REPORT TO THE EMCDDA
by the Reitox National Focal Point

GRAND DUCHY OF LUXEMBOURG
DRUG SITUATION 2001

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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.

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Luxembourg, October 2002

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Summary


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 drug action plan addresses current needs in terms of specialised infrastructures, human and financial resources, collaboration networks and required developments in the field of drug research. Primary prevention measures were included in a second phase in 2002. The Ministry of Health guarantees financial and human resources required for the implementation of the drugs action plan.

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. The grand ducal decree on substitution treatment entered in force in February 2002 according to the law of 27 April 2002.

A recent study (Origer 2002) did for the first time allow to estimate the direct economic costs of policies and interventions in the field of illicit drug use referred to year 1999.

The direct economic costs of national policies related to illicit drug use reached approximately 23.345 million euros in 1999, which represents an annual per capita expenditure of 54.- €. 39% of estimated expenditures are related to supply reduction measures against 59% that are devoted to demand reduction interventions. Annually 1% of public resources are invested in drug research and international cooperation respectively. The total annual costs the collectivity has to stand for annually represents 0.013% of the gross national product and 0.05 of the total state budget in 1999.

Law enforcement indicators

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 in seized quantities of heroin and cocaine from 1996 onwards has been confirmed by 2001 data.

Notwithstanding the quantities seized, the number of seizures has grown discontinuously since 1993. 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 confirmed in 2001. Summarily, quantities of seizures have been decreasing since 1996, while the number of offenders involved has stabilised for the last three years.

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

1 If not specified, data refer to 2001. Figures between brackets refer to 2000 if not specified.
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 5 years.

Towards 2001 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 2001 the number of cannabis seizures went from 167 to 488. During the same period, the number of offenders involved has marked an increase from 242 to 668.

**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 2001 (1,455). The number of drug law offenders (‘prévenus’) has increased from 1,263 in 1995 to 1,775 in 2001. 92 arrests on the same charge have been reported in 2001 (recent decrease).

The population of drug law offenders counts 87 per cent of males; a proportion that has been varying between 79 and 89 per cent during the past decade. Since 1998, non-natives have been representing about 50% of drug law offenders. 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%) (2001: 9.5%).

The proportion of prison sentences for drug law offences has decreased significantly referred to 1996 data. In 2001, 119 new entries (18.6 %) (1996: 42.6%) of convicted drug law offenders have been reported by national penal institutions (of a total number of 641 entries in 2001). Nevertheless, 55 per cent of problem drug users indexed by RELIS in 1995 reported at least one prison journey during their lifetime; in 2001 the same proportion equalled 76 per cent.

**Epidemiological indicators**

**Drug use in 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 emphasise 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 prevalence (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 2001 figures 3,317 (1994: 2,213) (double counting excluded). 873 users have been indexed by national specialised drug demand reduction agencies and 1,340 persons by supply reduction agencies in 1994. Referred to 2001 the same agencies have indexed 1,392 and 1,925 respectively, which equals to a progress rate of 50%
27 per cent (32%) of indexed drug users, of which 53% 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 decrease since 1997, equals to 26 per cent (32%). On average, a problem drug user addresses 1.66 (1.7) drug treatment demands per year. For 1.3 per cent (3%) of registered cases it has been the first drug treatment demand during lifetime (inter-institutional).

The first treatment demand is motivated in 62% of indexed cases by medical and/or psychosocial problems. 45% of respondents have addressed their first treatment demand in an emergency context. 80% of indexed users have already received substitution treatment prior to the 2001 indexing. 44 % of the latter were admitted to the medium threshold national methadone programme and 56% have been provided substitution treatment (prescription of Méphénon ®) by the national GP network (low threshold)

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

**Gender distribution** has remained fairly balanced since 1994 (2001: 19 % females, 81 % males). The proportion of non-natives problem drug users (PDUs) among the overall national drug population has known a significant increase between 1996 (18%) and 1999 (48%) followed by a stabilisation in 2001 (40%). The population of non-natives drug users largely consists of Portuguese nationals (2000: 57%, increase); a proportion, which is consistently higher than the one observed in the general population.

Compared with 1995, the mean age, applied to the total drug population (28 Y, 1M), has markedly increased, (2001: 29Y, 1M). 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 and in the total drug population. 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 (national drug monitoring system) figures referred to 71 per cent and 23 per cent respectively.

The mean age of native and non-native PDUs tend to balance as well as the difference in age in proportion to gender. Generally speaking, the profile of female users has known most significant changes during recent years. In comparison with male users, one could mention a lower mean age at first consume of cigarettes, at first use of illicit drugs and an earlier start of a physical addiction state reported by female users.

**Residential status** of problem drug users has improved over the last 4 years. Geographic distribution, according to electoral districts, suggests that 42.4 per cent (36%) come from the centre region and 38.3 per cent (44.5%) from cities in the South of the country. Northern cantons also show an increasing trend.

All indicators included, the employment status of respondents has declined for the last four years. The unemployment rate 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 associated to an increasing social dependency.

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 2001.
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:

<table>
<thead>
<tr>
<th></th>
<th>1997</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEM USE : HRC DRUGS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average prevalence</td>
<td>2.100</td>
<td>2.350</td>
<td>2.450</td>
</tr>
<tr>
<td>Total prevalence rate</td>
<td>5.7 /1000</td>
<td>5.43 /1000</td>
<td>5.59 /1000</td>
</tr>
<tr>
<td>Total prevalence rate – age: 15-54</td>
<td>8.8 /1000</td>
<td>9.58 /1000</td>
<td>9.86 /1000</td>
</tr>
<tr>
<td><strong>PROBLEM USE : MAIN DRUG – HEROIN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence heroin</td>
<td>1.680</td>
<td>1.975</td>
<td>2.010</td>
</tr>
<tr>
<td>Total prevalence rate – heroin</td>
<td>4 /1000</td>
<td>4.57 /1000</td>
<td>4.58 /1000</td>
</tr>
<tr>
<td>Total prevalence rate – heroin – age: 15-54</td>
<td>7 /1000</td>
<td>8.05 /1000</td>
<td>8.09 /1000</td>
</tr>
<tr>
<td><strong>INTRAVENOUS DRUG USE (IDU)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence IDU</td>
<td>1.370</td>
<td>1.780</td>
<td>1.715</td>
</tr>
<tr>
<td>Total prevalence rate – IDU</td>
<td>3.25 /1000</td>
<td>4.12 /1000</td>
<td>3.91 /1000</td>
</tr>
<tr>
<td>Total prevalence rate – IDU – age: 15-54</td>
<td>5.71 /1000</td>
<td>7.26 /1000</td>
<td>6.90 /1000</td>
</tr>
</tbody>
</table>

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 a large majority of indexed users. The significant increase of opiate use by inhalation in 1998 has stabilised was followed by a two-years decrease. RELIS respondents increasingly report cannabis use as primary drug. 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 2001 the same proportion figured 37.3 per cent.

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 indexes only current problem drug users and not exclusive recreational users.

The proportion of poly-drug use still on the increase represent the most common consume pattern. 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 5 years. In contrast to 1995 data, the switch to intravenous drug use occurs earlier in 2001.

Drug-related morbidity and mortality

Indicators retained by RELIS stress an overall stabilisation of the general health state of indexed drug users. HBV and HIV prevalence rates\(^2\) are stable. However, one should emphasise that the HCV infection rate has been increasing noticeably and tends to reflect the average rate observed in the E.U. 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 2001 figures 16.3 per cent.

The number of fatal overdoses indexed at the national level has shown an increasing trend from 1985 to 1994 (29 cases), followed by a slow decrease until 1997 (10 cases). Afterwards, the prevalence has increased anew to reach 18 cases in 2001. In terms of drug-related mortality (direct and indirect deaths), 23 cases have been indexed in 1992; prevalence has stabilised since 1995 figuring roughly 40 cases per year.

\(^2\) HIV and hepatitis figures refer to both, injecting and non-injecting drug users
Compared with national prevalence figures on problematic drug users in 2000 \(N = 2,450\), in 1999 \(N = 2,350\) and in 1997 \(N = 2,100\) (Origer 2001), overdose cases represents a rate varying between 0.48% in 1997 and 1.1% in 2000 (0.77% in 99). Referred to the total number of drug-related deaths, indexed by national law enforcement agencies and forensic institutes, the same proportion shows weaker variations: 1.346% in 2000, 1.361% in 1999 and 1.333% in 1997.

The overdose rate in the national general population figured 4.08 overdose deaths per 100,000 inhabitants in 2001 (2.09 od. cases in 1997). An international comparison shows that the overdose rate of the G. D. of Luxembourg is among the highest within EU Member states, even though it has known a significant decrease in 2001. Results of toxicological analysis performed on overdose victims refer to the presence of opiate traces in 91 per cent of cases. In 70 per cent of autopsy cases heroin consume was reported, increasingly in association with substitution drugs.

**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. Since the opening of EU borders, better-organised distribution networks tend to replace micro networks maintained by the users themselves. 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 2001 the same proportion figured 4 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 decreasing during past years, with the exception of cannabis, on the increase (hashish: 7.4 €/gram, marijuana: 6.2 €/gram).

In terms of purity, samples of 'suspect substances' analysed by the National Laboratory of Health (LNS) in 2001, revealed an increase in THC concentration in cannabis and a decreasing Cocaine purity. Referred to other analyses substances trends are unclear.

**Harm reduction activities**

The number of sterilised syringes distributed (2001: 224,609 / 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 (2001: 155,516 (69%) / 1996: 28,646 (38%)) has increased accordingly. Refering to facilities included in the needle exchange programme, a majority of drug injectors procure their injection material from automatic dispensers. 2 of 3 injectors report clean needle use. All syringes providing facilities and selling points included, pharmacies constitute the main source of provision (32%, decrease) reported by intravenous drug users. The most significant increase during recent years has been observed at the level of specialised treatment agencies.

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 158 patients in 2001. 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 delivered by the Union of Health Insurance Founds refer to 849 (1999: 745) patients who did receive substitution treatment in 2001 by means of the prescription of methadone or buprenorphine containing medicaments (MEPHENON ®, METHADICT ® and SUBUTEX ®). In 2001, the number of GPs prescribing the listed drugs reached 147 (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 1

NATIONAL STRATEGIES:
INSTITUTIONAL & LEGAL FRAMEWORK
1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

Drug abuse is defined as a behaviour associated to health and social risks rather than a socially reprehensible criminal act. The Governmental declaration of August 1999\(^3\), 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.

The Ministry of Health is currently in charge of the coordination of drug demand reduction measures. The strategic framework of drug demand reduction interventions has been defined by the national drug coordinator, appointed in 1999 by the Minister of Health, by means of a national action plan on drugs and drug addiction covering the period 2000 to 2004. The drug action plan relies on six intervention areas, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and low threshold services. A special division for social medicine and drug addiction is about to be implemented within the Directorate of Health. A close link between the EMCDDA national focal point and the policy level is ensured by the fact that the NFP will be implemented in the referred division and that the head of focal point has been appointed National Drug Co-ordinator.

The role of the Interministerial Group on Drugs, currently chaired by the Ministry of Health, has been enhanced in order to guarantee an overall coordination of demand and supply reduction policies.

1.2 Legal framework

- LAWS

The basic national drug law, namely: ‘Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie\(^4\)’ 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:

- law of 7 July 1989 (Official gazette: A 1989, p. 923),
- law of 8 August 2000, modifying

a) the 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\(^5\) 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.

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\(^4\) Official gazette A 1973, p.319
treatment, needle exchange and other state licensed means which could materialise in shooting galleries or medically controlled heroin distribution programmes.


(Règlement grand-ducal 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.)

- **GRAND DUCAL DECREES ON SUBSTITUTION TREATMENT AND DRUGS PRESCRIPTION**

The grand ducal decree of 7 December 2001\(^7\) regulates the duration prescription validity of certain controlled prescription drugs and fixes prescription coverage duration to 3 months for methylphenidate, 21 days for oral morphine, and transdermic fentanyl and 14 days for methadone.


The grand ducal decree of 30 January 2002\(^8\) regulating the modalities of drug substitution treatment at the national level is considered to be a valuable instrument towards the quality and control management of drug substitution treatment at the national level. Summarily the referred decree:
- provides an official definition of drug substitution treatment and nationally involved treatment providers (GPs, specialised agencies, pharmacies),
- defines treatment admission criteria
- lists controlled substances to be prescribed in the framework of substitution treatments. In addition, heroin prescription is given a legal basis in the framework of the implementation of a pilot project to be coordinated by the Directorate of Health (Ministry of Health),
- foresees mandatory licences for substitution treatment to be granted by the minister of Health to substitution treatment providers as well as training requirements,
- foresees the creation of a special surveillance commission on drug substitution treatment entrusted with the control of the execution of the substitution decree

(Règlement grand-ducal du 30 janvier 2002 déterminant les modalités du programme de traitement de la toxicomanie par substitution)

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GRAND DUCAL DECREES CONTROLLING NEW SUBSTANCES AND PRECURSORS

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

- Grand ducal decree of 4 March 1974 regarding certain toxic substances
- Grand ducal decree of 20 March 1974 regarding certain psychotropic substances
- Grand ducal decree of 26 March 1974 establishing the list of controlled narcotics
- Grand ducal decree of 8 May 1993 regarding commerce of narcotics and psychotropic substances
- Grand ducal decree of 2 February 1995 regarding the production and distribution of certain substances used in the illicit production of narcotics and psychotropic substances
- The grand ducal decree of 23 February 2001\(^9\) includes norephedrine in the list of nationally controlled substances used for the illicit production of narcotics and psychotropic substances

(Règlement grand-ducal du 23 février 2001 modifiant le 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)

- The grand ducal decree of 14 December 2001\(^10\) includes 2C-B (4 – bromo –2,5 –diméthoxyphénéthylamine) in the list of nationally controlled substances

(Règlement grand-ducal du 14 décembre 2001 modifiant l’annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques)

- The grand ducal decree of 29 April 2002\(^11\) includes PMMA (paraméthoxyméthamphétamine or N-methyl-1-4 - (méthoxyphenyl)-2-aminopropane) in the list of nationally controlled substances following the Council decision of 28 February 2002.

(Règlement grand-ducal du 29 avril 2002 modifiant l’annexe du règlement grand-ducal modifié du 4 mars 1974 concernant certaines substances toxiques)

The full text of the current basic national drug law as well as recent decrees may be accessed through the following web sites: http://www.etat.lu/memorial or http://eldd.emcdda.org/databases/eldd_search.cfm.

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) has presented a proposition of law to the Parliament on 4\(^\text{th}\) 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.

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On 28 August 2002, a Member of Parliament from the Ecological Party deposited a proposition of law on the regulation of prescriptions of medicines containing cannabinoids (i.e. Marinol®, Cesamet®) to a certain patients according to a detail list of eligible diseases.

1.3 Laws implementation

Prosecution policy

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

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

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1.4 Developments in public attitudes and debates

a) Public perception of the drug issue

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

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

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

REFERENCE

European Commission (2001). Public opinion regarding security and victimisation in the E.U. Contact with drug related problems. Eurobarometer surveys n° 44.3 and 54.1, Brussels

<table>
<thead>
<tr>
<th>Year of data collection</th>
<th>1996 and 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single/repeated study</td>
<td>Repeated study</td>
</tr>
<tr>
<td>Context</td>
<td>Eurobarometer</td>
</tr>
<tr>
<td>Area covered</td>
<td>National representativity</td>
</tr>
<tr>
<td>Age range</td>
<td>12-60 years</td>
</tr>
<tr>
<td>Data coll. Procedure</td>
<td>Phone interviews</td>
</tr>
<tr>
<td>Sample size</td>
<td>609 valid cases</td>
</tr>
</tbody>
</table>

Figure 1.4.d presents the distribution of answers to the question: 'Over the last 12 months, how often were you personally in contact with drug-related problems in the area where you live? (e.g. seeing people dealing in drugs, taking or using drugs, finding used syringes, etc.)'

<table>
<thead>
<tr>
<th></th>
<th>Often</th>
<th>From time to time</th>
<th>Rarely</th>
<th>Never</th>
<th>Often or from time to time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>81</td>
<td>8</td>
</tr>
<tr>
<td>2000</td>
<td>3</td>
<td>7</td>
<td>7</td>
<td>80</td>
<td>10</td>
</tr>
</tbody>
</table>

Although the observed percentages are low compared with most of the other EU Member States, a slight increase of the number of respondents reporting contact with drug-related problems is observed from 1996 and 2000.

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 public debate on the future creation on injection rooms and heroin distribution programmes are highly influenced by the perceived need to reduce nuisance and risks associated to iv drug use.

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.
b) Orientation of main public debates

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.

Controversial debates on **drug use in prison** are still ongoing. Both, prescription of pharmaceutics to drug users in prison and illicit drug use in prison are frequently on the agenda having led to a more general discussion on the need of general health care and specialised drug treatment in prison. The discussion has been boosted by the recent still ongoing implementation of a general psycho-medico-social treatment concept for drug addicts and inmates with psychiatric disorders within prison.

The **cannabis topic** has also remained in the front line of public interest. Several members of parliament have raised questions on the **impact of the new drug law** on an increasing prevalence of cannabis use among youngsters.

Furthermore members of parliament have emphasised the **use of new information technologies in the promotion and illicit distribution of drugs**, high national drug prevalence rates compared to other Member states, potential risks of new synthetic **drugs** (e.g. GHB known as the date rape drug) and finally the criticism raised by the **INCB report** on cannabis decriminalisation and the projects of heroin distribution programmes and injection rooms.

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 (e.g. inhabitants of the concerned area) on the one side and practical oriented non-opponents on the other side. The site where those infrastructures will be implemented is of 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.

c) 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 (especially low threshold interventions) and, recently, early warning mechanisms following the emergence of new synthetic drugs and measures retained by the national drugs action plan 2000-2004 and drug use in prison.
1.5 Budgets and funding arrangements

a. Funding directly related to drug issues

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'.

The Ministry of Health guarantees Financial and human resources required for the implementation of the drugs action plan 2000 – 2004.

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 following figures are provided by the Origer (2002) study:

<table>
<thead>
<tr>
<th>Intervention field</th>
<th>Expenditure</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply reduction (Law enforcement)</td>
<td>9.105 million euros</td>
<td>39%</td>
</tr>
<tr>
<td>Demand reduction (Social and Health care)</td>
<td>13.774 million euros</td>
<td>59%</td>
</tr>
<tr>
<td>Research</td>
<td>0.233 million euros</td>
<td>1%</td>
</tr>
<tr>
<td>International activities</td>
<td>0.232 million euros</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23.345 million euros</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Origer 2002

b. Drugs direct Funding at national level

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. Therefore, in accordance to national needs and the work plan of the EMCDDA, a national study on direct economic costs of drug policies and interventions has been performed from 1999 to 2002 and refers to data from 1999 (Origer 2002).

C. Results from specific national surveys on expenditure

See section 14: key issue or download study report (Origer 2002) at: [http://www.relis.lu](http://www.relis.lu)
Part II

EPIDEMIOLOGICAL SITUATION
2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

From 1996 until today

A decrease of heroin use as preferential consume pattern in PDUs has been observed from 1999 onwards (2001: 69%). Cocaine use in the same population has stabilised although inhalation mode is preferred compared with previous years. Ecstasy-like substances show an increasing demand even though seizure figures do suggest an inverse and currently stable trend. The use of substances such as MBDB, GHB, 4-MTA, Ketamin or PMMA (have been reported at the national level.

All indicators on cannabis use (problematic and recreational) are on the increase since four years. Whilst preference patterns have persisted over the past four years, significant changes have occurred in the route of administration.

Data from 1998 and 1999, confirmed a decisive reduction in intravenous opiates consume associated to an amplification of the inhalation mode (also known as ‘blowing’ or ‘chasing the dragon’); 2000 and 2001 data suggest a stabilisation of the referred trend. Specialised drug agencies have recently started to provide ‘blowing material’ (e.g. aluminium foils) in order to encourage non-iv use of heroin and reduce risks associated to intravenous use, which may have influenced consume patterns.

Cannabis use is still developing in youngsters especially in association with ecstasy consume. The average age of first consume of cannabis, ecstasy and i.v. heroin tends to decrease. Between 1994 and 2000, the number of cannabis seizures went from 167 to 490 as well as the number of offenders involved has marked an increase from 242 to 668. Cannabis showing high THC concentrations is increasingly found on the national market.

Compared with 1995, the average age, applied to the total drug population (28Y, 1M), has markedly increased, (2001: 29Y, 1 M). The proportion of PDUs aged 35 and more and those younger than 19 years 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 (8.6%), in the total PDU population (3.9%) and to the percentage of students in problem drug users (17%). 80 per cent and 42 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. 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 an earlier start of a physical addiction state reported by female users.
The proportion of poly-drug use (2000: 83 % stable), 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 5 years. For instance, 23 per cent (25%) of current problem drug users were younger than 14 years at the moment of first cannabis use and 42 per cent (47%) were still underage (< 18 years) as they first injected opiates. In contrast to 1995 data, the switch to intravenous drug use occurs earlier in 2001.

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 42.2 per cent (39.4%) come from the centre region and 38.3 per cent (41.6%) from cities in the South of the country. Eastern cantons figured 5 per cent in 1996 and 5.7 per cent in 2001 and Northern cantons have been showing a slow but constant increase from 1996 onwards.

### 2.2 Drug use in the population

#### a) Main results of surveys and studies

#### b) General population

To date, no national, large-scale (representative) population survey on drug use has been conducted. The NFP is currently negotiating the future implementation of a nation wide drug survey with the Ministry of Health and the CePT in the framework of the yet to be approved national action plan on drug prevention.

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.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EN:</td>
<td>Drug prevention at the communal level</td>
</tr>
<tr>
<td>Year of data collection</td>
<td>1998</td>
</tr>
<tr>
<td>Single/repeated study</td>
<td>Single study</td>
</tr>
<tr>
<td>Context</td>
<td>Drug Prevention – Public Health – Cross sectional</td>
</tr>
<tr>
<td>Area covered</td>
<td>7 council districts of the Grand Duchy of Luxembourg</td>
</tr>
<tr>
<td>Age range</td>
<td>12-60 years</td>
</tr>
<tr>
<td>Data coll. Procedure</td>
<td>Anonymous self-administrated questionnaires</td>
</tr>
<tr>
<td>Sample size</td>
<td>667 valid cases</td>
</tr>
<tr>
<td>Response rate (M, F, T)</td>
<td>33.9%</td>
</tr>
</tbody>
</table>
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.

**Fig. 2.2.a.1 Lifetime prevalence according to age**

(Fischer 1999)

<table>
<thead>
<tr>
<th>Substance</th>
<th>LIFETIME PREVALENCE (15-34 years)</th>
<th>LAST 30 DAYS PREVALENCE (15-34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>15.8%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1.2%</td>
<td>0%</td>
</tr>
<tr>
<td>Heroin</td>
<td>1.9%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>LSD</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>2.6%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Source: Fischer 1999

EN.: 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*
c. 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 by 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: Matheis J. et al. (1995) ‘Schüler an Drogen’, IEES, Luxembourg. EN.: Students and Drugs

- **Year of data collection**: 1992
- **Single/repeated study**: Repeated study 1983 – 92
- **Context**: Public Health
- **Area covered**: Nation wide
- **Type of school**: 5th years of all types of secondary school classes at the national level
- **Age range**: 16-20 years (AGE ENTERING 5th CLASS)
- **Data coll. Procedure**: Anonymous self-administrated questionnaires in school classes
- **Sample size**: 1,341
- **Response rate (M, F, T)**: 96%

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.


- **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%
<table>
<thead>
<tr>
<th>Substance</th>
<th>Lifetime prevalence (13-16 years)</th>
<th>Current use prevalence (13 – 16 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>4.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Solvents</td>
<td>3.7%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Heroin</td>
<td>5.2%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.4%</td>
<td>1.2%</td>
</tr>
<tr>
<td>LSD</td>
<td>1.8%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Source: Dikes 1996

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%

Fig. 2.2.a.5. Lifetime prevalence according to age (valid %) (HBSC 2000)

Table:

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

Table: Surveys: category 2

EN: Ecstasy type drugs in the G. D. of Luxembourg

Year of data collection: 1997
Single/repeated study: Single
Context: Public Health – primary drug prevention
Area covered: Nation wide
Type of school: 2nd and 6th years of classical (N: 311) and technical (N: 355) secondary schools
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%
EN: Cannabis – Rapid assessment of the current national situation.

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

Fig 2.2.a.6 Lifetime prevalence of drug use according to age groups
(valid %)
(Meisch 1998)

<table>
<thead>
<tr>
<th>Drug</th>
<th>13-14</th>
<th>15-17</th>
<th>18-22</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>7.2</td>
<td>18.6</td>
<td>22.9</td>
<td>13.5</td>
</tr>
<tr>
<td>Solvents</td>
<td>4.3</td>
<td>2</td>
<td>2.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.3</td>
<td>1</td>
<td>0.9</td>
<td>0.6</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1.5</td>
<td>1.6</td>
<td>4.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.6</td>
<td>0.5</td>
<td>0</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Fig. 2.2.a.7. Current and lifetime prevalence of cannabis use according to school levels
(valid %)
(Fischer 2000)

<table>
<thead>
<tr>
<th>School Level</th>
<th>Lifetime Prevalence</th>
<th>Current Use Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th class (13-15 years)</td>
<td>14.5</td>
<td>4.64</td>
</tr>
<tr>
<td>12th class (16 - 20 years)</td>
<td>43.4</td>
<td>13.45</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th></th>
<th>Cannabis</th>
<th>Heroin</th>
<th>Cocaine</th>
<th>Amphet.</th>
<th>Ecstasy</th>
<th>LSD</th>
<th>Psilocybin</th>
<th>Medic.</th>
<th>Solvents</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBSC (2000)</td>
<td>27.4</td>
<td>1.2</td>
<td>2.3</td>
<td>3.7</td>
<td>3.1</td>
<td>2.1</td>
<td>4.8</td>
<td>2.5</td>
<td>3.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Fischer (2000)</td>
<td>25.3</td>
<td>1.3</td>
<td>2.9</td>
<td>3.4</td>
<td>2.8</td>
<td>5.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cannabis</th>
<th>Heroin</th>
<th>Cocaine</th>
<th>Amphet.</th>
<th>Ecstasy</th>
<th>LSD</th>
<th>Psilocybin</th>
<th>Medic.</th>
<th>Solvents</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBSC (2000)</td>
<td>38.9</td>
<td>1.3</td>
<td>2.8</td>
<td>4.6</td>
<td>5.2</td>
<td>2.7</td>
<td>7.1</td>
<td>3.3</td>
<td>3.8</td>
<td>1.7</td>
</tr>
<tr>
<td>Fischer (2000)</td>
<td>43.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matheis (1995)</td>
<td>10.1</td>
<td>0.9</td>
<td>1.2</td>
<td>9.9</td>
<td>1.2</td>
<td>2.1</td>
<td></td>
<td>3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matheis (1985)</td>
<td>9.3</td>
<td>1.2</td>
<td>2</td>
<td></td>
<td>3.7</td>
<td></td>
<td></td>
<td>4.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

![Graph showing prevalence of substances among school population](image)

**Fig. 2.2.b.6 LAST 30 DAYS PREVALENCE: SCHOOL POPULATION - 13-20 years (Fischer 2000)**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Fischer (2000) 1999 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>13.8</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.6</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.3</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1.1</td>
</tr>
<tr>
<td>LSD</td>
<td>1</td>
</tr>
<tr>
<td>Psilocybin</td>
<td>1.8</td>
</tr>
</tbody>
</table>

d. Specific groups

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

### Reference c.2

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

**EN:** Epidemiological study on HIV and HCV prevalence in prisoners

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

**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.
2.3 Problem drug use

a. National and local prevalence

Overview of national drug prevalence studies

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

Source: Origer, 2001
<table>
<thead>
<tr>
<th>Tab. 2.3.a. Prevalence and prevalence rates according to selected sub-groups (1997 – 2000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL POPULATION</strong></td>
</tr>
<tr>
<td>National population on 1st July</td>
</tr>
<tr>
<td>1997: 421,000</td>
</tr>
<tr>
<td>1999: 432,450</td>
</tr>
<tr>
<td>2000: 438,500</td>
</tr>
<tr>
<td>National population aged between 15 and 54 years on 1st July</td>
</tr>
<tr>
<td>1997: 239,818</td>
</tr>
<tr>
<td>1999: 245,308</td>
</tr>
<tr>
<td>2000: 248,440</td>
</tr>
<tr>
<td><strong>HRC USERS IN CONTACT WITH THE NATIONAL INSTITUTIONAL NETWORK</strong> (low threshold agencies not included)</td>
</tr>
<tr>
<td>Total number of indexed users (multiple counts excluded)</td>
</tr>
<tr>
<td>Outpatient: /</td>
</tr>
<tr>
<td>Inpatient: /</td>
</tr>
<tr>
<td>1997: 1,198</td>
</tr>
<tr>
<td>1999: 1,024</td>
</tr>
<tr>
<td>2000: 1,024</td>
</tr>
<tr>
<td>Number of drug treatment demanders in specialised institutions</td>
</tr>
<tr>
<td>Outpatient: /</td>
</tr>
<tr>
<td>Inpatient: /</td>
</tr>
<tr>
<td>1997: 757</td>
</tr>
<tr>
<td>1999: 624</td>
</tr>
<tr>
<td>2000: 557</td>
</tr>
<tr>
<td>Number of drug law offenders (ad minima consume of HRC drug(s))</td>
</tr>
<tr>
<td>1997: /</td>
</tr>
<tr>
<td>1999: 551</td>
</tr>
<tr>
<td>2000: 510</td>
</tr>
<tr>
<td><strong>PROBLEM USE: HRC DRUGS</strong></td>
</tr>
<tr>
<td>Average prevalence</td>
</tr>
<tr>
<td>1997: 2,100</td>
</tr>
<tr>
<td>1999: 2,350</td>
</tr>
<tr>
<td>2000: 2,450</td>
</tr>
<tr>
<td>Total prevalence rate</td>
</tr>
<tr>
<td>1997: 5 /1000</td>
</tr>
<tr>
<td>1999: 5.43 /1000</td>
</tr>
<tr>
<td>2000: 5.59 /1000</td>
</tr>
<tr>
<td>Total prevalence rate – age: 15-54</td>
</tr>
<tr>
<td>1997: 8.8 /1000</td>
</tr>
<tr>
<td>1999: 9.58 /1000</td>
</tr>
<tr>
<td>2000: 9.86 /1000</td>
</tr>
<tr>
<td><strong>PROBLEM USE: MAIN DRUG – HEROIN</strong></td>
</tr>
<tr>
<td>Prevalence heroin</td>
</tr>
<tr>
<td>1997: 1,680</td>
</tr>
<tr>
<td>1999: 1,975</td>
</tr>
<tr>
<td>2000: 2,010</td>
</tr>
<tr>
<td>Total prevalence rate – heroin</td>
</tr>
<tr>
<td>1997: 4 /1000</td>
</tr>
<tr>
<td>1999: 4.57 /1000</td>
</tr>
<tr>
<td>2000: 4.58 /1000</td>
</tr>
<tr>
<td>Total prevalence rate – heroin – age: 15-54</td>
</tr>
<tr>
<td>1997: 7 /1000</td>
</tr>
<tr>
<td>1999: 8.05 /1000</td>
</tr>
<tr>
<td>2000: 8.09 /1000</td>
</tr>
<tr>
<td><strong>INTRAVENOUS DRUG USE (IDU)</strong></td>
</tr>
<tr>
<td>Prevalence IDU</td>
</tr>
<tr>
<td>1997: 1,370</td>
</tr>
<tr>
<td>1999: 1,780</td>
</tr>
<tr>
<td>2000: 1,715</td>
</tr>
<tr>
<td>Total prevalence rate – IDU</td>
</tr>
<tr>
<td>1997: 3.25 /1000</td>
</tr>
<tr>
<td>1999: 4.12 /1000</td>
</tr>
<tr>
<td>2000: 3.91 /1000</td>
</tr>
<tr>
<td>Total prevalence rate – IDU – age: 15-54</td>
</tr>
<tr>
<td>1997: 5.71 /1000</td>
</tr>
<tr>
<td>1999: 7.26 /1000</td>
</tr>
<tr>
<td>2000: 6.90 /1000</td>
</tr>
</tbody>
</table>

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)
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.

**Local prevalence studies**

The only local prevalence study on problem drug use in Luxembourg City has been performed in collaboration with the EMCDDA in 1997 by extrapolation of national prevalence figures. 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.
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 but more recently also in major cities of the Northern district.

### 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 2001 figures 3,317 persons (double counting included). 1.392 persons were indexed by treatment agencies and 1.925) by law enforcement agencies. The number of drug law offenders admitted to prison is the only indicator on decrease over the last 4 years.

22 per cent (32%) of indexed drug users, of which 53% were non-natives, have been in contact for the first time in 2001 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 (5%) of registered cases it has been the first drug treatment demand during lifetime (inter-institutional).

Gender distribution has remained fairly balanced since 1994 (2000: 19 % females, 81 % 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 3-years stabilisation (2001:40%). Since 1994, the duration of residence in the G. D. of Luxembourg of non-native problem drug users has been increasing. The population of non-natives largely consists of Portuguese nationals (2000: 57%, 9); a proportion that is consistently higher than the one observed in the general population. Persons of French and Italian origin respectively count for 13 and 8 percent in non-native problem drug users.

Compared with 1995, the mean age, applied to the total drug population (28Y, 1M), has notably increased, (2001: 29Y, 1M). The proportions of PDUs aged 35 and more and those younger than 19 have 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 total PDU population (3.9%) and to the percentage of students in problem drug users (17%). 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 mean age of native and non-native problem drug users tend to balance. The difference in age in proportion to gender has increased until 2000 mainly due to the low 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, 8M) at first consume of cigarettes, at first use of illicit drugs (15Y6M) and an earlier start of self-reported physical addiction state reported by female users. Average age at first use of illicit HRC drugs has decreased 1 year and 1 month from 1994 to 2001.

The educational level (acquired school levels) of indexed HRC users showed a slight decrease in 2001, even though the average age at the end of studies have been remaining stable.

Residential status of problem drug users has improved for the last 5 years. The proportion of persons reporting stable accommodation has increased from 31 per cent in 1995 to 66 per
cent in 2001. At the time of their last indexing, 26 per cent of users lived with their parents or a member of the family of origin. Geographic distribution, according to electoral districts, suggests that 42.2 per cent (39.4%) come from the centre region and 38.3 per cent (41.6%) from cities in the South of the country. Eastern cantons are stable and Northern cantons have been showing a recent increase (13.8%).

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, showing, however, a notable decrease in 2001. Data on revenues confirm observed trends in occupational status, namely a weakening of financial autonomy (2001: 30%) associated to an increasing social dependency (2001: 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 8 per cent and the latter from 59 to 44 percent between 1995 and 2001.

Opiates are referred to as primary drug by 77 per cent (3) of indexed users. Cocaine and cannabis use are reported as primary drug by 11% (4) 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 (3%), 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 been showing an upward trend for the last three years (7%). The observed trend is even more significant if exclusively referred to drug treatment demanders (16%). 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 2001 the same proportion figured 37.3 per cent.

b. Risk behaviours and trends

Intravenous drug use, mainly heroin and heroin/cocaine cocktails (speedball), prevail among indexed drug users although heroin use as primary consume pattern tends to decrease (68%). 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 three-years decrease reaching 22% in 2001.

Poly-drug use (2001: 83 % stable) represents 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 2001.

In contrast to 1995 data, the switch to intravenous drug use occurs earlier in 2001. The average duration of intravenous drug use of RELIS respondents is 10 years and 5 month (1998: 7 Y, 4 M). Generally speaking, the duration of i.v. use increases while the average age at the moment of first iv use (2001: 20 years and 3 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 (2001: 224,609 / 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 (2001:
155,516 (69%) / 1996: 28,646 (38%) has increased accordingly. Referring to facilities included in the needle exchange programme, a decreasing majority of drug injectors procure their injection material in pharmacies (32% 41) The referred figure 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). The proportion of syringes provided by automatic dispensers and specialised drug agencies have known significant increases since 1995. The growing tendency in syringe distribution on re-collection is partly explained by the fact that new agencies, addressing socially marginalized populations (prostitutes, homeless, etc.) have joined the needle exchange programme and that infectious disease prevention activities have been intensified. 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.

![Fig. 2.3.b.1 Needle sharing by i.v. PDUs during the last month. (Valid %) [1996-2001]](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 49% of RELIS respondents have reported condoms use. No notable trend has emerged since the set up of RELIS.

The RELIS protocol includes specific annually collected 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).
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 2001 (3%) 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 five years. Gender distribution shows an upward trend in female treatment demanders (2001: 45% / 1997: 34%). Age distributions have to be analysed according to the geographical situation of treatment centres. The proportion of treatment demanders in the centre region of the Grand Duchy, aged 30 years and beyond (56%) has sensibly increased, in 2001 while the same age group has stabilised (59.5%) for two years in the South of the country. Treatment demands for problem opiate use or for multiple-use, including opiates, is still the main client pattern although one observes a clear decrease for several years (2001: 59% / 1997: 72%). Cannabis-related demands show a clear upward trend (2001: 10% / 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 show a rising proportion of female users (2001: 32% / 1997: 26%). The mean age of clients has been slowly decreasing since 1997. In 1997, the proportion of clients aged 15 years and below has passed from 7% in 1997 to 42.9% in 2001. Cannabis use is the main reason of demand (2%), 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 decrease (2001: 13.5% / 1997: 18%) and the observed mean age still is on the increase (2001: 28Y11M / 1998: 27Y). The referred age distribution reflects an overall trend observed in most adult drug treatment demanders, that is, a decrease of patients under 25 and an increase of patients older than 25 years. 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 i.v.

- **Inpatient, detoxification**
  Drug detoxification units throughout the country show a stable trend regarding number of admissions and patients. First treatment demands tend to decrease (23% in 1999 and 19% in 2001). Gender distribution has remained fairly unchanged and the mean age of clients has been on the decrease for the last five years (2001: 30Y4M / 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 proportion of female substitution treatment demanders (32.9%) is bigger than the proportion of female PDU’s in the overall drug treatment population. The mean age of clients (33Y, 9M) has significantly increased compared with 1997 data (28Y2M) and the proportion of native substitution treatment demanders has stabilised (75% in 2001). The socio-economical situation of substituted patients is consistently more beneficial than the one observed in other treatment demanders. The number of patients who do receive substitution treatment by prescription from independent general practitioners is on the increase (2000: 849 /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 six years (2001: 30,316 / 1996: 6,456), and so has the number of syringes distributed by the same agencies. The proportion of new clients within low threshold settings has 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. 72% of clients are aged between 18 and 35 years. 68% of clients (stable) are natives.

c. 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 60% in 2000 (45% iv / 15% non iv). Drug treatment demanders have witnessed an increasing preference for heroin by inhalation as opposed to injection.

Cocaine use as main reason of treatment demand shows a low and decreasing prevalence (7%). Cocaine prevalence as secondary drug, however, tends to increase. 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 16% in 2001.

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 and indirect

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

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

‘Lethal intoxication, voluntary, accidental or of undetermined intent, confirmed by forensic and contextual evidence, and caused directly by the use of illicit drugs or by any other drug(s) if the victim has been known to be a regular consumer of illicit drugs’. Death has occurred due to an adverse somatic reaction to substance intake’. 
2. The statistical department of the Directorate of Health maintains the General Mortality Register (GMR) indexing all deaths that occurred on the national territory by means of death certificates provided by GPs. Since 1998 the GMR applies the 10th revision of the International Classification of Diseases (ICD-10). A special software jointly developed by the statistical department and the national focal point allows to extract drug-related death cases from the GMR by the application of a predefined standard (e.g. DRD).

The NFP has recently published the results of a 2 years research: Epidemiological study on drug-related deaths and analysis of methodological aspects of indexing procedures applied in the Grand Duchy of Luxembourg from 1992 to 2000 (Origer & Dellucci 2002)

The first part of the study is devoted to a longitudinal analysis of epidemiological characteristics of drug related deaths (direct & indirect) (1992-2000). The second part focuses on methodological aspects with regard to the production and collection of reliable prevalence and incidence data on drug related mortality. Data presented in the present section have been provided by the latter study.

Figure 3.2.a.1 Evolution of drug-related death cases (direct - indirect - total mortality) from 1992 to 2001 (Origer & Dellucci 2002)

Direct/acute drug-related deaths

Source: Origer & Dellucci 2002
The number of fatal overdoses indexed at the national level has shown an increasing trend from 1985 to 1994 (29 cases), followed by a slow decrease until 1997 (10 cases). Afterwards, the prevalence has increased anew to reach 26 cases in 2000. In terms of drug-related mortality (direct and indirect deaths), 29 cases have been indexed in 1990; prevalence has stabilised since 1995 figuring roughly 40 cases per year.

Compared with national prevalence figures on problematic drug users in 2000 ($N = 2,450$), in 1999 ($N = 2,350$) and in 1997 ($N = 2,100$) (Origer 2001), overdose cases represents a rate varying between 0.48% in 1997 and 1.1% en 2000 (0.77% in 99). Referred to the total number of drug-related deaths, indexed by national law enforcement agencies and forensic institutes, the same proportion shows weaker variations: 1.346% in 2000, 1.361% in 1999 and 1.333% in 1997.

The overdose rate in the national general population figured 6.43 overdose deaths per 100,000 inhabitants in 2000 (3.95 od. cases in 1999 and 2.09 in 1997). An international comparison shows that the overdose rate of the G. D. of Luxembourg is among the highest within EU Member states, even though it has known a significant decrease in 2001.

The steep decrease of acute overdose cases between 1994 and 1997 has been associated to the regionalisation and extension of the methadone substitution programme as well as to the development of low threshold facilities. Whether the upward trend in acute drug deaths from 1997 onwards 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 latest study on drug-related deaths (Origer & Dellucci 2002). It is worth recalling that the number indirect drug deaths have decreased in 2001 reaching the prevalence observed in 1998/99 it is, however, not possible to detect a trend on basis of available data.

- Indirect drug-related deaths

Origer and Dellucci (2002) have developed a methodology to extract indirect drug-related death cased from the GMR on basis of the application of a nationally adapted DRD (ICD-10) standard. Summarily the method consists in applying an adapted broad version of DRD (vers..2.0) and correct the latter by data from different reliable sources. A full text version of the study can be downloaded under: http://www.relis.lu

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 stabilised between 1998 and 1999 (21 cases) (see figure 3.2.1).

b) Deaths related to opiates and to other drugs

Since 1992, results of toxicological analysis performed on overdose victims refer to the presence of opiate traces in almost all direct drug death cases. Heroin has been detected in a vast majority of acute drug death cases, either exclusively (36 – 66.7%; average 46.5%), or as primary drug associated to other substances (21.5 – 62.5%; average 39.6%). In all reported cases heroin has been administrated intravenously. Forensic data from 2000 suggested a decrease of heroin-related deaths (72%), which, however, has not been confirmed by 2001 data (94% of cases involved heroin use). Deaths exclusively due to cocaine use remain very rare. Ecstasy-related deaths have not been
reported thus far. **Multiple substance use** has been increasingly reported during last years. In terms of associated drugs detected in blood samples of victims, cocaine and methadone are most represented. **Methadone** traces in blood samples have increasingly been detected for the last two years. **Buprenorphine** (SUBUTEX ®) has been first detected in direct drug deaths in 1999.

**Table 3.2.b.1.** Substance(s) detected in acute drug death cases (1992 – 2000) (Origer & Dellucci 2002)

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<td>without heroin</td>
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<td>56.25</td>
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</table>

Source: Origer & Dellucci 2002

c) **Number, characteristics and trends**

**Figure 3.2.c.1** Gender distribution of direct drug death cases (1992 - 2001)

Gender distribution of direct drug death cases reflects the sex ratio observed in the total number of drug-related deaths and in the overall drug population (Origer 2002). The only exception to the 1/3 – 1/4 proportion has been observed in 1997. There appears to be no consistent trend during the last 10 years.
Table 3.2.c.1. Age distribution of direct drug death cases indexed from 1992 to 2001 (Origer & Dellucci 2002)

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<td>20 - 24</td>
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<td>13</td>
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<td>63</td>
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<td>6</td>
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<tr>
<td>Mean age</td>
<td>31.5</td>
<td>29</td>
<td>29.35</td>
<td>32.3</td>
<td>26.7</td>
<td>28.5</td>
<td>29.85</td>
<td>26.8</td>
<td>24.6</td>
<td>28.4</td>
<td>28.7</td>
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</table>

The mean age of direct drug-related death cases shows quite important fluctuations over time (mean age from 1992 to 2001: 28.7 years). However, from 1998 on the mean age have followed an increasing trend confirmed by 2001 data. Age group 20 to 35 years is most represented. Overdose victims are significantly younger than indirect drug deaths cases (30, 9 years).

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

A majority of drug-related deaths cases (direct & indirect) are natives (64.6 to 90.9%). The same observation applies to direct and indirect drug deaths analysed separately. The non-native subpopulation of victims is primarily composed of Portuguese citizens, which proportion is much higher than the one observed in the general population. Portuguese natives are followed by Italians and citizens from border countries, whose proportion have remained fairly stable during the last four years.
d. Overall 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 & Pauly 2000). The cohort included 242 opiate drug addicts followed from 1991 to 1999. Mortality data have been collected from treatment agencies, the RELIS database, the GMR and the Special Overdose Register of the SPJ. In accordance to applied methodologies, results show mortality rates varying between 2.36 and 2.51 per cent.

Origer & Dellucci (2002) reported 38 drug-related death cases in 2000. Applied to the estimated number of problematic drug users in 2000 (2,450) (Origer 2001), one obtains a rough mortality rate of 1.51%. The difference might be explained by the fact that the cohort study only included IDUs whereas the prevalence estimation, on which the present calculation is based, refers to PDUs.

**Causes of death**

The following charts present the exhaustive list of indexed acute drug deaths as indexed by the GMR by means of the ICD-10 standard from 1998 and in 2001 (Origer & Dellucci 2002).
A vast majority of acute drug death cases have been recorded as “accidental poisoning” (X40 – X49), which is consistent with the national definition of an acute overdose death. Since the implementation of ICD-10 coding by the GMR (1998), 76% overdose cases have indexed as follows: X42.-, T40.-, T42.- T43.-. At a more restricted level the code sequence: X42.-, T40.- includes 81% of all reported overdoses. The remaining cases have been attributed non-redundant codes (see figures II.3.2.d.1-4).

As regards indirect drug-related deaths, results of the comparative study on drug-related deaths (Origer & Dellucci 2002), reveal that the main causes of indirect deaths between 1996 to 2000 are, in order of importance: Suicide (35%), associated cardio-vascular or pulmonary complications (14%), pharmaco-dependance (12%), undefined intoxication (9%), liver failure 9% and AIDS (2%).

### 3.3 Drug-related infectious diseases

#### 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 2001, 510 HIV infected persons have been registered at the national level; 83 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 16.3 per cent since the registration of the first HIV case in Luxembourg in 1984.

Intravenous drug use appears to be the third most reported transmission mode of HIV infection (new HIV infections (16.3%) and declared AIDS cases (17.5%)) after homosexual and heterosexual status. This sequence has remained fairly stable for the last three years. The proportion of intravenous drug use transmission modus has noticeably decreased between 1998 (23%) and 2001 (17.5%), although the number of newly indexed HIV infection has increased from 30 to 40 cases during the same period.

---

14 Valid percentage
Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2001, 73% of RELIS indexed PDUs reported a HIV test during the last 5 months. Female PDUs tend to report higher testing rates than males.

In 1997, a significant decrease of HIV rates in drug users, mainly in IDUs, occurred. Consequently, HIV rates in current IDUs have stabilised and the number of HIV infected persons in drug treatment demanders went up (4.78%). It may appear unusual that the HIV rate in IDUs is lower than the rate observed in the overall drug treatment population (in 2000 and 2001). This may be linked to the recent 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, one should pay particular attention to the future evolution of HIV infection rates. It is worth noting that treatment demanders present the highest HIV infection and AIDS rates. AIDS prevalence is on the increase while HIV infection prevalence seems to have stabilised for several years.

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

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<td>3.2</td>
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<td>2.9</td>
<td>4.3</td>
<td>4.07</td>
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<td>HIV rate in drug treatment demanders</td>
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<td>3.8</td>
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<td>4.78</td>
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<td>3.9</td>
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<tr>
<td>HIV rate in current IDUs prisoners</td>
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<td>4.4</td>
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**Source:** RELIS 2001

### Table 3.3.a.2

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<td>/</td>
<td>1.66</td>
<td>1.76</td>
<td>2.43</td>
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**Source:** RELIS 2001
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.b.1** Notified hepatitis cases in general population (1995-2001)

Hepatitis B and C indicators (self-reports) 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 54% in 2001. The above referred prison study (Schlink 1999), provides a 37% HCV infection rate in IDU prisoners (saliva sample test). Data on viral hepatitis related to drug use (IVDUs) are currently not available from the National Health Laboratory.

**Table 3.3.b.1** Synopsis of national data on self-reported HBV infection rate in drug using populations (valid %)

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<td>HBV rate in drug users (RELIS)</td>
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<td>30</td>
<td>30</td>
<td>28</td>
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<td>HBV rate in drug treatment demanders</td>
<td>/</td>
<td>27</td>
<td>32</td>
<td>27</td>
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<td>HBV rate in IVDUs (RELIS)</td>
<td>/</td>
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<td>35</td>
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Source: RELIS 2002

**Table 3.3.b.2** Synopsis of national data on HCV infection rate in drug using populations (valid %)

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<td>32</td>
<td>46</td>
<td>50</td>
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<td>Self-reported HCV rate in drug treatment demanders</td>
<td>/ 29</td>
<td>41</td>
<td>53</td>
<td>54</td>
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<td>HCV rate in IVDUs prisoners (saliva tests)</td>
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<td>/</td>
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</tr>
<tr>
<td>Self reported HVC rate in IVDUs (RELIS)</td>
<td>45</td>
<td>50</td>
<td>53</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>

Source: RELIS 2002 (Öniger 2002)

HBV infection in PDUs and in drug treatment demanders is on a decrease while HCV prevalence in general population and in PDUs has significantly increased during the last 4 years.
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 self reported by respondents. The proportion of indexed drug users reporting at least one overdose (as defined) (60%) during lifetime has slowly increased during the last five years. This trend is partly due to an aging IVDU population. However the temporary stabilisation observed during the last two years might be related to an increased proportion of PDUs who prefer inhalation as administration mode of heroin.

![Fig. 3.4.a.1 Non fatal, medically assisted drug overdoses in RELIS respondents (1994-2001) (\%)](source: RELIS 2002)

b. Psychiatric co-morbidity

At the national level, there exist no specialised institution for dual diagnosis (e.g. drug addiction – psychiatric co-morbidity). 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, represents 31% (30%). Figure 3.4.b.1 shows the reasons of previous psychiatric care demands by RELIS respondents.
c. Other important health consequences

- **General Health state**

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDU except for HCV prevalence. In 2001, 65 per cent of problem drug users reported a self-perceived satisfying general health condition against 53 per cent in 1997 (Origer 2002).

- **Suicide attempts**

One indexed PDU of two has already attempted suicide during lifetime. A stabilisation of the observed upward trend, however, seems to install.

- **Drugs and driving**

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

![Fig. 3.4.b.1 Reasons of previous psychiatric care (1996-2001)](chart1)

![Fig. 3.3.c.1 Detection of THC (cannabis) in persons involved in traffic accidents (1995-2001)](chart2)
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. Criminal behaviour, unemployment and poor education has to be viewed as both causes and consequences of drug abuse. 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, however, contributed to somehow differentiate a highly undifferentiated view on drug abuse by the general public.

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 supports this statement.

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

Fig. 4.1.a.1 Educational level of RELIS respondents (2001)

Housing status of registered drug users has improved for the last 6 years, 66 percent of PDUs reported a stable housing situation. This positive evolution may be linked to an increased awareness of the housing problem and the set up of new housing networks for socially deprived people by specialised agencies. One could refer for instance to a project retained by the national drug action plan 2000 - 2004. The project called ‘Les Niches’ functions as a social real estate agency for drug addicts. Flats and apartments are rented by a drug-counselling centre and provided to drug addicts in need by means of tailor made renting contracts. One of the medium term aims of the project is to allow demanding drug addicts to take over the renting contract on basis of their own financial means and thus dispose of a stable accommodation.
68 per cent (72%) of respondents reported **current or past drug abuse within their family of origin** and 81% 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 and may show a stabilisation around approximately 50 % in 2001.

Data on revenues confirm observed trends in occupational status:

- weakening of **financial autonomy** associated to an increasing social dependency (e.g. Guaranteed Minimum Income: 33%);
- illegal activities and **revenues** have seen a downward trend that has stabilised since 1998.
- the proportion of respondents reporting **major depths** (>2,500 EURO) (44%) has stabilised at a high level.
4.2 Drug offences and drug-related crime

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

Definition of legal concepts and law enforcement interventions

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

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

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

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

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

- ‘Détention’ (Eng. Imprisonment) : Deprivation of liberty. Distinction is made between protective custody (prior to the judgement) and regular detention (following conviction).
a. Drug related arrests data

As can be seen in tables 4.2.a.1-2, the total number of arrests (92) has decreased compared with previous years. The observed decrease, however, is subtle and might rather be interpreted as a stabilisation. Heroin is the main substance involved in drug-related arrests, followed by cocaine and cannabis. Simultaneous use and traffic appears to be the most frequent charge.

### Table 4.2.a.1  Arrests broken down by type reporting institution (1995-2001)

<table>
<thead>
<tr>
<th>Year</th>
<th>95</th>
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<th>97</th>
<th>98</th>
<th>99</th>
<th>2000</th>
<th>2001</th>
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<td>154</td>
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<td>108</td>
<td>117</td>
<td>92</td>
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</table>

### Table 4.2.a.2  Arrests broken down by type of offence and substances involved (1995-2001)

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<td>18</td>
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<td>8</td>
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<td>17</td>
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<td>Traffic/Deal</td>
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</tr>
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<td>Use</td>
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<td>2</td>
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</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>4</td>
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<td>Ecstasy (MDMA, etc.)</td>
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</tr>
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</tr>
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<td>6</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>1</td>
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<td>LSD</td>
<td>Use &amp; Traffic</td>
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<td></td>
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</tr>
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<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### Source
Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2001.
b. Prosecution data

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP), stable between 1996 and 1998, shows an important increase from 1998 onwards (2001:1,455). 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 1,776 drug law offenders in 2001. The number of arrests on the same charge has decreased from 154 in 1997 to 92 in 2001 (see table 4.2.b.1). This latter trend may be partly due to the decimalisation of cannabis by the modified drug law of 27 April 2001 and the subsequent law enforcement response.

Table 4.2.b.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), Police and Board of Customs from 1995 to 2001. One should emphasise that the Gendarmerie and the Police have merged into a single force in 2000, namely the Grand Ducal Police.

<table>
<thead>
<tr>
<th>Year</th>
<th>S.P.J.</th>
<th>Gendarmerie</th>
<th>Police&lt;sup&gt;16&lt;/sup&gt;</th>
<th>Customs&lt;sup&gt;16&lt;/sup&gt;</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>123</td>
<td>117</td>
<td>137</td>
<td>238</td>
<td>258</td>
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<tr>
<td>1996</td>
<td>198</td>
<td>137</td>
<td>265</td>
<td>343</td>
<td>339</td>
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<td>1997</td>
<td>198</td>
<td>232</td>
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<td>359</td>
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<tr>
<td>1998</td>
<td>198</td>
<td>232</td>
<td>265</td>
<td>782</td>
<td>489</td>
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</tbody>
</table>

Source: Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 88% (85%) males; a proportion that has been varying between 79 and 89% during the past decade. Since 1995, non-natives have been representing the majority of drug law offenders (52-63%). In 2001, however, non-natives only represented 48% of the total population of ‘prévenus’. The proportion of first drug law offenders has stabilised around 35% for the last three years. The percentage of minors (< 18 years) among drug law offenders has increased since 1993 (3%) (2001: 9.2%).

Table 4.2.b.2 Socio demographic data on ‘prévenus’ (1986-2001)

<table>
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<tr>
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<th></th>
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<td>3</td>
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<td>27</td>
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<tr>
<td>15-19</td>
<td>121</td>
<td>212</td>
<td>179</td>
<td>320</td>
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<td>270</td>
<td>249</td>
<td>415</td>
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<tr>
<td>20-24</td>
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<td>447</td>
<td>321</td>
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<td>TOTAL</td>
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<td>1,137</td>
<td>1,071</td>
<td>1,531</td>
<td>1,174</td>
<td>1,368</td>
<td>1,170</td>
<td>1,939</td>
<td>1,758</td>
<td>1,776</td>
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</table>

Source: Specialised Drug Department of the Judicial Police

<sup>16</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/dossi/rapact2001/index.html](http://www.gouvernement.lu/gouv/fr/dossi/rapact2001/index.html)
Table 4.2.b.3 Type of drug law offences broken down by substances involved (1999-2001)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Offence</th>
<th>1999 (N)</th>
<th>1999 (IVDUs)</th>
<th>2000 (N)</th>
<th>2000 (IVDUs)</th>
<th>2001 (N)</th>
<th>2001 (IVDUs)</th>
</tr>
</thead>
<tbody>
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<td>Heroin</td>
<td>Use &amp; Traffic</td>
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<td>193</td>
<td>113</td>
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</tr>
<tr>
<td></td>
<td>Traffic</td>
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<td>57</td>
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<td>43</td>
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<td></td>
<td>Use</td>
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<td>599</td>
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<td>45</td>
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<td>21</td>
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<td>25</td>
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<td>31</td>
<td>17</td>
<td>61</td>
<td>54</td>
<td>6</td>
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<tr>
<td>Cannabis</td>
<td>Use &amp; Traffic</td>
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<td></td>
<td>195</td>
<td></td>
<td>171</td>
<td>12</td>
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<td>8</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use</td>
<td>5</td>
<td></td>
<td>3</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total number of 'interpellation' motives independently of involved substances</td>
<td>Use &amp; Traffic</td>
<td>90</td>
<td>295</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>209</td>
</tr>
<tr>
<td></td>
<td>Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>382</td>
<td>1,258</td>
</tr>
<tr>
<td>Total</td>
<td>Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>472</td>
</tr>
<tr>
<td>Total number of 'prévenus'</td>
<td>Use &amp; Traffic</td>
<td>1,939</td>
<td>1,758</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,776</td>
</tr>
</tbody>
</table>

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP 1999-2001)

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.b.4 Distribution of ‘prévenus’ according to first offence and underage status (1992-2001)

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

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2001.

Table 4.2.b.5 Distribution of first offenders (use and use/traffic) and substance involved ad minima (1992-2001)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk substance involved ad minima</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>162</td>
<td>91</td>
<td>154</td>
<td>170</td>
<td>121</td>
<td>104</td>
<td>109</td>
<td>157</td>
<td>133</td>
</tr>
<tr>
<td>Cocaine</td>
<td>64</td>
<td>15</td>
<td>39</td>
<td>46</td>
<td>34</td>
<td>20</td>
<td>30</td>
<td>60</td>
<td>37</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>5</td>
<td>0</td>
<td>15</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>18</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Type 'Ecstasy'</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>47</td>
<td>20</td>
<td>26</td>
<td>26</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Illicitly acquired medicaments</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Illicitly acquired substitution substances</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
c. Convictions data and court sentences for drug offences

No data available.

d. Imprisonment for drug-related crime

The Grand Duchy of Luxembourg counts two state prisons; one situated in the vicinity of Luxembourg-City (CPL) and the other in the North of the country (CPG). The proportion of prison sentences for drug law offences has been decreasing since 1998. In 2001, 119 new entries (18.6 %) (1997: 36%) in national penal institutions referred to the ‘DELIT- STUP’ (Drug law offence) codes have been reported (of a decreasing number of entries in 2001: 641). The referred trend reflects the decreasing number of drug-related arrests previously reported.

Table 4.2.d.1 Prison entries for drug offences (1989 – 2001)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New prison entries (Total)</td>
<td>713</td>
<td>685</td>
<td>858</td>
<td>796</td>
<td>859</td>
<td>767</td>
<td>641</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New entries of drug law offenders</td>
<td>163</td>
<td>244</td>
<td>277</td>
<td>157</td>
<td>246</td>
<td>288</td>
<td>296</td>
<td>292</td>
<td>309</td>
<td>167</td>
<td>139</td>
<td>161</td>
<td>119</td>
</tr>
</tbody>
</table>


![Fig.4.2.d.1 New prison entries and new drug law offenders admitted to prison (1989-2001)](source)


e. Drug-related crime

The data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences’ items: The following results are worth to be retained for 2001:

- 92% of drug users indexed² by specialised health care institutions have already been in conflict with law enforcement agencies during lifetime. 79% of the total PDU population show multiple law enforcement contacts.

² 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
drug law (e.g. petty crime) has been decreasing since 1997 (38%), and has stabilised in
2001(17%). The extension of substitution treatment and the intensification of socio-
economic reintegration measures appear to have contributed to the currently observed
situation.

76% (9) of indexed PDUs have already served at least one prison sentence during
lifetime. The proportion of PDUs having served more than one prison sentence at the
time of reporting (36%) is still on the increase.. 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.

4.3 Social and economic costs of drug consumption

See Key issue 14.

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. Transit
seizures have indeed been increasing during the last 3 years.

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. Quantities of seized heroin and cocaine have been showing a discontinuous but
overall decreasing trend from 1996 onwards. Significant variations are mostly due to
irregularly occurring transit seizures. Seizures of heroin destined to the national market are
far lower and more stable in terms of quantities (1.351 kg in 2001).

Cannabis still is the most seized substance in terms of number of seizures. Quantities of
seized cannabis as reported by Police and Customs have also been increasing since 1998.
In 2000 and 2001 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 490 as well as the number of offenders involved has marked an
increase from 242 to 668.

Notwithstanding the quantities seized, the number of seizures has grown discontinuously
since 1993 (2001: 960). The number of cocaine and ecstasy like substances' seizures has
stabilised and one observes a moderate but continuous increase of amphetamines seizures since 1997, which however has not been confirmed by 2001 data. The total number of offenders involved in drug seizures has known a steep increase from the mid-nineties towards 1999 and currently seems to stabilise (1,168 offenders in 1999 and 1,071 in 2001).

The number of persons involved in heroin traffic has been following a general upward trend, reaching 674 offenders 2001. Summarily, quantities of seizures have been decreasing since 1996, while the number of persons involved has shown a significant increase until 1999. The development of distribution micro networks may partly contribute to the current situation. 64 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. A major transit seizure occurring in 2001 (40.000 pills) does distort the observed trend since the 272 pills destined to the national market seized in 2001 reflects the figures of previous years.

---

**Fig. 5.2.1 Total quantity of seizures: heroin, cocaine, ecstasy (1990 - 2001)**

Source: Specialised Drug Department of the Judicial Police 2001

**Table 5.2.1 Number and quantities of drug seizures – TOTAL (Police & Customs) 1997-2001**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Unit</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hashish</td>
<td>kg</td>
<td>57</td>
<td>0.868</td>
<td>44</td>
<td>1.974</td>
<td>115</td>
</tr>
<tr>
<td>Manhuana</td>
<td>kg</td>
<td>133</td>
<td>34.787</td>
<td>190</td>
<td>4.956</td>
<td>255</td>
</tr>
<tr>
<td>Plants</td>
<td>units</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>222</td>
<td>5</td>
</tr>
<tr>
<td>Heroin</td>
<td>kg</td>
<td>237</td>
<td>2.525</td>
<td>189</td>
<td>3.592</td>
<td>306</td>
</tr>
<tr>
<td>Cocaine of which crack</td>
<td>kg</td>
<td>54</td>
<td>8.983</td>
<td>22</td>
<td>5.995</td>
<td>56</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>gr</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>66</td>
<td>5</td>
</tr>
<tr>
<td>Ecstasy type</td>
<td>pills</td>
<td>12</td>
<td>367</td>
<td>22</td>
<td>145</td>
<td>10</td>
</tr>
<tr>
<td>-----------------</td>
<td>------</td>
<td>--------</td>
<td>---------------</td>
<td>--------</td>
<td>---------------</td>
<td>--------</td>
</tr>
<tr>
<td>Cannabis (total)</td>
<td>kg</td>
<td>96</td>
<td>3.165</td>
<td>64</td>
<td>3.398</td>
<td>110</td>
</tr>
<tr>
<td>Hashish</td>
<td>kg</td>
<td>38</td>
<td>0.648</td>
<td>20</td>
<td>1.587</td>
<td>41</td>
</tr>
<tr>
<td>Marihuana</td>
<td>kg</td>
<td>58</td>
<td>2.517</td>
<td>44</td>
<td>1.811</td>
<td>69</td>
</tr>
<tr>
<td>Plants</td>
<td>units</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Heroin</td>
<td>kg</td>
<td>152</td>
<td>1.055</td>
<td>73</td>
<td>0.680</td>
<td>86</td>
</tr>
<tr>
<td>Coclaine of which crack</td>
<td>kg</td>
<td>44</td>
<td>3.043</td>
<td>10</td>
<td>1.525</td>
<td>27</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>gr</td>
<td>1</td>
<td>0.5</td>
<td>3</td>
<td>21.5</td>
<td>2</td>
</tr>
<tr>
<td>Ecstasy type</td>
<td>pills</td>
<td>6</td>
<td>16</td>
<td>7</td>
<td>49</td>
<td>1</td>
</tr>
<tr>
<td>LSD</td>
<td>doses</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Psilocybin</td>
<td>gr</td>
<td>1</td>
<td>57.6</td>
<td>2</td>
<td>295</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td>ml</td>
<td>4</td>
<td>940</td>
<td>9</td>
<td>955</td>
<td>2</td>
</tr>
<tr>
<td>Mephenon pills</td>
<td>pills</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>71</td>
</tr>
</tbody>
</table>

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: 9.2 €/gram, marijuana: 7.1 €/gram) and brown heroin, on the decrease (70 € /gram). Heroin is frequently sold as ‘boulette (meat ball)’ containing 0.3 grams for 25. - euros. Typical street retail cannabis is sold in pieces of 2.5 to 3 grams for 25. - euros. Ecstasy retail prices tend to decrease.

Table 5.3.1 Price per unit evolution at the street level (1994-2001)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Price</td>
<td>Price</td>
<td>Price</td>
<td>Price</td>
<td>MIN.</td>
<td>MAX.</td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
<td></td>
<td>MEAN</td>
<td></td>
</tr>
<tr>
<td>Hashish</td>
<td>5 – 6</td>
<td>5 – 6</td>
<td>5 – 6</td>
<td>7.4</td>
<td>6.7</td>
</tr>
<tr>
<td>Marijuana</td>
<td>2.5 – 3</td>
<td>6.2</td>
<td>6.7</td>
<td>7.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Cocaine</td>
<td>100 – 150</td>
<td>100 – 150</td>
<td>120 – 170</td>
<td>90</td>
<td>74.4</td>
</tr>
<tr>
<td>Heroin</td>
<td>65 – 150</td>
<td>65 – 150</td>
<td>90 – 150</td>
<td>90</td>
<td>50</td>
</tr>
<tr>
<td>(brown)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy</td>
<td>9 – 13</td>
<td>12.4</td>
<td>8.7</td>
<td>12.4</td>
<td>10.7</td>
</tr>
</tbody>
</table>


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 2001, revealed the following margins of purity of active substance: brown heroin: 13.62 per cent; cocaine: 56.09 per cent (θ); hashish (THC): 7.12 per cent (θ). In 2001, toxicological analysis of samples sold as ecstasy showed margins ranging from 35.61 to 109.75 mg of active substance (mostly MDMA) in analysed pills.

Table 5.3.2 Purity of drugs at street level (1994-2001)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MIN.</td>
<td>MAX.</td>
<td>MEAN</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Purity (%)

<table>
<thead>
<tr>
<th>Substance</th>
<th>MIN.</th>
<th>MAX.</th>
<th>MEAN</th>
<th>MIN.</th>
<th>MAX.</th>
<th>MEAN</th>
<th>MIN.</th>
<th>MAX.</th>
<th>MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis Hashish Marijuana</td>
<td>60-90</td>
<td>2</td>
<td>5.13</td>
<td>3.46</td>
<td>2.65</td>
<td>11.7</td>
<td>8.03</td>
<td>2.3</td>
<td>12.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>60-90</td>
<td>60-85</td>
<td>45.8</td>
<td>88.76</td>
<td>70.66</td>
<td>28.3</td>
<td>92.2</td>
<td>60.25</td>
<td>24.95</td>
</tr>
<tr>
<td>Heroin (brown)</td>
<td>15-23</td>
<td>17-25</td>
<td>7.2</td>
<td>27.7</td>
<td>12.17</td>
<td>2.8</td>
<td>54.9</td>
<td>17.59</td>
<td>3.9</td>
</tr>
<tr>
<td>Ecstasy type</td>
<td></td>
<td></td>
<td>18.7</td>
<td>52.3</td>
<td>35.5</td>
<td>35.61</td>
<td>109.75</td>
<td>67.25</td>
<td></td>
</tr>
</tbody>
</table>

**Sources:** Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2001.

Purity: For cocaine, heroin and amphetamines, purity is expressed in percentages of pure active substance at the street level. For cannabis, purity refers to percentage of THC. For ecstasy-type substances, purity refers to percentage of MDMA-HCL in relation to total mass in 2000 and to mg of active substance per pill in 2001.

---

### 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 **mean age 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 (9) 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. (1995-2001)

<table>
<thead>
<tr>
<th>Preferential substance</th>
<th>Primary drug</th>
<th>Secondary drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95 97 99 00</td>
<td>2001</td>
</tr>
<tr>
<td>CANNABIS AND DERIVATIVES</td>
<td>5 4 3 7 11</td>
<td>20 14 24 26 28</td>
</tr>
<tr>
<td>N</td>
<td>405 237 677 731 724</td>
<td>362 229 440 530 561</td>
</tr>
</tbody>
</table>

**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 PDUs.
**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>
<thead>
<tr>
<th>Preferential substance</th>
<th>Primary drug</th>
<th>Secondary drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95 97 99 2000 2001</td>
<td>95 97 99 2000 2001</td>
</tr>
<tr>
<td>LSD</td>
<td>3 3 1 1</td>
<td>3 3 1 1</td>
</tr>
<tr>
<td>ECSTASY-TYPE</td>
<td>1 1 2 1 3</td>
<td>4 6 4 4 4</td>
</tr>
<tr>
<td>STA</td>
<td>1 1</td>
<td>4 1 2 3</td>
</tr>
<tr>
<td>N</td>
<td>405 237 677 731 724</td>
<td>362 229 440 530 561</td>
</tr>
</tbody>
</table>

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.
Figure 6.2 Seizures Amphetamines, Ecstasy, LSD (1988 - 2001)

![Graph showing seizures of Amphetamines, Ecstasy, and LSD from 1988 to 2001.](image)

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2001.

### Heroin / Opiates

Latest 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 76 per cent ( []) of indexed PDUs. 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 three-years decrease reaching 22% in 2001. Intravenous heroin use as primary consume pattern has stabilised (47%). 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 5 years. For instance, 42 per cent (1998: 39.5%) of current PDUs (2001) were still underage (< 18 years) as they have first injected opiates.

### Table 6.3 Preferential drug consume of problem drug users – Opiates. Valid percentages. (1995-2001)

<table>
<thead>
<tr>
<th>Preferential substance</th>
<th>Primary drug</th>
<th>Secondary drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEROIN / OPIATES (i.v.)</td>
<td>64</td>
<td>70</td>
</tr>
<tr>
<td>HEROIN / OPIATES (other route)</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Other opiates</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>405</td>
<td>237</td>
</tr>
</tbody>
</table>

Source: RELIS 2001
Seizure data: Important variations have been observed with regard to heroin and other opiates’ seizures. A decrease of the number of seizures since 1999 is worth to be mentioned. Quantities seized do not allow to detect a consistent trend since 1996.

**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 2001 data. Crack use is insignificant at each preference level.

**Table 6.4** Preferential drug consume of problem drug users – Cocaine. Valid percentages. (1995-2001)

<table>
<thead>
<tr>
<th>Preferential substance</th>
<th>Primary drug</th>
<th>Secondary drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>COCAINE (i.v.)</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>COCAINE (other route)</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

**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 7 years (except in 1998). No seizure of crack has been reported thus far by national authorities.
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.

RELIS data from 2001 have shown that up to 83 per cent (1999: 82%) of drug treatment demanders are multiple-drug users. The referred rate has shown great stability since the set up of the drug monitoring system. Alcohol and tobacco use is associated to the profile of a vast majority of multiple-drug users. Solvent use appears to be very low, which may be linked to a fairly high purchase power of Luxembourg’s youngsters compared to other countries.

7 Discussion

7.1 Consistency between indicators

Major efforts have been made during the last years as to the quality of RELIS data, and their cross validation with other national data sources. 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. The most striking example might be seen in the increasing cannabis use prevalence in all target groups.
Special attention has to be paid to the relation between the **significantly increasing number of distributed injection materials** in the framework of the national needle exchange programme and the observed stabilisation of **intravenous PDUs prevalence** (Orger 2002). One should however refrain from a linear causality interpretation since increasing syringes distribution and recollecting may be linked to the actual development of needle exchange facilities and target harm reduction priority setting (which happens to be the case in Luxembourg).

**Infectious disease** rates in problem drug users have been compared to the results of a highly representative study in prison population published in 1999 (Schlink 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 since the beginning of more structured monitoring routines. The **number of drug law offenders** (‘prévenus’) has also increased during the same period. 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 Methodological limitations and data quality

Data on **non-specialised treatment** and counselling agencies or units are scarce since separate indexing of drug patients does 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 2001, the national prison administration has joined the RELIS network, thus providing RELIS configured data on new PDUs’ prison entries.

Some RELIS items had to be reformatte in the light of international data requirements and incompatible national data formats, which generated problems in terms of data comparison. Another limitation in data quality might be attributed to self-reported items such as infectious disease status. Self-reports could lead to underestimation of infection rates amongst PDUs.

A major achievement during year 2001 has to be seen in the full operationnality 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.

GPs are known to be difficult to include in any drug monitoring system. A step-by-step approach has allowed the NFP to involve 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:

- Maintenance of reporting system coverage at the inter institutional level;
- Inclusion of general practitioners and emergency rooms in the information network
- 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;
- Improvement of infectious disease data (switch from self-reports to diagnosis data)
- Compatibility of drug-related death registers and implementation of the DRD standard – ICD-10 (in progress);
- Access to court data;
- Increase of data sources and implementation of a data transmission protocol in the framework of the early warning system on synthetic drugs.
- Gender specific and ethnical research
PART III
DEMAND REDUCTION INTERVENTIONS
8 Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

The Ministry of Health is in charge of the coordination of drug demand reduction measures.

The strategic framework of drug demand reduction interventions has been defined by the national drug coordinator, appointed in 1999 by the Minister of Health, by means of an action plan on drugs and drug addiction covering the period 2000 to 2004. The drug action plan relies on six intervention areas, namely: primary prevention, outpatient counselling facilities, detoxification services, inpatient therapeutic centres, post-therapeutic measures and low threshold services. A special division for social medicine and drug addiction is about to be implemented within the Directorate of Health. 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.

The role of the Interministerial Group on Drugs, currently chaired by the Ministry of Health, has been enhanced in order to guarantee an overall coordination of demand and supply reduction policies.

8.2 Approaches and new developments

a) New and innovative approaches

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.

In terms of secondary and tertiary prevention emphasise is currently laid on harm reduction measures, diversification of treatment offers, double diagnostics, expansion and regulation of substitution treatment and housing projects associated to socio-professional reintegration programmes.

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

b) Socio-cultural developments relevant to demand reduction

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 four 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.

c) Developments in public opinion

General public perceives primary prevention measures as the most important strategies towards drug demand reduction. Increasing concern is felt in respect to the availability and easy accessibility of drugs in schools environments. The strong adherence to more traditional concept makes intricate the current approach towards the development of risk and harm reduction measures. These measures are seen as complementary to primary prevention offers by policy makers and professionals and not as a replacing alternative. Yet, the disproportional costs related to the initial implementation of shooting galleries or heroin distribution facilities for instance, compared to ongoing prevention activities often leads to biased public debates on the sustainability of such projects. The message to be transmitted to the general public relies on the idea that a viable drug strategy has to be based on complementary and target group-oriented interventions defined by the current situation of
each involved person, even though this could mean that innovative yet questionable strategies have to be implemented.

d) New research findings

In 2001 the CePT released a synthesis document on cannabis use (CePT 2000), which included an analysis of the legal status and implications of cannabis use following the amendment of the basic drug law (1973) in 2001. The document is to be seen as a reaction to an obvious confusion in general public about concepts such as decriminalisation, depenalisation and legalisation, enhanced by the long debates in parliament.

Worth mentioning is the first comprehensive evaluation report on the national substitution programme (Dellucci 2002) and the recent study on direct economic expenditures in the field of drug policies and interventions (Origer 2002) Results are reported in chapter 11 and 14 respectively.

Furthermore a comparative study on drug-related mortality (Origer and Dellucci 2002) has been published in 2002. A summary of results has been reported in chapter 3.

e) Specific events during 2001 and 2002


June 2001 (15 & 16): Motivation workshop for volunteers in the field of primary drug ‘Prevention needs volunteers!-Volunteers need…!?’ organised by CePT and ZePF

July 2001 (2.-7.): IRON TEAM – a trans-border Rally for youngsters.

Juli 2001: Cabaret on the theme of drug use « Hey, das geht gut rein » by Jemas Solo organised by a local drug prevention group.

Juli 2001: Conference by Dr Bernhard Spitzer on: ‘Drug in society – Modern approaches towards drug therapy’.

October 2001 (17): Conference by Mme Teresa GARCIA on: ‘Youngsters – law offenders, drug users, trespassing limits’ organised par Caritas Luxembourg and MSF.

December 2001: CePT launched the joint campaign ‘No alcohol to youngsters under 16’.

December 2001: Launch of media campaign: ‘What’s what? Drugs’n more › by SNJ and CePT.

April 2002 (17): Round table on: Professional secret and drug care, organised by SPOS and CePT.

9 Prevention

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/

a) Organisation and co-ordination within national structures

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.

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. The national drug coordinators office as well as the NFP are implemented within the AST department. The AST has coordination and financial control missions (supervision of financial contract implementation of subsidised NGOs) in the field of drug addiction and psychiatry. Furthermore, the national drug coordinator is responsible for the conceptualisation and the implementation of activities included in the drugs action plan 2000 – 2004 (see 1.1).

b) National Strategy

An example of collaboration between the AST and the CePT may be seen in the recent set up of a national drug prevention action plan jointly with the drug coordinator since the latter is in charge of the overall national drug action plan 2000 – 2004. The first version of the national drug action did not include primary prevention aspects since priority was given to the set-up of lacking care facilities. In a second phase, primary prevention action priorities were submitted to the Minister of Health for approval.

Following priorities of the yet to be approved primary prevention action plan are as follows:

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

**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.

c) **Expenditures on drug prevention**

According to Origer (2002) the sum of drug prevention expenditures during 1999 reached 583,000.- euros and 672,000.- euros in 2000. This figure includes staff and operating costs of agencies and ministerial department **specialised** in drug prevention. The total expenditure has known a slight increase in 2001 mainly due to an increase in financial resources allocated to the CePT. If the drug prevention action plan previously mentioned is approved, the budget related to primary drug prevention will know a significant raise in 2003

### 9.1 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 1996, 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. 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 2001, CePT in collaboration with the pedagogical innovation department of the Ministry of Education has further developed a project called ‘d’Schoul op der Sich’ (**School on quest**) (see EDDR). 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.

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18 The exact estimation of prevention related costs is hazardous since multiple factors influence the development of a youngster. Education, leisure activities, sport, etc may have a positive impact on resources building, they however can not be quantified in terms of exclusive input.
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. The CePT is providing training on site interventions and documentation to participating schools. The project has started in 2000 and will be concluded in 2003.

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.

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

The project ‘OUT-TIME’ jointly implemented by the CePT and the SNJ links drug prevention to adventure pedagogical instruments and focus on pupils in 5th and 6th classes of primary schools. Target groups are educational staff, pupils and parents. The methodology of the project is based on the hypothesis that youngsters who are physically in a good shape, are mentally challenged and who can rely on stable orientation marks such as empathic parents show a lower probability to use (abuse) drugs. On the other hand youngsters are in quest of stimulation, excitation, challenges, competition and limits. A possible way to do drug prevention could therefore consist in providing opportunities for the latter experiences in a secured framework so as to transmit the message that all these emotions can be reached without using drugs. Stress and frustration management, experience of personal limits, relaxation after physical and mental efforts are some of the targeted experiences During 2001, 14 primary school classes have participated in the project which takes place in a Youth centre in the countryside. The ‘OUT-TIME project has been evaluated by the University of Koblenz. On basis of the evaluation results it has been decided to prolong the project for another year.

9.2 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, Game boys, Play Stations, Pokémen, 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 and 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). Currently regional teams specialised in drug prevention meet in a autonomous working and training group that reports to the Mondorf Group. 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.

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

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

Training interventions in drug demand reduction are increasingly developed at the national level. The CePT publishes an annual training directory including training activities ranging from evaluation methodologies to demand reduction action-research strategies. The Department for Scientific and Applied Research may finance training activities following request.

The CePT provides training targeted at drug prevention and public health actors, educators, youth animators and teachers in the fields of primary prevention, intervention methodologies, evaluation strategies and multiplicator training.

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 conventional 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.

### 9.3 Family and childhood

Even though interventions aiming at the promotion of positive life experiences within the family and the Kindergarten are not expressively addressed in the national drug prevention action plan, there are 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 lucid material destined to potential multipliers as for instance teachers, parents...
and youth animators. The first prevention box, targeting 3 to 5 years old children has been released in September 2001. Due to its success, the 3-5 years prevention box will be reedited and a second one for children aged 11 to 15 years is about to be released.

Information campaigns on drugs organised by the CePT or/and the Division of Preventive Medicine (Directorate of Health) generally reach parents though 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.

9.4 Other programmes

a) Description of interventions

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 and the Ministry of Health, has been inaugurated by the CePT on the 1st of October 1995.

The anonymous 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 and 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.

<p>| Table 9.4.a.1 Client core statistics of national drug help line (1997-2001) |
|----------------------------------|---|---|---|---|---|
| Number of calls                  | 1997 | 1998 | 1999 | 2000 | 2001 |
| Gender                           |      |      |      |      |      |
| male                             | 40%  | 50%  | 36%  | 37.4%| 61.8%|
| female                           | 60%  | 50%  | 64%  | 62.6%| 38.2%|
| Self implied demander status     |      |      |      |      |      |
| alcohol                          | 39%  | 50.5%| 42.5%| 46.8%| 16.2%|
| pharmaceutics                    | 38%  | 40.6%| 29.3%| 41.7%| 19.5%|
| heroin/cocaine                   | 12%  | 10.9%| 13.3%| 8.3% | 6.4% |
| cannabis                         | 9%   | 6.5% | 11%  | 7.5% | 7.1% |
| nicotine                         | 1%   | n.a. | 2%   | 1.4% | 1.5% |
| ecstasy type                     | 0.5% | 2.8% | 0.5% | 1.2% | 0.5% |
| other                            | 0.5% | n.a. | 1.4% | 1.8% | 12.6%|</p>
<table>
<thead>
<tr>
<th>Age distribution</th>
<th>&lt; 11</th>
<th>12-15 years</th>
<th>16-19 years</th>
<th>20-24 years</th>
<th>25-30 years</th>
<th>31-40 years</th>
<th>41-50 years</th>
<th>&gt; 50 years</th>
<th>unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.1%</td>
<td>0.7%</td>
<td>2%</td>
<td>5%</td>
<td>4.5%</td>
<td>26%</td>
<td>57%</td>
<td>4.7%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0.8%</td>
<td>2%</td>
<td>2%</td>
<td>7.2%</td>
<td>40.6%</td>
<td>34.8%</td>
<td>12.6%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0.5%</td>
<td>2.6%</td>
<td>4%</td>
<td>9%</td>
<td>26.5%</td>
<td>42.6%</td>
<td>14.8%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0.5%</td>
<td>1.8%</td>
<td>2%</td>
<td>7.8%</td>
<td>14.2%</td>
<td>49%</td>
<td>9.7%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>1.7%</td>
<td>3.5%</td>
<td>7.6%</td>
<td>14.5%</td>
<td>51.3%</td>
<td>9.5%</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

Source: CePT 2001

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 and 150 volunteers are currently involved in the project. The funding of this community project is jointly ensured by the involved district councils, the EU (Drug Prevention Programme DG-V) and CePT.

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

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

During 2001 the local prevention groups organised the following activities:

- Conferences and seminars
- Theatre and cabaret
- School interventions
- Prevention boxes’ diffusion
- Campaign against alcohol
- Leisure and holiday activities
- Editing of newspaper articles

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

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. In 2001 the ZePF was commissioned to evaluate the alcohol campaign. The evaluation report has been published in 2002 (Fischer 2002) (see key issue 15)

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 (2002-2004) 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. The referred campaign will also address the use of pharmaceuticals products.

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.

Internet

The use of new information technologies as for instance Internet in the field of drug demand reduction has significantly developed in recent years. Prior to 2000 only few field agencies had access to Internet or operated a proper home page. The NFP maintains an Internet
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).

b) Research projects and evaluation results

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.

CePT is mostly involved in drug prevention 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. In 2001, there have been no research projects specifically aiming at drug prevention. Evaluation activities are addressed in respective chapters.

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.

The majority of drug demand reduction research relies on public funding. 'Conventional' 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.

10 Reduction of drug-related harm

a) Role of harm reduction within the national drug policy strategy

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 PDU 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. 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.

b) Harm reduction practice

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

Objectives of HR interventions are straightforward, that is a better management of risk factors and damage associated to drug use and a reduction of public nuisance. Traditionally HR measures have been focusing on IVDUs since most exposed to a variety of health risks. Nevertheless, initiatives such as the provision of aluminium foils to heroin users and the current discussion on the future distribution of ‘strawbags’ for sniffing purposes witness a slowly developing change in the definition of target groups. Furthermore infectious diseases prevention does not focus specifically on IVDUs as shows a new action-research project on HIV and Hepatitis infection among PDUs staring by the end of year 2002.

HR teams are mainly composed of social workers, nurses and GPs. The budget 2001 of the Ministry of Health foresees a 100% increase of HR staff in the framework of the set-up of shooting galleries and controlled heroin distribution.

c) Range of services

The following HR services do currently exist at the national level:

- Needle exchange programme (provision of syringes, ascorbic acid, filters, aluminium foils, condoms, etc.)
- Street and outreach work
- Low threshold contact centres
- Injection rooms (financing ensured and currently under construction)
- Medical controlled heroin distribution program (financing ensured but not yet implemented)

d) Networking between HR professionals
e) Co-ordination of national policies and local practice

Actors of the national HR intervention network are closely linked, partly due to the fact that most of involved institutions also provide other types of services. The overall coordination of HR activities is ensured by the Ministry of Health via the national drug coordinator and the so-called coordination platforms, which include representatives of the involved conventioned agencies and a delegate of the Ministry of Health. Furthermore, a ‘drugs agencies group’ meets monthly in order to share experiences and find common solutions. A practical example

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19 A ‘straw bag’ contains one-way straws especially designed not to hurt the nasal cavities, thus avoiding wounds and bleeding, a special liquid to smooth tissues, a professional condom and lubricants.
of networking and coordination mechanisms might be seen in the conceptualisation of the national drugs action plan. Political priorities have been clearly presented to involved field agencies that had the opportunity to actively collaborate in the design of specific actions and strategies.

f) Expenditures on specific harm reduction projects

Table 10.f.1 summarises direct expenditures on selected harm reduction intervention referred to year 2001:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Breakdown</th>
<th>Cost in Euros</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle exchange</td>
<td>Provision of syringes</td>
<td>300,000. -</td>
</tr>
<tr>
<td>Low threshold services</td>
<td>ABRIGADO KONTAKT 25</td>
<td>439,000. -</td>
</tr>
<tr>
<td></td>
<td></td>
<td>194,000. -</td>
</tr>
<tr>
<td>Injection room % night shelter centre</td>
<td>Construction Staff</td>
<td>1,735,000. -</td>
</tr>
<tr>
<td></td>
<td></td>
<td>142,000. -</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>268,481,000. -</td>
</tr>
</tbody>
</table>

Source: Origer 2002

10.1 Description of interventions

a. Outreach work in recreational settings

Outreach work (OW) is defined as measures aiming at contacting target groups in their own environment. Recreational settings are referred to as leisure context not defined by a specific population (e.g. PDUs excluded).

Outreach work in recreational settings is fairly limited and needs further development. Most of OW is target to problematic drug populations as injectors for instance. Several services (JDH, ABRIGADO, etc.) provide outreach services. 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 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 population.

The national AIDS prevention agency (AIDSBERODUNG – Red Cross), established in 1988, and convectioned 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).

As far as recreational settings are concerned, CePT has launched in the beginning of 1995, a pilot project on community-based drug prevention (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.

b. 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 led to a clearly increased user rate since 1994. Regarding the quantity of distributed syringes table 10.1.b.1 shows an increase of 294 per cent during the period 1996 to 2001. 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.

<table>
<thead>
<tr>
<th>Table 10.1.b.1 National needle exchange programme 1996-2001</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distributed syringes</strong></td>
</tr>
<tr>
<td>76,259</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
<tr>
<td>(38%)</td>
</tr>
</tbody>
</table>

Source: RELIS 2002

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 (RED CROSS), is the main national counselling and prevention centre for HIV and AIDS. Prevention campaigns or conceptualised by the AIDSBERODUNG team in collaboration with an important network of volunteers. The proportion of i.v. drug users in HIV positive clients has been increasing over the last 4 years (e.g. 2001: 26% / 1998: 19%). Moreover, outreach interventions targeted at (drug using) prostitutes aiming to establish contact and to prevent dissemination of infectious diseases have taken place.

Facing an increasing rate of drug users within its clients, AIDSBERODUNG has joined the RELIS network in 2001. In the framework of the World Aids day (1.12.2001) AIDSBERODUNG in collaboration with the Division of Preventive Medicine (Directorate of Health) have launched a national media campaign called ‘Don’t stop passion, stop AIDS’. Special attention is paid to peer education in the framework of an interactive prevention game called: ‘Roundabout AIDS’
According to EMCDDA’s key indicators and with a view to improve quality of national data on infectious diseases, the NFP has set up an **action-research plan** (2001-2003) with the objective to estimate HCV and HIV prevalence in recent drug injectors based on medical diagnosis data (blood sample testing) and to implement required health care infrastructures. The provisional budget of the project is estimated at 25.000. - EUR. The NFP has been granted a full financing of the project by the FLTS. In October 2002 the project has been approved by the National Ethics Committee on Research.

**c. Prevention of drug related overdoses**

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

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

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

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

- A majority of drug-related deaths cases (direct & indirect) are **natives** (64.6 to 90.9%). The same observation applies to direct and indirect drug deaths analysed separately. The **non-native** subpopulation of victims is primarily composed of Portuguese citizens, which proportion is much higher than the one observed in the general population. Italians follow Portuguese natives and citizens from border countries which proportion has remained fairly stable during the last four years.

The results of the study are currently discussed and already gave rise to a parliamentary question. Several strategies could be implemented as for instance:

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

The law of 27 April 2001 introduced an important modification of the basic drug law with regard to overdose prevention. Art.10-1 of the referred law exempts drug users who call for
assistance in case another user is in need of medical help, from prison sentences. This change should contribute to reduce drug-related deaths occurring in consumer groups.

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

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

A second step foresees the provision of first aid and harm reduction training to drug users and peers.

d. User rooms / safe injection rooms

The law of 27 April 2001 has set a legal framework several drug care facilities duly licensed by State, which also refer to services as injection rooms and controlled distribution of certain narcotics (e.g. heroin). The implementation of such facilities has been included in the national drugs action plan 2000-2004 of the Ministry of Health.

The implementation of a drug injection room has to be seen as a part of a broader harm and nuisance reduction oriented project. The national drug action plan refers to the creation of an emergency shelter facility for drug addicts that will be implemented in the vicinity of the city railway station. During the planning phase of this centre it has been decided to integrate a drug injection room due to obvious advantages to combine both of them (in terms of logistics staff and situation). The construction of the emergency centre will raise costs of about 1,735,000. - Euros. The requested funds have been provided by the FLTS and staff costs will be taken in charge by the Ministry of Health (6.5 staff members: psychologists, educational staff, nurses). Architectural plans are about to be finalised and the construction start is scheduled for the beginning of 2003.

The emergency centre will provide the whole range of harm reduction services, counselling facilities, accommodation, washing, laundering and storing facilities. It should be added that the night accommodations are not to be seen as a permanent housing; there will indeed be daily admissions. Target population for the consumption room is primarily defined by IVDUs. Inhalers might be admitted in a second phase.

The main objective of the project is the reduction of drug-related harm and nuisances. More precisely it aims as reducing the risks of infectious diseases, overdoses and public nuisance in the neighbourhood, contact making with difficult to reach addicts, provision of special designed night shelter facilities and avoiding unnecessary prison journeys over night. The project was designed with the support of law enforcement agencies. The public nuisance is an important factor in the public debate around the project. The site has its pro and cons although there is a general consensus that in terms of proximity to the hard drug scene and the reduction of nuisance, the site is adequate. One may add that the area in which the centre will be implemented has known major problems since a series of non inhabited houses served drug addicts as ‘wild’ injection rooms to the distress of the immediate environment.
An expert group is currently visiting similar projects in the EU in order to fine-tune the concept and implement quality control standards.

10.2 Standards and evaluation

a,b) Professional standards and evaluation studies on HR measures

There exists a different approach in HR interventions targeted at recreational settings and those referring to PDU populations. Although the latter adapt to current professional practices by means of international exchanges there is an obvious lack of evaluation procedures. As far as HR interventions in recreational settings are concerned (mainly provided by the CePT) professional standards do exist and all projects are evaluated by external evaluator. A more detailed description of the applied methodologies can be found in the presentation of respective projects.

c) HR training activities

Law regulates continuous training to be provided to staff members of specialised 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. Most HR training is provided abroad but more recently the CePT has been developing a fairly comprehensive training programme including outreach interventions a summary of which can be found in sub-chapter 9.2.

d) Recent HR research projects


11 Treatments

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

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

11.1 ‘Drug free’ treatment and health care at the national level

a) Definition

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

For the purpose of the present report low threshold and harm reduction services have been excluded: Distinction will be made between:
- Detoxification
- Outpatient treatment
- Inpatient treatment

b/c) Admission criteria, availability, financing and delivery of drug free treatment services

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 an 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.

With regard to evaluation procedures, one might stress that the methadone programme is evaluated on basis of a specially design software. Conventioned drug agencies are evaluated by means of the RELIS 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 a so called ‘Injonction therapeutique’ which gives the convicted person the right to choose between imprisonment or treatment. A specialised department of the Directorate of Health, namely the «Service Multidisciplinaire de Lutte contre la Drogue», treats those demands.

Figure 11.1.b.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 2001. Intra-institutional multiple counts are excluded meaning that all treatment demanders indexed by a given agency is only indexed once by the referred agency during a reporting year. Inter-institutional multiple counts are not excluded since a given treatment demander may have contacted several national agencies during a given year. More detailed admission data, including low threshold agencies are produced in respective sub-chapters.

Table 11.1.b.1 Clients admission statistics of drug treatment institutions (Inter-institutional multiple counting included) (1994-2001)

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>NUMBER OF ADMISSIONS (A) AND/OR CONSULTATIONS (C) AND/OR CONTACTS (CO)</th>
<th>NUMBER OF DRUG TREATMENT DEMANDERS (inter-institutional multiple counts excluded)</th>
</tr>
</thead>
</table>
Table 11.1.b.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 11.1.b.2 Distribution of HRC drug users according to type of institutional contact (multiple counts excluded)

<table>
<thead>
<tr>
<th>TYPE OF TREATMENT</th>
<th>Indexed HRC users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
</tr>
<tr>
<td>A. Specialised treatment</td>
<td></td>
</tr>
<tr>
<td>A.1 Inpatient:</td>
<td>757</td>
</tr>
<tr>
<td>A.2 Outpatient:</td>
<td>218</td>
</tr>
<tr>
<td>A. Specialised treatment</td>
<td>624</td>
</tr>
<tr>
<td>B. Problem drug users law offenders (SPJ)</td>
<td>551</td>
</tr>
<tr>
<td>TOTAL NUMBER OF HRC DRUG USERS INDEXED</td>
<td>1,198</td>
</tr>
</tbody>
</table>

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 reduce 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.

| Table 11.1.b.3 Clients core statistics BU-V CHNP 1997-2001 |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Number of admissions | 226  | 251  | 272  | 247  | 242  |
| Number of first admissions | 70   | 62   | 66   | 47   |      |
| Number of patients (multiple counts excluded) |       | 158  | 155  | 161  | 153  |
| Gender distribution |       |尊重 |       |      |      |
| Male | 72% | 80.5% | 70% | 76% | 77% |
| Female | 28% | 19.5% | 30% | 24% | 23% |
| Age distribution |       |       |      |      |      |
| 1997: m=28 Y 2 M |       |       |      |      |      |
| 1999: m=30 Y 4 M |       |       |      |      |      |
| < 15 | 1% | 0.20% | 0% | 1% | 0% |
| 15-19 | 1% | 4.80% | 8% | 4% | 5% |
| 20-24 | 31% | 24% | 23% | 22% | 17.5% |
| 25-29 | 25% | 32% | 32% | 31% | 27.5% |
| 30-34 | 26% | 21% | 25% | 24% | 23.5% |
| 35-39 | 13% | 16% | 9% | 13% | 16.5% |
| > 40 | 3% | 2% | 3% | 5% | 10% |
| Post detoxification referral |       |       |      |      |      |
| Home or family | 42% | 23% | 25% | 12% | 50.3% |
| Return to drug scene | 29% | 46% | 31% | 35% | 19.7% |
| Return to drug scene or home |       |       | 20% | 23% | 2% |
| Inpatient therapeutic treatment |       |       |      |       |      |
| Treatment abroad | 2% | 1% | 2% | 0% | 0% |
| Institution / ‘Foyer’ | 1% | 5% | 3% | 1% | 4% |
| Other |       |       |      |      |      |

Source: RELIS 2001

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

**Jugend- and Drogenhëllef Foundation. (JDH) (nation wide)**

- 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: 13 staff members
- Street work / Outreach
- Open Door

<table>
<thead>
<tr>
<th>Table 11.1.b.4</th>
<th>Clients core statistics outpatient treatment - JDH 1997-2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of treatment demanders</td>
<td>410</td>
</tr>
<tr>
<td>Number of first demanders</td>
<td>179 (44%)</td>
</tr>
<tr>
<td>Number of counselling sessions</td>
<td>1,584</td>
</tr>
<tr>
<td>Gender distribution</td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>64%</td>
</tr>
<tr>
<td>female</td>
<td>36%</td>
</tr>
<tr>
<td>Age distribution</td>
<td></td>
</tr>
<tr>
<td>&lt; 20</td>
<td>10%</td>
</tr>
<tr>
<td>20-24</td>
<td>11%</td>
</tr>
<tr>
<td>25-29</td>
<td>15%</td>
</tr>
<tr>
<td>30-34</td>
<td>18%</td>
</tr>
<tr>
<td>35-39</td>
<td>18%</td>
</tr>
<tr>
<td>≥ 40</td>
<td>8%</td>
</tr>
<tr>
<td>Demand motive</td>
<td></td>
</tr>
<tr>
<td>opiate abuse / multiple use</td>
<td>60%</td>
</tr>
<tr>
<td>cannabis</td>
<td>10%</td>
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<tr>
<td>alcohol abuse</td>
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</tr>
<tr>
<td>cocaine/amphetamines</td>
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<tr>
<td>psychosocial or psychiatric prob.</td>
<td>2%</td>
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<tr>
<td>after-care</td>
<td>6%</td>
</tr>
<tr>
<td>drug addiction of relative</td>
<td>2%</td>
</tr>
<tr>
<td>other</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Fondation JDH, 2001

<table>
<thead>
<tr>
<th>Table 11.1.b.5</th>
<th>Intervention in prisons JDH 1998 - 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1998</td>
</tr>
</tbody>
</table>

0.4
Number of clients (prisoners) | 43 | 61 | 73 | 75
---|---|---|---|---
Number of counselling sessions | 260 | 401 | 476 | 434
Proportion of clients showing no previous contact with JDH | 63% | 36% | 34% | 33%
Gender distribution | | | | |
- female | 17% | 8% | 14% | 16%
- male | 83% | 92% | 86% | 84%
Age distribution | | | | |
- 15-19 | 3% | 0% | 3% |
- 20-24 | 3% | 14% | 21.5% | 17%
- 25-29 | 35% | 52% | 36% | 33%
- > 30 | 37% | 31% | 42.5% | 47%
Main substance involved | heroin/ multiple use | 93% | 84.5%
- cocaine | 0% | 1%
- cannabis | 0% | 5.5%
- other substances | 1% | 7%
- other | 8% | 0%

Source: Fondation JDH 2001

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

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

| Table 11.1.b.6 Clients core statistics MSF SOLIDARITE-JEUNES 1997 - 2001 |
|---|---|---|---|---|
| Number of clients | 1997 | 1998 | 1999 | 2000 | 2001 |
| Number of first clients | n.a. | 27 | 46 | 99 | 132 | 195
| Gender distribution | | | | | |
| - Female | 26% | 28% | 26.3% | 34.1% | 32,3% |
| - Male | 74% | 72% | 73.7% | 65.9% | 67.7% |
| Age distribution | | | | | |
| - < 15 | 7% | 11% | 16.1% | 12.6% | 13,8% |
| - 15-18 | 82% | 81% | 73.8% | 74.2% | 80,9% |
| - > 18 | 11% | 8% | 10.1% | 12.9% | 11,3% |
| Main substance involved | | | | | |
| - Cannabis | 45% | 49% | 65.7% | 78% | 72,3% |
| - Heroin | 33% | 22% | 21.2% | 12.9% | 7,2% |
| - Solvents | 7% | 11% | 5.1% | 1.5% | 0,5% |
| - Ecstasy | 4% | 12% | 3% | 3.8% | 3,6% |
| - Cocaine | 3% | 1% | | | 2,6% |
| - LSD | 4% | 3% | 1% | | |
| - Other | 7% | 3% | 3.1% | | 13,8% |

Source: Solidarité Jeunes (MSF), 2001

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'. 31 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 are operational since July 2002 and are situated in the vicinity of the main centre in order to take advantage of training and social reintegration facilities offered by the CTM.

Staff members: 13
Therapeutic offer:
- individual therapies
- family-oriented therapies
- thematic talking groups
- gender specific groups
- work based therapy
- sport therapy
- professional training
- preparation to post-cure facilities
- corporal therapy and relaxation
- leisure activities
- puppet theatre

| Table 11.b.7 Clients core statistics Centre Thérapeutique de Manternach - Syrdallrschlass (1997-2001) |
|--------------------------------------------------------|--------|--------|--------|--------|--------|
| Total number of patients (new patients and patients from previous year still in treatment) | 1997   | 1998   | 1999   | 2000   | 2001   |
| Number of admissions (during 1999)                      | 39     | 47     | 43     | 34     |
| Number of admitted patients (during 1999)               | 36     | 37     | 40     | 37     | 31     |
| Average monthly occupation (patients)                   | 20.1   | 21.6   | 21.1   |
| Provided therapy days                                   | 6,580  | 8,101  | 7,348  | 7,910  | 7,709  |
| Gender distribution                                     |        |        |        |        |        |
| male                                                    | 82%    | 87.5%  | 77.9%  | 75%    | 86.5%  |
| female                                                  | 18%    | 12.5%  | 22.1%  | 25%    | 13.5%  |
| Age distribution                                        |        |        |        |        |        |
| < 20                                                    | 6.5%   | 7.2%   | 3.4%   | 8.4%   | 3.9%   |
| 20-25                                                   | 43.5%  | 35.7%  | 32.2%  | 26.8%  | 15.4%  |
| 26-30                                                   | 25.8%  | 23.2%  | 25.4%  | 35.7%  | 44.2%  |
| > 30                                                    | 24.2%  | 33.9%  | 39%    | 28.6%  | 36.5%  |
| Nationality                                             |        |        |        |        |        |
| Luxembourg                                             | 69.4%  | 66%    | 64.4%  | 73.2%  | 69.8%  |
| Portugal                                                | 9.7%   | 12.4%  | 18.6%  | 8.9%   | 7.7%   |
| Italy                                                   | 6.5%   | 8.9%   | 6.8%   | 5.4%   | 15.4%  |
| Spain                                                   | 3.6%   | 3.4%   | 7.1%   | 3.9%   |
| Germany                                                 | 4.8%   | 1.7%   | 1.8%   | 1.9%   |
| France                                                  | 4.8%   | 1.8%   | 1.7%   | 1.8%   |
| Belgium                                                 | 1.6%   | 1.8%   | 1.7%   |
| Ex                                                      | 1.6%   | 1.8%   | 1.8%   | 1.9%   |
|---------------|------|------|------|------|------|------|--------------|----------------|
| bachelor      | 82.3%| 85.7%| 81.3%| 87.5%|      |      |              |                |
| married       | 1.6% | 1.6% | 3.6% | 8.5% | 3.5% | 5.8% |              |                |
| separated     | 3.2% | 3.2% | 1.9% | 3.4% | 1.8% |      |              |                |
| divorced      | 12.9%| 8.8% | 6.8% | 5.4% | 1.8% | 9.6% |              |                |
| widowed       |      |      |      |      |      |      |              |                |

### Drug treatment abroad covered by national health insurance scheme

#### Table 11.1.b.8 Drug treatment abroad covered by health insurance scheme

<table>
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<tr>
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<tr>
<td>&lt; 20 years</td>
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<td></td>
<td></td>
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<td></td>
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<td>20 to 25 years</td>
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<td></td>
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<tr>
<td>&gt; 25 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL number of treatment demanders</td>
<td>55</td>
<td>57</td>
<td>71</td>
<td>91</td>
<td>102</td>
<td>97</td>
<td>71</td>
<td>73.2</td>
</tr>
<tr>
<td>Mean age</td>
<td>27Y</td>
<td>11M</td>
<td>29Y</td>
<td>9M</td>
<td>30Y</td>
<td>7</td>
<td>29Y</td>
<td></td>
</tr>
</tbody>
</table>

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

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

### 11.2 Substitution and maintenance programmes

#### a) Objectives for substitution treatment

Substitution treatment is a medical assisted treatment with agonists and with antagonists (and antagonistic agonists). The objectives of substitution and maintenance treatment are manifold. They range from non-dose digressive out-patient low threshold maintenance to abstinence oriented (digressive doses) rehabilitation offers. The primary goal is to been seen
in the psycho-social and medical stabilisation of the patient by replacing street drugs by quality controlled substitution drugs. The further development and outcome of the treatment is assessed individually. Both components, condition of the patient and reduction of public nuisance are considered.

b) Admission criteria to substitution treatment

c) Availability, financing, organisation and delivery of substitution treatment

Prior to 2002 two types of substitution treatment facilities did exist:

The former 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 there existed 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 ®) (Buprenorphone).

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. The grand ducal decree of 30 January 2002\(^2\) regulates the practical modalities of substitution. The new law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of substitution treatment licenses granted to GPs, the application of training requirements for prescribers and adequate control mechanisms of multiple prescriptions (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a structured substitution treatment programme provided by specialised agencies (JDH) and a lower threshold substitution treatment offer provided by freelance state licensed GP’s.

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

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

Internal rules and the evaluation process of the structured 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,

---

\(^2\) The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: http://www.eldd.emcdda.org
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).

National control and coordination of substitution treatment is ensured by the so-called ‘Surveillance Commission on Substitution Treatment’\textsuperscript{21}, established in 2002. It is composed of delegates from the programme, the Directorate of Health, the AST, two pharmacists and two GPs affiliated to the programme, and is in charge of admissions, releases and exclusions of substitution treatment demanders or patients.

d) Substitution drugs and mode of application

Until 2001 methadone, and buprenorphine have been prescribed as part of a long-term treatment with an abstinence goal. There are, however, a series of cases in which substitution treatment has to be considered rather as a harm reduction or maintenance intervention than abstinence oriented therapeutic action. The grand-ducal decree of 30 January 2002 lists medicaments as well as magisterial preparations containing methadone (liquid oral form in programme and pill form in lower threshold prescription) and buprenorpine if the notice mentions substitution treatment as a possible therapeutic indication. Furthermore, morphine-based (salt) medications can be prescribed if the listed substances are deemed inadequate by medical authority. Finally, the decree allows for heroin prescription in the framework of a pilot project managed by the Directorate of Health. The list of substance can be rapidly adapted by amending the referred decree.

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.

e) Psycho-social counselling

In addition to 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,
- short, medium and long term therapies,
- gender specific and pregnancy counselling

\textsuperscript{21} The decree of 30 January 2002 replaces the former ‘Methadone Commission’ by the ‘Surveillance commission on substitution treatment’ mandated to control all aspects of substitution treatment at the national level. The composition of the new commission is similar to the one of the former Methadone commission.
f) Diversion of substitution drugs

It has been brought to the attention of the NFP that diverted MEPHENON ® (methadone in pill form prescribed by GPs) is increasingly available on the national black market. This situation is largely due to multiple prescription of mephenon ® and dealing by patients with other drug addicts. Given that currently there does not exist a centralised substitution treatment register, prescribing GPs have major difficulties in determining rapidly whether their patient has already been prescribed a substitution drug by one or more of his/her colleagues. In that respect, it has been decided to set up a national substitution treatment register within the Directorate of Health in order to reduce illicit diversion of substitution drugs. The register should become operational in the course of 2003.

g) Evaluation results, statistics, research and training

The union of national sickness funds annually provides the number of patients receiving referred substitution drugs on prescription as well as the number of prescribing GPs. 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 11.2.g.1 Ambulatory, low threshold prescription of substitution drugs by the national network of liberal GPs

<table>
<thead>
<tr>
<th>YEAR</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of indexed patients (double counting controlled)</td>
<td>745</td>
<td>844</td>
<td>849</td>
</tr>
<tr>
<td>Number of prescribing GPs (double counting controlled)</td>
<td>125</td>
<td>145</td>
<td>147</td>
</tr>
</tbody>
</table>

Source: Union des Caisses de Maladie 2001

The national drug substitution programme had a total capacity of 30 places in 1993. In year 2001 the number of admitted patients seems to have stabilised (158 patients) Gender distribution is stable but mean age of treatment demanders tends to increase.

Table 11.2.g.2 Clients Statistics: National Drug Substitution Programme (JDH) – 1997-2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of clients</td>
<td>158</td>
<td>186</td>
<td>164</td>
<td>158</td>
</tr>
<tr>
<td>Gender distribution</td>
<td></td>
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</tr>
<tr>
<td>male</td>
<td>68%</td>
<td>70.5%</td>
<td>64%</td>
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<td>female</td>
<td>32%</td>
<td>29.5%</td>
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<tr>
<td>Nationality</td>
<td></td>
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</tr>
<tr>
<td>Luxembourg</td>
<td>73%</td>
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<td>16%</td>
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<td>4%</td>
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<td>Cap-Verde</td>
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<td>Ex-Yugoslavia</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>n.a.</td>
<td>10.5%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>25-29</td>
<td>n.a.</td>
<td>29%</td>
<td>25.5%</td>
<td>28%</td>
</tr>
<tr>
<td>30-34</td>
<td>n.a.</td>
<td>33%</td>
<td>32%</td>
<td>29%</td>
</tr>
<tr>
<td>35-38</td>
<td>n.a.</td>
<td>18%</td>
<td>20.5%</td>
<td>23%</td>
</tr>
<tr>
<td>≥ 40</td>
<td>n.a.</td>
<td>9%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>Duration of drug dependency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 3 years</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>16%</td>
<td>16%</td>
<td>17%</td>
<td>6%</td>
</tr>
</tbody>
</table>
A first scientific evaluation of the methadone programme first occurred in 1995. In 1998, new evaluation software has been developed in collaboration with the NFP, which, in the medium term, aims at the integration of substituted patients' data directly in the RELIS database. In 2000 and 2001 a second and third evaluation by an external expert occurred on basis of data provided by the referred evaluation software.

The main conclusions of the evaluation exercise (Dellucci 2002) show the following trends (1993 – 2001):

- higher proportion of female treatment demanders compared with general PDU population
- a large majority of treatment demanders spend 1 to 36 months 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 and the Centre 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 share of patients relying on social welfare funds.
- decrease of the abandonment rate but less referral to inpatient therapeutic agencies

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

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

11.3 After-care and re-integration

a) Links with national strategy and legislation

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 finally introduced the dimension of co-ordinated synergies in the field of housing, training and other socio-professional reintegration measures.

**b) Objectives, definitions and concepts of reintegration**

The primary objective of after-care intervention is the stabilisation build on previous treatment measures. Providing housing facilities might target fundamental needs; on the other hand it is a necessary condition to initiate a social reintegration process even if the occupation or professional training situation of the person is not yet addressed.

**c) Accessibility for different target groups**

Re-integration measures often start where treatment interventions stop. The national action plan does not share this point of view since in different respects it refers to a rather merged approach. The housing project ‘Niches’ described bellow gives priority to accommodation providing whether the therapeutic process (counselling or substitution) is ongoing or not.

Likewise 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 are operational since July 2002 and take advantage of training and socio reintegration facilities offered by the CTM.

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 referred to under chapter 12.

**d) Organisation, financing, managing, availability and delivery of services**

As most of drug-related intervention strategies, after-care and re-integration measures are coordinated and financed by the ministry of health by means of collaboration convention with specialised agencies or via the national drug action plan.

In the framework of the drugs action plan, the JDH has been allocated the necessary funds and human resources to set-up a housing project aiming at problem drug users (niches project). 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 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 an 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 residents and specialised staff. 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.

12 Interventions in the Criminal Justice System

Even though the Ministry of Health has been entrusted with the coordination of national drug policies in 2000, the supply reduction and law enforcement fields has remained a competence of the Ministry of Justice. A series of synergies in fields such as treatment interventions in prison, low threshold facilities and the current implementation of shooting galleries have been developed between both involved ministries on basis of decisions taken by the interministerial committee on drugs. The national drug monitoring system includes all nationally available law enforcement sources, which enables policy makers to rely on an holistic picture of the national drug population.

12.1 Assistance to drug users in prisons

There exist two state prisons at the national level; the CPL situated in the vicinity of Luxembourg City and the CPG implemented in the east of the country. Chart 12.1 provides general admission data (new entries) and number of admissions according to drug-related convictions in both prisons from 1989 to 2001. On 31 December 2001, the total prison population stood at 341 (CPL: 285 / CPG: 56).

Fig.12.1 Admission data of national prisons (CPL, CPG) 1989-2001
The law of 27 July 1997 concerning the modification of the penitentiary organisation regulates the creation of specialised medical units for drug addicts and psychiatric patients within prison. In 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 in prison'). 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 first phase of the project is currently implemented on focuses on the diversification of treatment supply, prevention and harm reduction intervention as well as quality improvement of training activities for prison staff. Joint financing by the Ministry of Justice, the FLTS and the EU (regarding evaluation) is 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 situation observed in national prisons and will provide only fragmentary information on planned activities with regard to the ‘global drug care programme’.

a. Abstinence oriented treatments

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.

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

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

b. Substitution treatment

Regarding substitution treatment in prison, no formal or binding guidelines do currently exists. 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 filed agencies (Substitution, HIV, hepatitis, etc.),
- to a lesser extend, 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 extend. Prescription of benzodiazepines is widespread.

c. Harm reduction measures

In 1998, the Ministry of Justice commissioned the medical department of the state prison (CPL) to perform an epidemiological study on HIV and HCV prevalence in prison population (Schlink 1999). 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.

<table>
<thead>
<tr>
<th>Dr. Schlink J. (1999), Etude épidémiologique des infections à l’HIV et à l’hépatite virale C dans les prisons luxembourgeoises, CPL, Luxembourg.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EN:</strong> Epidemiological study on HIV and HCV prevalence in prisoners</td>
</tr>
<tr>
<td><strong>Year</strong></td>
</tr>
<tr>
<td><strong>Single/repeated study</strong></td>
</tr>
<tr>
<td><strong>Context</strong></td>
</tr>
<tr>
<td><strong>Area covered</strong></td>
</tr>
<tr>
<td><strong>Type sample</strong></td>
</tr>
<tr>
<td><strong>Age range</strong></td>
</tr>
<tr>
<td><strong>Data coll. procedure</strong></td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
</tr>
<tr>
<td><strong>Sampling frame</strong></td>
</tr>
<tr>
<td><strong>Response rate (M, F, T)</strong></td>
</tr>
</tbody>
</table>

**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.
The Schlink study provides the latest figures on HIV and HCV prevalence in prisoners according to drug use status. Table 12.1.c.1 provides infection rates of IDU prisoners according to Schlink (1999).

Table 12.1.c.1 Synopsis of HIV and HCV infection rates in prison population (valid %)(1998)

<table>
<thead>
<tr>
<th>Prison population</th>
<th>Infection rate in 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV rate in total prison population</td>
<td>1.5%</td>
</tr>
<tr>
<td>HIV rate in IDU prisoners</td>
<td>4.4%</td>
</tr>
<tr>
<td>HCV rate in total prison population</td>
<td>15%</td>
</tr>
<tr>
<td>HCV rate in non-IDU prisoners</td>
<td>5%</td>
</tr>
<tr>
<td>HCV rate in IDU prisoners</td>
<td>37%</td>
</tr>
</tbody>
</table>

Source: Schlink 1999

Presently, the Schlink 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 12.1.c.2 provides data on infection rates as determined by routine voluntary testing procedures at the moment of prison admission: In 2002, 432 serological tests have been performed on inmates in order to detect hepatitis A, B, C, and syphilis infections. The same year 500 HIV test have been processed.

Table 12.1.c.2 Infection rates as provided by routine testing procedures applied to new prison entries (valid %)

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>0.8% (N: 250)</td>
</tr>
<tr>
<td>HAV</td>
<td>41% (N: 212)</td>
</tr>
<tr>
<td>HBV</td>
<td>40% (N: 212)</td>
</tr>
<tr>
<td>HCV</td>
<td>31% (N: 212)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>0.9% (N: 212)</td>
</tr>
</tbody>
</table>

Source: CPL (1997-2001)

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

Drug testing: urine tests 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 ann 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.

Currently no needle exchange takes place in national prisons. The provision of injection material is foreseen in the framework of the implementation global 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 materiel and advice.

d. Community links

The involvement of community health care structures in and out prison treatment trends to increase. Although there exist no proper pre-release units or specific treatment communities for offenders outside prison, the probation service focus on treatment continuation a social integration after release in close collaboration with community health services. A practical application of this interaction can be seen in the pre-admission of a drug substituted inmate to the medium threshold substitution care programme managed by JDH two months before release.

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, offers a large variety of services with the primary aim to prevent minor aged drug offenders to enter in the criminal justice system. Interventions are based on a holistic approach of the problem, including the involved person him/herself and his/her family. 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 institution.

12.2 Alternatives to prison for drug dependant offenders

Alternatives to drug-related offence sentences do exist and have been previously described. 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.

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.

12.3 Evaluation and training

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.

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

13 Quality Assurance

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 natures, 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.
PART IV
KEY ISSUES
14 Demand Reduction Expenditures on Drugs in 1999

14.1 Concepts and definitions

Data provided in the present section originates from the recent study (Origer 2002b): ‘Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies’. The main objective of the referred study is the estimation of direct economic costs of policies and interventions in the field of illicit drug use. The figures refer to budgetary year 1999. The study exclusively addresses direct economic costs, thus excluding ‘costs of indirect consequences’ and ‘non quantifiable costs’ as well as expenditures related to the acquisition of illicit drugs by the consumer him- or herself. The applied methodology relies on the concepts of the ‘Cost of Illness’ (C.O.I.) theory.

It is the first time a detailed analysis of supply and demand reduction intervention costs have been performed at the national level. Results allow for breakdown in the following categories and sub-categories:

- Supply reduction interventions
  + Involved Ministries
  + Police
  + Customs
  + National Funds
  + Criminal Justice
  + Prisons
  + Toxicological analysis for law enforcement purpose

- Demand reduction interventions
  + Involved ministries
  + NGO financing
  + Prevention activities
  + Treatment interventions
  + Harm reduction measures
  + Social security costs
  + Drug-related infectious diseases

- Research activities

- International Contributions

More specific breakdown can be performed in each of the listed sub-categories. Considered data sources are manifold and summarily include: State budget, activity reports and tailor-made questionnaires and ad hoc breakdowns performed by involved administrations, institutions and NGOs. The full research report can be downloaded at: http://www.relis.lu.

14.2 Financial mechanism, responsibilities and accountability

One may distinguish summarily between two major types of expenditures. The first refer to the financing – set-up, maintenance and developing - of drugs demand reduction
infrastructures such as specialised care facilities, prevention programmes and research activities (functional costs). The second type includes expenditures generated by health care consumers (consumption costs).

As far as functional costs are concerned, funding of drugs demand reduction infrastructures 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. Required resources may be estimated on basis of previous years balances or redefined in the framework of new strategies and/or national action plans (see. Drugs action plan 2000 – 2004).

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 guarantees adequate funding to the latter and 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.

Referring to health care consumption costs one should stress that services provided by state conventionned NGOs are free of charge. Health care demanders addressing the general health care system (GPs, specialists, hospitals, etc.) have to pay by their own means and are partially reimbursed by sickness funds. In case a health care consumer is not covered by a social security scheme or due costs are beyond his/her financial resources, cost sharing may occur via a social subvention system.

### 14.3 Expenditures at the national level

In 1999, the direct economic costs of national policies related to illicit drug use (all categories included) reached approximately 23.345 million euros, which represents an annual per capita expenditure of 54.- €. Based on the results of the latest national drug prevalence study (Origer 2000), an average annual cost per problem drug user of 9,934.- € has been calculated.

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

Fig. 14.3.1 Breakdown of direct economic costs of national policies related to illicit drug use - 1999
Supply reduction 39%  
Demand reduction 59%  
International Research Contributions 1%  

Total drug demand reduction expenditures figured 13.774 million euros in 1999. Cost under A and B. are to be considered.

A. Drug-related expenditures in year 1999 of the main ministries involved in drug demand reduction interventions are as follows:

<table>
<thead>
<tr>
<th>Ministry</th>
<th>Expenditures (million euros)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>5.753</td>
</tr>
<tr>
<td>Ministry of Family, Social Solidarity and Youth</td>
<td>2.358</td>
</tr>
<tr>
<td>Ministry of Education, Professional Training and Sports</td>
<td>0.570</td>
</tr>
<tr>
<td>Ministry of Finance – Fund against drug trafficking</td>
<td>0.111</td>
</tr>
<tr>
<td>Other Ministries</td>
<td>0.030</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>8.722</strong></td>
</tr>
</tbody>
</table>

Figures produced under A. refer to direct economic costs centrally covered by state. Regional or local funding is insignificant.

B. Another share to be consider under the present sub-section refers to social security reimbursement expenditures including:

<table>
<thead>
<tr>
<th>Description</th>
<th>Expenditures (million euros)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare and medicaments provided to IVDUs/HIV/AIDS patients²²</td>
<td>1.264</td>
</tr>
<tr>
<td>Drug substitution treatment²¹</td>
<td>0.237</td>
</tr>
<tr>
<td>Drug-related hospitalisation²¹</td>
<td>2.475</td>
</tr>
<tr>
<td>Drug treatment abroad²⁶</td>
<td>0.976</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4.952</strong></td>
</tr>
</tbody>
</table>

### 14.4 Expenditures of specialised drug treatment centres

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²² Funds allocated to national demand reduction projects only have been included
²¹ Exclusively includes patients who present a HIV seropositive status or suffer from AIDS who have been infected trough intravenous drug use.
²⁶ Includes medical consultation and prescribed substances costs caused by substitution treatment receivers via the national GPs network. Expenditures related to the medium threshold State financed substitution programme or included in the budget of the Ministry of Health.
²⁶ Includes hospitalisation costs and medical consultation fees during hospitalisation.
²⁶ Refers to duly drug treatment episodes abroad that are duly approved and taken in charge by Social Security.
The overall budget of the Ministry of Health directly allocated to the financing of specialised treatment and prevention centres 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 €. This remarkable increase is mainly due to the implementation of projects retained by the national drug action plan 2000 – 2004.

More precisely, referring to 1999, one could distinguish between three categories of specialised centres financed by different competent ministries27:

- Outpatient specialised treatment centres28: 1.855 million euros
- Inpatient specialised treatment centres: 4.703 million euros
- Specialised prevention centres: 0.583 million euros

**TOTAL:** 7.141 million euros

Fig. 14.4.1 Breakdown of direct economic costs related to the financing of specialised centres - 1999

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14.5 Conclusions

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27 Presented figures include all direct expenditures related to the financing of specialised treatment and prevention centres provided by different ministries. As in 1999 all involved centres have been state financed no distinction between private and public institution is made.

28 Including low threshold services.
As shown in figure 14.3.1, drug demand reduction (DDR) expenditures represent 59% of the total drug expenditures at the national level. In other words, in 1999, 13.774 million euros have been invested in DDR activities by the state. The share of DDR expenditures is greater than the one dedicated to supply reduction field.

One should bear in mind that although most of retained figures have been calculated rigorously on basis of reliable data sources, some calculations were based on estimation and extrapolation methodologies. These methodologies may introduce a calculation bias mainly due to unspecific budget lines and unclear limits between drug specific interventions and general health or education offers. This bias may be reduced by strategies such as centralisation of competences and the clearly budgetised action plans according to an annual time framing. Initial investment cost may indeed be disproportional in a given year compared to the annual operational cost a given project or infrastructure may generate and significantly distort result of comparative analysis.

Origer (2002) analysed data of year 1999 and the study report was published in 2002. Given the complexity of budgetary procedures and the time required by “tailor made” financial breakdowns, annual updates or the implementation of routine indicators appear to be difficult.

Since 1999 the national situation has significantly changed. First of all DDR competences have been centralised within the Ministry of Health, secondly a national drug coordinator has been appointed in charge of the conceptualisation and the implementation of a drugs action plan. The drugs action plan 2000 – 2004 includes precise financial requirement in terms of investment costs and annual operational cost. These achievements facilitate direct DDR expenditure estimations. Nevertheless an exhaustive annual data collection remains a questionable goal in terms of cost-benefit.

In coming years efforts will be made in order to improve DDR budgetary coherence and transparency of DDR related budget lines in addition to the implementation of a set of cost indicators relying on ready to use data sources or easily available estimations from a representative sample of annual DDR expenditures.

### 14.6 Methodological information

The quoted study (Origer 2002) has been the first research performed on DDR cost assessment at the national level thus far. The methodology applied by Origer (2002) relied on the concepts of the ‘Cost of Illness’ (C.O.I.) theory. Methodological limits have already been addressed and possible solution to improve data quality has been presented. One may add that the experience gathered in the framework of a direct economic cost study provides a clear picture of what might be the complexity of a social cost study (e.g. Kopp, P., & Fenoglio, P. 2000) and clearly suggest that in terms of feasibility, comparison at the European level should be based on a limited number of direct economic DDR expenditures indicators rather than on more complex methodologies.

### 15 Drug Use Among Young People Aged 12-1

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The full research report can be downloaded at: [http://www.relis.lu](http://www.relis.lu)
15.1 Prevalence, trends and patterns of use

a) General population surveys and special surveys on people 12-18

To date, no national, large-scale (representative) population survey on drug use has been conducted. The results from the Fischer and Krieger study (1999) are currently the most reliable source providing an exploratory picture of the national drug use prevalence in general population. Most representative national data comes from school surveys. A presentation of methodological information and a summary of main results can be found in chapter 2.2. Following data could be retained:

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.

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.

A recent survey conduced in the framework of an evaluated national alcohol prevention campaign Fischer (2002) provides figures on alcohol use by youngsters aged 12 to 18. Wine appears to be the first preference of youngsters aged 12 to 14. At 15 years beer is most prevalent and spirits consume rises from 17 years on. Simultaneous use of illicit drugs has not been investigated by the Fischer (2002) study.
15.2 Health and social consequences

a) Deaths and overdoses

Graph 3.3.c.1 shows age distribution of illicit drug overdose deaths between 1992 and 2000 according to Origer and Dellucci (2002). 9% of overdose victims were younger than 20 years. The proportion of overdose deaths aged 12 to 18 is very weak (rarely more than 1 case per year). The vast majority of overdose deaths were male and showed heroin traces documented by forensic evidence. No death case directly related to ecstasy consume has been reported to date.

As far as indirect drug-related deaths are concerned the same comments on age distribution apply.

b) Hospital emergencies

No information currently available
c) Driving accidents

Currently the NFP only disposes of data on cannabis detection related to traffic accidents. The evolution curve of THC detection in persons involved in traffic accidents clearly shows an upward trend. Almost 50% of analyses samples contained THC traces. Positive test results, however, are not a prove that THC use is to be considered as the cause of accident. No data on age distribution of involved persons are currently available.

Fig. 15.2.c.1 Detection of THC (cannabis) in persons involved in traffic accidents (1995-2000)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of THC detection tests applied</th>
<th>Number of THC positive tests</th>
<th>Valid percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>33</td>
<td>10</td>
<td>30.3</td>
</tr>
<tr>
<td>1996</td>
<td>36</td>
<td>10</td>
<td>27.8</td>
</tr>
<tr>
<td>1997</td>
<td>65</td>
<td>21</td>
<td>32.3</td>
</tr>
<tr>
<td>1998</td>
<td>76</td>
<td>25</td>
<td>32.9</td>
</tr>
<tr>
<td>1999</td>
<td>82</td>
<td>29</td>
<td>35.4</td>
</tr>
<tr>
<td>2000</td>
<td>125</td>
<td>60</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: LNS 2001

d) Demand for treatment

According to RELIS 2001 data the proportion of treatment demanders aged 12 to 18 varied between 5 and 12 from 1996 to 2001 showing a decreasing trend for the last 3 years (5% in 2001). 20% of target population addressed their first treatment in 2001. 50% of total population (12-18) were male, 100% natives and presented an unstable occupational situation or were students. 80 % of treatment demanders report previous law enforcement contact. As far as drug use pattern are concerned the following main drugs were reported:

Table 15.2.d.1 Reported main drug of drug treatment demanders aged 12 to 18 in 2001

<table>
<thead>
<tr>
<th>Reported main drug</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis derivatives</td>
<td>53%</td>
</tr>
<tr>
<td>Heroin i.v.</td>
<td>12%</td>
</tr>
<tr>
<td>Heroin other route of administration</td>
<td>18%</td>
</tr>
<tr>
<td>Ecstasy type</td>
<td>12%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: RELIS 2001

80% of respondents show multiple drug use patterns and 20% have already received substitution treatment before being indexed by RELIS. 20% of treatment demanders who did not report alcohol as primary drug reported alcohol as secondary problem drug.

15.3 Demand and harm reduction responses

a) Prevention programmes and campaigns

Prevention campaigns on licit and illicit drug use is jointly coordinated by the Division of Preventive Medicine (Ministry of Health) and the CePT. The community drug prevention programme coordinated by CePT is seen as the most representative intervention setting. It has been launched, as a pilot project by CePT (see 9.4) in the beginning of 1995. The main idea was to focus prevention activities on the very environment and daily life experiences of young people. Various demand reduction activities have been undertaken, either developed by CePT, SNJ and several youth centres, or initiated by the respective District Councils. 13
district councils and 150 volunteers are currently involved in the project. District councils, the EU (Drug Prevention Programme DG-V) and CePT jointly ensured the funding of the project.

The annual “adventure weeks” organised by the Mondorf Group jointly with the SNJ and the CePT do fit in a broader programme named “Adventure pedagogy and primary addiction prevention”. The project has already been mentioned previously (see 9.2). It 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.

CePT activities do also include primary prevention of licit drug use such as alcohol. The already mentioned campaign on alcohol use under 16 has been launched in 2000 and externally evaluated in 2002 (Fischer 2002). Target groups included youngsters under 16, supermarkets, cafés, nightlife settings and service stations. Alcohol selling points have been informed on current legislation and provided with prevention material. National legislation forbids selling of alcohol to people aged under 16.

Summarily, evaluation results showed that significant positive changes (meaning refusal of alcohol selling to youngsters under 16) did only occur in shops, and supermarkets. Nightlife settings have shown little change.

b) Specific harm reduction interventions in nightlife settings

Currently there exist no legal framework allowing specialised agencies to provide for pill testing in nightlife settings. Discussions that have been held during the amendment process of the national drug legislation (amended in 2001) did not come to a decision. Prevention material and info flyers on synthetic drugs and multiple drug use are provided to bars and nightlife establishments. There remains however an obvious lack of interventions in the referred settings especially with regard of scarce data on quality of synthetic drugs to be assessed by the national early warning system. Harm reduction does indeed highly rely on knowledge about currently circulating drugs and patterns of use. The Interministerial committee on drugs currently addresses this topic.

c) Other demand reduction responses

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. 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 institution. In 2001 89% of clients were aged under 18. 72% reported cannabis as primary drug followed by heroin 7%. The MSF project, which also included mediator interventions in school settings, aims to provide alternative solution to law enforcement and repression strategies, in order to limit or prevent irreversible consequences on youngsters on prevent a potential criminal spiral.

15.4 Methodological information


16  Social Exclusion and Re-integration

16.1 Definition and concepts

Social exclusion and marginalising are seen as major correlates of drug use. The relationship is however complex since it is defined by numerous factors such as:

**Primary definition of concepts:** How to define social exclusion? What’s the respective impact of a precarious financial situation, occupational factors, family reliance, peer pressure or influence?

**Causality link:** Does social exclusion lead to drug use or does drug use or abuse induce short, medium or long term social marginalising?

**Identity:** There may be an individual choice behind the exclusion from common society norms. Drugs may enhance the adherence to a certain live style or the opposition to it.

**Sampling frame:** Research on the relationship between socio-economic factors and drug use has to look at all population groups and differentiate possible interpretations of observed links.

**Type of drug:** A series of drugs are used to facilitate social interaction or to make it more bearable. In how far a defence mechanism oriented towards socialising can lead to a radical suppression of the anxiety source, meaning that abuse of “social drugs” may lead to depression and avoidance of social interaction?

There might be sound definitions of social exclusion (e.g. a multi-dimensional phenomena that hinders individuals to fully participate in contemporary society.) However defining factors inducing or enhancing the phenomena is more than challenging. Currently, there exists no commonly accepted political definition on social exclusion\(^{30}\) at the national level.

In the field of drug research the conceptual difficulty is often overtopped by notions such as risk and protective factors, which may lead to a deterministic approach since the referred factors tend to include acquired competences or given environmental settings. The question often is: ‘What could possibly happen under given conditions?’ Drug use is the target variable and social exclusion is referred to as a possible determinating factor. The question if drug use may lead to social exclusion is far more complicated since drug use is an observable medically retraceable behaviour whereas social exclusion is highly context related. There has been no research on drug use behaviour among socially deprived or excluded population due to the reasons stated above. Thus far, research focused on socio-economic characteristics of known drug users. (Section 16.2. no information available)

The RELIS protocol includes specific 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 use have shown to be closely related to drug abuse behaviour (Origer 1998). The author insisted that the relationship between listed factors and drug use is defined by simultaneous occurrence without informing on a possible causality link.

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16.2 Drug use patterns and consequences observed among socially excluded population

n.a.

16.3 Relationship between social exclusion and drug use

Two studies on the relationship between drug use and associated social factors could be quoted. The Fischer study (1998) included items on individual resources and education factors in relation to cannabis use. Origer (1998) analysed the simultaneous occurrence of drug use and socio-economic factors in PDU's. Furthermore the national drug monitoring system RELIS includes a series of routine socio-economic indicators. The following results should be stressed:

Low education levels: Figure 16.3.1. shows educational levels of PDUs indexed by RELIS between 1995 and 2001 compared to results of the PSELL study\textsuperscript{31}, which assessed educational levels of the general population on basis of a representative sample in 1994. Comparative results clearly stress lower education of PDUs with respect to secondary and tertiary school levels. The same comment applies to started but non-concluded school levels.

![Fig. 16.3.1 Acquired school level of indexed PDUs. 1995 - 2001 (valid %)](image)

Source: RELIS 2001

Higher unemployment rates of PDUs and family members: Employment status of RELIS indexed PDUs is compared to official national unemployment rates in 2001 provided by the national statistics board STATEC\textsuperscript{32}. Unemployment rates of PDUs are significantly higher than those observed in general population. Moreover, 64% of jobless PDUs in 2001 do not go on the dole, which represents a disproportional share compared to general population. Occupational status of parents tends to reflect the situation of respective PDUs.


Low professional profiles of parents: STATEC provides recent figures on professional classes in general population. Figures have been reformatted to fit RELIS categories. It clearly appears that worker status is most represented in PDU’s parents or parental authority. Worth mentioning is the fact that a higher proportion of PDU’s parents report a free-lance status compared to general population.

Non-autonomous financial resourcing and indebtedness: The national drug monitoring protocol includes detail items on primary income sources. Figure 16.3.4 summarises the observed situation in PDUs according to three main categories. Financial autonomy means that the respondent is him- herself at the source of the income. Social dependency refers to income ensured by social welfare or by parents, relatives or partners. Data on general population is not available, but there is clearly a higher proportion of PDUs relying on social welfare illegal activities and prostitution than the one observed in general population.
The same comments applies to the indebtedness status as can be seen in figure 16.3.5. Major depths refer to the incapacity of reimbursement (e.g. loans) or depths higher than 2,500 euros.

Unstable accommodation: in 2001, 31% of PDU’s reported an unstable residential situation or institutional accommodation. This appears to be a high proportion compared to general population even though residential situation has progressively improved during the last seven years.
High police records and incarceration rates: Between 1995 and 2001 between 63 and 92% RELIS respondents (PDUs) have shown previous police records. In 83% of cases police records mentioned drug offences. 55 to 76% of total RELIS respondents report previous prison journeys among whose 47% report multiple incarcerations.

Foreign nationality: Distribution of native non-native nationalities among PDUs reflects proportions observed in general population. However, PDUs of Portuguese origin (2001: 57%) are largely over represented in the national non-native population compared with official demographic general population figures provided by STATEC (2001: 35.5%). More information on the current situation will be provided under 16.4.

Drug abuse within the family of origin: A last indicators worth mentioning is the reported drug abuse within the family of origin of indexed PDUs. 69% of respondents report illicit drug use or abuse of licit drugs by one or more members of his/her family of origin.

16.4 Political issues and reintegration programmes

During the EU Council of Nice in December 2000, Member states adopted objectives to fight against poverty and social exclusion and agreed to provide national action plans by June 2001. In response the Grand Duchy of Luxembourg designate the Ministry of Family and Social Solidarity in collaboration with other involved ministries and NGOs to draw the so-called National Action Plan on Social Inclusion (PANincl.). A catalogue of more than 100 specific projects or interventions has been included in the PANincl. The Ministry of Heath has been asked to provide projects in the fields of psychiatry and drug addiction. The national drug coordinator selected a series of projects included in the national drugs action plan, namely housing, reintegration and professional training projects.

The national drug action plan and the PANincl. have largely promoted the implementation of social reintegration interventions. Focus is currently laid on diversification of post treatment facilities and frontline low threshold services for youngsters such as broader professional training facilities, ‘real life’ transition centres or supervised accommodation facilities for ex
drug users and services that aim at prevent social exclusion in Youngsters by early and targeted interventions (cf. project Youth Solidarity – MSF).

Furthermore, special attention is paid to non-native drug using populations, especially to users of Portuguese origin. The proportion of Portuguese PDUs within the national drug population is significantly higher than the proportion of Portuguese citizens in general population. Thus far the only comparative study on the relationship between ethnic factors and problematic drug use has been performed by Origer in 1998. Following results should be retained: Between 1995 and 1997, up to 50% of foreign drug treatment demanders indexed by specialised treatment institutions in Luxembourg were of Portuguese origin. The same ethnic group is also over-represented within the drug-related death register. These observations have led the EMCDDA focal point of Luxembourg to commission a study on three sub-populations: native drug treatment demanders, Portuguese drug treatment demanders living in Luxembourg and finally a sample of Portuguese drug addicts treated in Portugal. The comparison of core socio-demographic data has revealed important differences between the selected samples. Portuguese drug addicts treated in Luxembourg appear to be very low aged (M=25 years, 9 months) and show a noticeably lower educational level than the other studied samples. Regarding substance-related data, it should be stressed that 98% of Portuguese native addicts consume opiates as a primary drug, compared with 82% for the Portuguese addicts treated in Luxembourg. 75% are IVDU’s whereas only 51.5% of Portuguese native addicts were injecting their primary drug at the moment of data collection. The Portuguese addicts resident in Luxembourg present the lowest needle-sharing rate (32%) whilst 21.9% of the Portuguese native drug treatment demanders are HIV positive compared with 4 % for both of the other populations.

Possible explanations of the high prevalence of Portuguese PDUs refer to linguistic factors and integration components. There could by a language gap between parents, who often plan to return to Portugal after a certain time, and children of the second generation who are in the process of integrating linguistically and culturally. On the other hand, the size of the Portuguese community in Luxembourg allows Portuguese people to create a kind of Portuguese micro society within the country. This kind of ‘vacuum’ integration may generate a series of problems when members of the community have to face national culture or social patterns (e.g. School, job, etc.)

The Origer (1998) study is seen as a 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 teams. Furthermore, the CePT is working on solutions for better integration of ethno-specific approaches within the national drug prevention strategy

In this line of thought, the Mondorf Group, jointly with CePT and 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),

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Saarland and Rheinland-Pfalz (Germany), the German speaking Community of Belgium and Luxemburg). The program aims at the reduction of risk factors and the enhancement of protection factors, by focussing more on 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 and thus contribute to the prevention of social exclusion mechanisms.

16.5 Methodological information


END OF REPORT
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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 indatating and encoding procedures are carried out at the very level of the field institutions. Thus, NFP is provided with individualised data (reporting protocols) without any reference to identifying information or attributors on the indexed persons, which is undoubtedly one of the major preoccupations of field institutions.

RELIS data processing is based on ORACLE © database software and allows for multiple variable breakdowns as well as separated data analysis for different treatment or law enforcement settings. Separate data can be provided for participation regions and institutions.
In terms of data provision, RELIS further relies on following national registers:

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

b. Register on drug law offenders (SPJ)

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

c. General Mortality Register (GMR)

GMR is run by the Health Statistics Department of the Directorate of Health. The main impediment towards refined data provision on drug-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, expressively includes the follow-up of the national EWS system. Governmental delegates represented within the Inter-ministerial Group have disseminated information on EWS within their respective administration and have undertaken the required steps towards an effective inter-ministerial collaboration.

The implementation of EWS relies on a network of institutional key-informants. Currently all specialised drug agencies (low/high threshold) at the national are involved in the data providing
process in terms of routine data transmission on new trends. Recently two new agencies have joined the EWS network, namely a counselling centre for drug users underage and a low threshold project. The 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 2,900 documents mainly in French, German and English language. Users of information services provided by the CDTL are mainly researchers, journalists, policy makers, drug treatment and prevention specialists, and general public. The majority of indexed documents are paper-based and abstracts are provided.

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

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

CLDDT is linked to the Centre de Documentation du Centre de Prévention des Toxicomanies run by CePT since 1996. The CePT documentation centre mainly 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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<td>AST</td>
<td>Service d’Action Socio-Thérapeutique</td>
</tr>
<tr>
<td>CNDS</td>
<td>Comité National de Défense Sociale</td>
</tr>
<tr>
<td>CePT</td>
<td>Centre de Prévention des Toxicomanies</td>
</tr>
<tr>
<td>CPOS</td>
<td>Centre de Psychologie et d’Orientation Scolaire</td>
</tr>
<tr>
<td>CRP-HT</td>
<td>Centre de Recherche Public - Henri Tudor</td>
</tr>
<tr>
<td>CRP-Santé</td>
<td>Centre de Recherche Public - Santé</td>
</tr>
<tr>
<td>CTM</td>
<td>Centre Thérapeutique de Manternach</td>
</tr>
<tr>
<td>CHNP</td>
<td>Centre Hospitalier Neuro-Psychiatrique</td>
</tr>
<tr>
<td>CPG</td>
<td>Centre Pénitentiaire de Givenich</td>
</tr>
<tr>
<td>CPL</td>
<td>Centre Pénitentiaire de Luxembourg</td>
</tr>
<tr>
<td>GHD</td>
<td>Groupe Horizontal « Drogues »</td>
</tr>
<tr>
<td>GID</td>
<td>Groupe Interministériel « Drogues »</td>
</tr>
<tr>
<td>EMCDDA/OEDT</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
</tr>
<tr>
<td>EMEA</td>
<td>Agence Européenne pour l’Evaluation des Médicaments</td>
</tr>
<tr>
<td>EUROPOL</td>
<td>Office Européen de Police</td>
</tr>
<tr>
<td>FLTS</td>
<td>Fonds de Lutte contre le Trafic des Stupéfiants</td>
</tr>
<tr>
<td>JDH</td>
<td>Fondation Jugend- an Drogenhëllef</td>
</tr>
<tr>
<td>LNS</td>
<td>Laboratoire National de Santé</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>OEDT/EMCDDA</td>
<td>Observatoire Européen des Drogues et des Toxicomanies</td>
</tr>
<tr>
<td>OGD</td>
<td>Observatoire Géopolitique des Drogues</td>
</tr>
<tr>
<td>PFN</td>
<td>Point Focal National de l’OEDT</td>
</tr>
<tr>
<td>PNUCID</td>
<td>Programme des Nations Unis pour le Contrôle des Drogues</td>
</tr>
<tr>
<td>RELIS</td>
<td>Réseau Luxembourgeois d’Information sur les Stupéfiants</td>
</tr>
<tr>
<td>SEPT</td>
<td>Semaine Européenne de Prévention des Toxicomanies</td>
</tr>
<tr>
<td>SNJ</td>
<td>Service National de la Jeunesse</td>
</tr>
<tr>
<td>SPJ</td>
<td>Service des Stupéfiants de la Police Judiciaire</td>
</tr>
<tr>
<td>TRANSRELIS</td>
<td>Réseau transfrontalier d’Information sur les Stupéfiants</td>
</tr>
<tr>
<td>ZePF</td>
<td>Zentrum für Empirische Pädagogische Forschung – Universität Landau</td>
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Annex V: excerpts from the Governmental declaration of 1999 and the coalition agreements

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

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

Concrètement, cela reviendra à créer chez nous des centres thérapeutiques, de faciliter l’accès à ces centres à l’étranger, de créer des infrastructures où, sous contrôle médical, nous dispenserez 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° la prévention, 2° la thérapie, 3° la prévention des risques et 4° la répression. Afin de mener une politique cohérente en la matière, le Ministre de la Santé regroupera au sein de son département les différentes compétences.

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

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

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

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