State prosecutor: 'If we admit that 50 of 400 inmates (CPL and*

CPG) are highly addicted to heroin and consume 1 gram per day; if we further admit that 250 prisoners consume approximately 1 gram per week, 600 grams of heroin may circulate in prison in one week, thus reaching 30 kilos per year, which represents a market value of approximately 2.5 million Euro per year.

### **13.3 Contextual information**

#### **a. Structural organisation**

The CPL is implemented within a 2-floors architectural concept counting several wings that host different prison populations. A special wing is dedicated to female prisoners, prisoners on remand and to prisoners on solitary confinement regime. Lifetime sentenced prisoners are not hosted in a specific wing as well as there is no drug-free section. Sport facilities and occupational ateliers are located in specific sections. Visit facilities are organised according to different security levels. A special room equipped with a bed is at disposal for inmates who receive the visit of their partners.

A consistent extension of prison buildings has been undertaken for 3 years. The opening of new wings and the reorganisation of currently existing facilities are foreseen by the beginning of 2002.

#### **b. Medical care facilities and related measures**

The right of health care is guaranteed to each prisoner by law. Each national prison counts a centralised in-house nursery. The permanent medical staff of the main national prison (CPL) is composed of one general practitioner and 8 nurses ensuring a 24 hours permanence. The future employment of a permanent in-house psychiatrist is foreseen. Medical offer in prison is completed by external freelance medical agents (e.g. dentists). Prisoners have the right to consult the medical doctor of their choice, even if the latter is not part of the permanent staff or the common external staff. Dentist care is provided in-house by an external dentist. Prescription and distribution of pharmaceuticals is under the responsibility of the prison GP. Demand for medical intervention can be addressed at different levels; direct demand at the nursery or to nurses doing their daily rounds or reported demand by guards and security staff members 24/24 hours.

The central prison administration has reached agreement with the main national general hospital (CHL) to ensure intensive, surgical or specialised medical treatment of prisoners. A routine protocol rules the transfer to high security units of CHL where specialised treatment can be provided.

### **13.4 Demand reduction policy in prison**

#### **a. Methodology for needs assessment**

Up to 2000, needs assessment applied to prisoners and ad hoc prison infrastructures did mainly rely on in-house resources on basis of bilateral exchange between prisoners' associations, prison guards' representatives and the prison administration.

The conceptualisation of the above referred 'global drug care programme in prison' performed by an external expert consultant provided the framework of a more systematic approach towards needs assessment. The strategy adopted by the mandated expert included multilevel consultation with all involved parties, including individual prisoners as well as respective representatives. The output of this consultation process is meant to reflect a consensus on priority needs as defined by all involved actors. The process evaluation as foreseen in the concept document will provide an opportunity to refine specific aspects and readjust interventions in the light of feasibility factors.

#### **b. Treatment interventions and prevention in the field of drug use**

At this stage, one should stress that there exists no special incarceration regime for drug users. Moreover, drug -related medical problems are treated by the general medical and paramedical staff of the prison. Drug testing is also performed by medical staff members, who do however stress the inaccuracy of the present situation.

**Detoxification treatment** is either provided in-house under the responsibility of the prison medical unit, or by external detoxification units of general hospitals according to strict rules and procedures.

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

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

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

Currently no **needle exchange** takes place in national prisons. The provision of injection material is foreseen in the framework of the implementation of the general health care programme for drug addicts within prison (2002). Condoms and lubricants are at disposal free of charge in a discreet location near the nursery. External prevention agents (HIV, AIDS) also provide prisoners with safer sex material and advice.

**Psychosocial and therapeutic** care is provided by both, in-house staff members and specialised external agents from conventional drug agencies. Therapeutic in-house

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

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

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

## **13.5 Evaluation of drug users treatments in prison**

### ***a. Main developments in evaluation activity and treatment impact assessment in prison***

To date, evaluation strategies as well as treatment impact assessment in prison are poorly developed. The global drug care programme in prison set up in accordance to the law of 27 July 1997 foresees a clearly defined evaluation strategy in terms of process and output assessment. Furthermore, the yet to be approved routine application of the RELIS protocol to new prison admissions will allow in the medium-term to assess future careers of former imprisoned drug law offenders in terms of subsequent law enforcement and treatment contacts, drug-related morbidity and mortality.

It has to be stressed that national prisons did participate in the RELIS monitoring system from 1993 to 1994 by providing data on a representative sample of drug using prisoners. For organisational reasons, this collaboration had to be suspended. Data thus collected during the referred period had allowed to perform a first epidemiological study of drug users in prison published in 1995 (Origer 1995). The results of the 1995 study were purely descriptive and did not allow for intervention impact assessment. The routine application of RELIS will allow RELIS database cross checks, thus providing a reliable evaluation tool with respect to former prisoners follow up.

## **13.6 Methodological issues**

National prison administrations rely on the Ministry of Justice. This also applies to medical in-house staff. Currently the Ministry of Health is merely providing additional

*resources in terms of specialised drug care within prison in order to fill obvious gaps. This situation is seen as an impediment towards a more structured drug intervention strategy within prison. In addition, as drug-related research has only developed following the set-up of the EMCDDA national focal point, initial priority setting has understandably resulted in a unbalanced representation of different research areas. The prison environment is to some extent a fairly complex research area with regard to the administrative constraints and security considerations. A clearly defined responsibility sharing between the Ministry of Justice and the Ministry of Health with regard to health care intervention within prison will presumably allow new data management strategies and an enhanced data access by the national focal point. The further development of interventions such as substitution treatment and needle exchange programmes as foreseen by the 'global drug care programme in prison' will provide additional indicators on drug use in prison and contribute to 'complete a currently still fragmentary picture' of the state of the problem.*

*Future research fields to be investigated appear to be the following:*

- feasibility of a routine drug monitoring system within prison (RELIS)*
- interventions' impact assessment within prison and after release,*
- relation between prison release and drug-related fatalities*
- prescription of medicaments (e.g. benzodiazepines) within prison*
- on-setting drug use in prison*
- availability and quality of drugs within prison*
- drug provision strategies by prisoners and disposition to drug-related risk behaviour prison*

**END OF REPORT**

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ANNEX

### a. RELIS drug monitoring system

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

The main objectives of RELIS are the following:

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

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

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

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

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

One of the main benefits of the described procedure is that no personal data can be inferred directly from the identification code. The 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 attributors on the indexed persons, which is undoubtedly one of the major preoccupations of field institutions.

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

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

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

#### **b. Register on drug law offenders (SPJ)**

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

#### **c. General Mortality Register (GMR)**

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

#### **d. Special Overdose Register (SR) of SPJ**

The SR is a paper-based register on acute and indirect drug-related deaths run by the SPJ. Over the past years, NFP has put major efforts in the development of a

computer-based indexing procedure (SPSS ®) of drug-related deaths by means of a comprehensive data form. NFP is currently maintaining a standardised database on acute drug-related deaths from 1985 to 1999. Anonymous drug-related death data is encoded at the SPJ and transmitted to the NFP according approved standards. Data on indirect drug deaths that are still paper based is also provided to the NFP.

#### **e. AIDS and HIV register (CRP-SANTE)**

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

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

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

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

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

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

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

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 nightclubs, public events or rave parties. No such activities have been planned or carried out under the authority of public administrations. Taking into account that the first official seizure of 'ecstasy' has only been recorded in 1994, harm reduction and close monitoring activities in this particular field were previously not viewed as a priority.

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

The drug issue is largely covered by various **media supports**. Press, Music, fashion and leisure industries are often the mirror of life styles and current trends in substance use. Information could be collected by screening the media targeted at young people and 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 and press department of the State's Ministry, a monthly national and international press review on drugs.

#### **g. Documentation Centres (NFP / CePT)**

The **Centre Logistique de Documentation sur les Drogues et les Toxicomanies (CLDDT)** is a logistic documentation service run by the NFP since 1995. CLDDT runs the only computer-based national documentation management base specifically focusing

on licit and illicit drugs. The CLDDT indexes about 2,700 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.

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### 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 pourrions 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 : 1<sup>e</sup> la prévention, 2<sup>e</sup> la thérapie, 3<sup>e</sup> la prévention des risques et 4<sup>e</sup> 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 améliorera aussi le suivi thérapeutique au Centre pénitentiaire.

La politique à mener en la matière **ne pourra conduire à une dépenalisation 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.

Annex V: Synopsis of national legislation – 1999 – Ministry of Health

RELEVÉ GÉNÉRAL DE LA LÉGISLATION – 1999 – **MINISTÈRE DE LA SANTÉ** SERVICE CENTRAL DE LÉGISLATION

**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 à 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 à 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. A 83 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 thyrostatique 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).

Règlement grand-ducal du 14 janvier 2000 modifiant l'annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques (Mém. A - 5 du 27 janvier 2000, p. 165)

Loi du 8 août 2000, modifiant

- a) certaines dispositions de la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie
- b) la loi du 26 juillet 1986 relative à certains modes d'exécution des peines privatives de liberté.

(Mém. A - 97 du 12 septembre 2000, p. 2189)

Règlement grand-ducal du 23 février 2001 modifiant le règlement grand-ducal du 2 février 1995 relatif à la fabrication et la mise sur le marché de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances illicites ((Mém. A - 25 du 28 février 2001, p. 761)

Loi du 27 avril 2001 modifiant la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie (Mém. A - 61 du 17 mai 2001, p. 1179)

Loi du 14 juin 2001 portant

1.approbation de la Convention du Conseil de l'Europe relative au blanchiment, au dépistage, à la saisie et à la confiscation des produits du crime, faite à Strasbourg ,le 8 novembre 1990;

2.modification de certaines dispositions du code pénal;

3.modification de la loi du 17 mars 1992

1.portant 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.