

L'ÉTAT DU PHÉNOMÈNE DES DROGUES ET DES TOXICOMANIES AU GRAND-DUCHÉ DE LUXEMBOURG

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

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ABBREVIATIONS

AST	Service d'Action Socio-Thérapeutique
CATF	Chemical Action Task Force
CePT	Centre de Prévention des Toxicomanies
CAS	Commission d'admission et de surveillance (CHDP)
CFSP	Common Foreign and Security Policy
CHNP	Centre Hospitalier Neuro-Psychiatrique
CICAD	Inter-American Drug Abuse Control Commission
CMO	Comprehensive Multidisciplinary Outline (UN)
CND	Commission on Narcotic Drugs
CNDS	Comité National de Défense Sociale
CNER	Comité National d'Ethique de Recherche
CNPD	Commission Nationale de Protection des Données
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
CPOS	Centre de Psychologie et d'Orientation Scolaire
CRP-HT	Centre de Recherche Public - Henri Tudor
CRP-Santé	Centre de Recherche Public – Santé
CTM	Centre Thérapeutique de Manternach
DEA	Drug Enforcement Administration (United States)
EWS	Early Warning System on New Synthetic Drugs
GID	Groupe Interservices Drogue (de la Commission européenne)
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMA	European Medicines Agency
EUROPOL	European Police Office
FBI	Federal Bureau of Investigation (United States)
FED	Fonds Européen de Développement
FATF	Financial Action Task Force on Money Laundering
FEDER	Fonds Européen de Développement Régional
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
HAT	Heroin Assisted Treatment
HDG	Horizontal Working Party on Drugs
Honlea	Heads of National Drug Law Enforcement Agencies
ICD	Interministerial Commission on Drugs
ICPO/Interpol	International Criminal Police Organization

ILO	International Labour Organization
INCB	International Narcotic Control Board
JDH	Fondation Jugend- an Drogenhëllef
LIH	Luxembourg Institute of Health
LNS	Laboratoire National de Santé
NDLEA	National Drug Law Enforcement Administration (Nigeria)
NFP	National Focal Point of the EMCDDA
NIDA	National Institute on Drug Abuse (United States)
OAS	Organization of American States
OCDE	Organisation de Coopération et de Développement Economiques
OGD	Observatoire Géopolitique des Drogues
OLAF	European Anti-Fraud Office
ONDCP	Office of National Drug Control Policy of the White House (United States)
PECO	Pays d'Europe Centrale et Orientale
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
REITOX	European Information Network on Drugs and Drug Addiction
SADC	Southern African Development Community
SCRIPT	Service de Coordination de la Recherche et de l'Innovation pédagogiques et technologiques
SEPT	Semaine Européenne de Prévention des Toxicomanies
SID	Système d'Information Douanier
SIS	Système d'Information Schengen
SNJ	Service National de la Jeunesse
SPG	Système de Préférences Généralisées
SPJ	Service des Stupéfiants de la Police Judiciaire
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organization
WHO	World Health Organization
ZePF	Zentrum für Empirische Pädagogische Forschung – Universität Landau



AVANT-PROPOS

Le rapport 2018 sur l'état du phénomène des drogues et des toxicomanies au Grand-Duché de Luxembourg (RELIS) vise à situer le contexte dans lequel s'inscrivent l'usage et le trafic illicites de drogues et les toxicomanies au niveau national en proposant une vue d'ensemble des évolutions historiques et des tendances actuellement observées en la matière.

Les experts, personnes, et institutions suivants ont été consultés: Dr Jean-Claude Schmit, Dr Arno Bache, Xavier Poos, Patrick Hoffmann, Guy Theisen, Guy Reinart, Simone Schram (Direction de la Santé) ; Catherine Trierweiler, Tara Desorbay (Ministère de la Justice) ; Fabienne Gandini (Administration des Douanes), Claude Frieden (CNS) ; Sophie Hoffmann, Raymond Herbrink, Alain Hensgen (Police Grand-Ducale) ; Dr Serge Schneider et Dr Michel Yegles (Laboratoire National de Santé) ; Claudia Allar (CNDS, Abrigado) ; Dr Carole Devaux (Luxembourg Institute of Health) ; Laurent Kocks (Programme TOX - CPL/CPG) ; Virginie Muller (CePT) ainsi que l'ensemble des ONG nationales spécialisées en matière de prévention et de prise en charge.

FOREWORD

The 2018 edition of the national report on the state of the drugs problem in the Grand Duchy of Luxembourg aims to describe the framework in which drug use and drug trafficking evolve at the national level by providing a comprehensive overview of historical developments and recent trends.

A particular thanks goes to the following experts, persons, and institutions consulted in the framework of the 2018 edition of the report: Dr Jean-Claude Schmit, Dr Arno Bache, Xavier Poos, Patrick Hoffmann (Directorate of Health); Catherine Trierweiler, Tara Desorbay, Guy Theisen, Guy Reinart, Simone Schram (Ministry of Justice); Fabienne Gandini (Customs Administration); Claude Frieden (CNS); Sophie Hoffmann, Raymond Herbrink, Alain Hensgen (Judicial Police); Dr Serge Schneider and Dr Michel Yegles (National Laboratory of Health LNS); Claudia Allar (CNDS, Abrigado); Dr Carole Devaux (Luxembourg Institute of Health); Laurent Kocks (Programme TOX - CPL/CPG); Virginie Muller (CePT) as well as all national specialised NGOs.

RESUME

RAPPORT NATIONAL SUR L'ÉTAT DU PHÉNOMÈNE DES DROGUES ET DES TOXICOMANIES AU GRAND-DUCHÉ DE LUXEMBOURG (RELIS - Edition 2018)

Depuis sa création en 1994, le Point Focal Luxembourgeois (PFN) de l'Observatoire Européen des Drogues et des Toxicomanies (OEDT) maintient et développe le dispositif de surveillance épidémiologique en matière de drogues et de toxicomanies, connu sous le nom de Réseau Luxembourgeois d'Information sur les Drogues et les Toxicomanies (RELIS).

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

Les efforts déployés depuis plus de 20 années ont permis de constituer une base de données nationale annuellement mise à jour, permettant notamment:

- de situer la prévalence, l'incidence et l'évolution de l'usage à haut risque de drogues illicites au niveau national ;
- de servir de support scientifique et de base de données pour l'activité de recherche ;
- d'évaluer les tendances nouvelles et l'impact de certaines interventions sur les comportements et caractéristiques de la population d'usagers de drogue à haut risque (UDHR) et de faciliter l'analyse des besoins et le processus décisionnel au niveau politique, notamment lors de la mise en place de plans d'action et de stratégies d'intervention en matière de lutte contre les addictions.

ORIENTATIONS POLITIQUES ET BUDGÉTAIRES

Le gouvernement a confié la coordination des actions de réduction de la demande et des risques associés aux drogues et aux toxicomanies au Ministère de la Santé, ce qui a donné lieu à la désignation d'un Coordinateur National « Drogues » en 2000.

Le programme gouvernemental de 2009 a servi de cadre à l'élaboration de la troisième stratégie nationale et du plan d'action pluriannuel en matière de lutte contre les drogues et les addictions. **La stratégie et le plan d'action 2010-2014** s'appuyaient sur les priorités fixées par le Ministère de la Santé et sur une collaboration soutenue avec les acteurs de terrain. Afin d'optimiser son impact, le plan d'action 2010-2014 a également tenu compte des éléments pertinents issus des traités UE et CE, **de la stratégie anti-drogue 2005-2012** et du **plan d'action drogues 2009-2012 de l'UE**. Le **plan d'action gouvernemental 2015-2019** a été élaboré sur base d'une **évaluation externe** du plan d'action 2010-2014. L'objectif général de la stratégie et du plan d'action nationaux est de contribuer à atteindre un niveau élevé de protection en termes de Santé publique, de Sécurité publique et de cohésion sociale.

Une stratégie de réponse aux drogues et aux toxicomanies qui veut faire face aux défis actuels repose prioritairement sur **deux piliers**, à savoir la réduction de la demande (RD) et la réduction de l'offre (RO) ainsi que sur **quatre axes transversaux** : 1. la réduction des risques, dommages et nuisances, 2. la recherche et l'information, 3. les relations internationales et 4. les mécanismes de coordination. Le Coordinateur National « Drogues », en collaboration avec le Groupe Interministériel « Toxicomanies » (GIT), suit et ajuste les processus de mise en œuvre du plan d'action en matière de lutte contre les drogues et les addictions.

Le budget global du Ministère de la Santé alloué aux services et programmes du domaine des drogues et des toxicomanies, est passé de 2.066.000.- EUR en 2000 à 13,994,013.- EUR en 2018 ce qui équivalait à un taux de progression de 577%.



INDICATEURS ÉPIDÉMIOLOGIQUES

A l'échelle mondiale (UNODC, 2018), le nombre global de personnes âgées de 15 à 64 ans ayant consommé au moins une drogue d'origine illicite a été estimé à 275 millions, soit environ 5.6% de la population mondiale dans cette classe d'âge. L'usage à haut risque de drogues illicites concerne quelque 31 millions de personnes, dont 10.6 millions sont des injecteurs. L'UNODC estime que 1 sur 8 usagers par injection sont VIH+.

Le cannabis reste de loin la drogue la plus consommée¹ au monde (192 millions de personnes). Le nombre d'usagers des stimulants de type amphétamine (STA) s'élèverait à 34 millions de personnes. La prévalence de « l'ecstasy » (21 millions de personnes) a diminué par rapport aux données de 2009. Le nombre de consommateurs d'opiacés se situe approximativement à 19 millions de personnes.

Au sein de l'UE, selon les dernières données de l'OEDT issues du *Rapport européen sur les drogues 2018 (Observatoire Européen des Drogues et des Toxicomanies 2018)*, plus de 92 millions de personnes (âgées entre 15 et 64 ans) ont déjà consommé une drogue illicite. Des évolutions positives sont à voir dans la baisse des nouveaux usagers d'héroïne, une diminution du recours à l'injection, et une stabilisation de l'usage de cannabis. En moyenne, la consommation de cocaïne a légèrement augmenté dans l'UE (5.1% en 2017 et 5.2% en 2018), certains pays étant particulièrement touchés. Aussi, le nombre de personnes en traitement reste élevé (1.4 millions d'Européens en 2015 et 1.3 millions en 2016) et le nombre d'infections VIH associés à l'usage de drogues a diminué. Les amphétamines et l'ecstasy demeurent les stimulants de synthèse les plus fréquemment consommés en Europe. Des données récentes suggèrent toutefois que l'usage d'amphétamines est stable ou en baisse chez les jeunes adultes.

En ce qui concerne le cannabis, environ 1% d'Européens adultes (de 15 à 64 ans) consomment du cannabis quotidiennement ou presque quotidiennement. En total, 14.1% de jeunes Européens âgés entre 15-34 années ont consommé du cannabis au cours de l'année écoulée.

Aussi, le nombre, le type et la disponibilité de nouveaux produits psychoactifs en Europe ont continué à croître. La mondialisation, les avancées technologiques et l'internet ont contribué au développement d'un marché ouvert à ces mêmes produits, majoritairement d'origine synthétique.

A l'échelle micro-géographique, les tendances au Grand-Duché de Luxembourg reflètent dans les grandes lignes celles observées au sein de l'UE, avec toutefois de variations au niveau de certaines prévalences.

Prévalence en population générale au G.-D. de Luxembourg

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

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

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

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

En matière d'études ciblées sur les populations jeunes, des données comparables issues d'enquêtes scolaires menées entre 2006 et 2014 (HBSC 2006 – 2014) témoignaient d'un taux de prévalence « vie » (consommation au moins une fois au cours de la vie) généralement stable en ce qui concerne la consommation de drogues illicites, toutes catégories confondues. Tous types de drogues illicites ont suivi cette même tendance à l'exception des « médicaments psychoactifs » et le LSD qui ont connu une consommation croissante. L'usage d'opiacés par les jeunes en âge scolaire continue toutefois de témoigner d'une prévalence basse.

Bien que le cannabis demeure la drogue illicite la plus consommée parmi les jeunes de 13 à 18 ans, une légère baisse au niveau de l'usage-vie à partir du début du 21^{ème} siècle a pu être observée au niveau national. Actuellement il est estimé que 17.1% (17.4% en 2010 et 22.6% en 2006) des jeunes âgés de 15 ans ont déjà consommé au moins une fois au cours de leur vie du cannabis (HBSC, 2014). Le taux de prévalence de l'usage récent (derniers 12 mois) de cannabis parmi ces mêmes jeunes a été stable entre 2006 et 2014 et la prévalence de l'usage actuel/courant (derniers 30 jours) de cannabis a augmenté modérément pendant la même période.

Prévalence de l'usage de drogues à haut risque (UDHR)²

Contacts institutionnels et recours aux institutions sanitaires pour des problèmes liés aux drogues illicites

Le nombre d'usagers de drogues à haut risque indexés par les institutions nationales en 2017 équivalait à 5.285 personnes (comptages multiples inclus³) (2002: 4.701).

A titre comparatif, on retiendra qu'en 2002, 2.383 personnes furent recensées par les **institutions de réduction de la demande (RD)** et 2.318 par les **instances de réduction de l'offre (RO)**. En 2017, ces mêmes instances ont recensé respectivement 2.992 et 2.293 personnes. Sommairement, le nombre de personnes entrées en contact avec des instances de réduction de la demande (RD) a augmenté de manière discontinue pour afficher un pic en 2015. Depuis 2016 une importante réduction du nombre de contacts avec des instances de réduction de l'offre (RO) a été observé. À noter enfin la baisse au niveau du nombre de contacts enregistrés par les services de bas seuil entre 2011 et 2013. Par contre, depuis 2014 des augmentations successives des contacts sont observées.

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

Le sex-ratio (M/F) de la population des UDHR recensés par RELIS est actuellement de 77/100. Sur les dix dernières années, on constate que la proportion de ressortissants étrangers parmi les UDHR recensés a témoigné d'importantes fluctuations affichant cependant des hausses marquées en 2015 (58%) et en 2016 (63%) face à un taux de non-luxembourgeois de 47.7% en population générale à l'échelle nationale (1er

² Le terme 'UDHR' sera utilisé pour désigner des 'Usagers de drogues à haut risque' tout au long du présent rapport.

³ Dans ce recensement les comptages multiples sont inclus ce qui signifie qu'une personne donnée a pu être indexée deux fois ou plus si on tient compte de l'ensemble des institutions spécialisées établies sur le territoire national. Dès lors, ce chiffre ne représente pas la prévalence (la taille) effective de la population d'UPD au niveau national (qui elle, se détermine par des méthodologies différentes).



janvier 2017). Une diminution à 38% des UDHR d'origine étrangère a été observée en 2017. La population des non-luxembourgeois(es) est principalement composée de citoyens portugais (39% de l'ensemble des UDHR non-luxembourgeois) suivi par de citoyens français.

L'âge moyen des usagers recensés est passé de 28 ans et 4 mois en 1995 à 38 ans et 6 mois en 2017. L'âge moyen des UDHR masculins a augmenté plus rapidement que celui des femmes à l'exception de l'année 2017 pour laquelle les données indiquent que les femmes UDHR sont en moyenne plus âgées que les hommes. L'écart entre les usagers les plus jeunes et les plus âgés s'est stabilisé récemment. Le pourcentage des UDHR de la classe d'âge 40 ans et plus a augmenté continuellement au cours des dernières années, tandis que le pourcentage d'UDHR âgés de moins de 30 ans affiche une tendance générale à la baisse. Bien que les données de 2017 suggèrent que les usagers luxembourgeois et usagères féminines sont en moyenne plus jeunes respectivement que les non-luxembourgeois et les hommes, ces différences ne sont pas statistiquement significatives.

On retiendra également l'accroissement marqué de l'âge moyen des victimes de **surdoses mortelles** au cours des derniers 20 ans (1992 : 28.4 ans ; 2016 : 41.1 ans ; 2017 : 41.5 ans).

Prévalence de l'UDHR et tendances de consommation

Les données nationales en matière de prévalence UDHR sont issues d'études sérielles menées en 1997, 1999, 2000, 2007, 2009 et 2017 (Origer, 2012⁴, 2017). En référence à l'étude sérielle de prévalence la plus récente (Origer, 2017), portant sur les données de 2015, la prévalence et le taux de prévalence actuels d'**Usagers de Drogues à Haut Risque** (UDHR) sont estimés respectivement à 2.250 personnes. Une tendance à la baisse du taux de prévalence UDHR au sein de la population nationale est observée depuis 2003. Une évolution similaire est également constatée pour ce qui est de **l'usage de drogues par injection** (UDI) à partir de 2009. La prévalence de **l'usage d'opiacés** (OU) a été estimée la première fois sur base de données de 2015 et se situe autour de 4.46 usagers par 1.000 habitants âgés entre 15 et 64 années ce qui équivalait à environ 1.700 personnes.

L'usage par injection d'héroïne et de cocaïne associé à une **polyconsommation généralisée** constitue le comportement le plus observé au sein des UDHR répertoriés par le réseau institutionnel. La consommation par injection diminue progressivement entre les UDHR. La proportion d'UDI a diminué de 62% en 2009 à 40.8% en 2017.

En 2016, la cocaïne en tant que drogue préférentielle a demeuré à un niveau élevé (17%) comparable aux années précédentes (2014 : 19.9% et 2015 : 19%). En 2017 la consommation préférentielle de cocaïne parmi les UDHR affiche une nouvelle hausse (21%).

Le nombre de personnes en contact avec le réseau institutionnel spécialisé pour usage (préférentiel) de **cannabis** a atteint 32.8% en 2016 (2015 : 23.1%). Par contre, en 2017 une diminution de ce taux a été observé. Il est important de noter qu'au cours de 2017, le nombre de données collectées par les agences de traitement spécialisées pour usage (préférentiel) de cannabis a considérablement diminué. Ainsi, ce résultat doit être considéré avec prudence et suivi au cours des prochaines années. Les demandes de traitement pour des substances de **type amphétamines et ecstasy** sont faiblement représentées, ce qui toutefois ne renseigne nullement sur la prévalence de leur usage en population générale étant donné que les données

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

RELIS portent sur l'ensemble des UDHR et ne recensent dès lors pas la totalité des usagers récréatifs. Le taux de **polytoxicomanie** a diminué de manière discontinue entre 2011 et 2014 (54%). Depuis 2014, ce taux augmente de manière discontinue et a atteint 76% en 2017.

OFFRES DE TRAITEMENT DES TOXICOMANIES

Le nombre de patients adultes en traitement ambulatoire et en traitement hospitalier est en hausse, tandis que le nombre de patients en traitement résidentiel spécialisé affiche une légère tendance à la baisse. Depuis 2010, le nombre de demandeurs de traitement de substitution s'est stabilisé et le nombre de contacts avec l'ensemble des structures d'accueil à bas-seuil a diminué entre 2010 et 2013 (2010: 140.093; 2012: 127.080; 2013: 124.048) et est à nouveau en hausse depuis 2014 (2014: 131.375; 2015: 142.054, 2016: 150.937 contacts). En 2017, le nombre de contacts avec des structures d'accueil à bas-seuil a encore augmenté pour atteindre 164.254 contacts.

Tous centres et services de traitement confondus, 27% des patients recensés par RELIS ont formulé leur première demande d'aide en 2017. Une tendance qui se confirme est la hausse de la proportion de patients en traitement de substitution âgés de 40 ans et plus (54.7%). En ce qui concerne des patients en traitement de substitution, 51.3% sont luxembourgeois.

MORBIDITÉ ET MORTALITÉ LIÉES À LA CONSOMMATION ILLICITE DE DROGUES

La prévalence des cas **VIH/sida** au sein de la population d'UDHR était globalement stable avant 2014, selon les données RELIS (auto-déclaré) et selon la proportion d'UDI parmi les cas de nouvelles infections VIH (Laboratoire de rétrovirologie). Plus précisément, de 2004 à 2013 cette proportion variait entre 4% et 6% (données RELIS) et entre 2 et 8 cas d'UDIs parmi les nouveaux patients VIH (données du Laboratoire de rétrovirologie). À partir de 2014, une tendance à la hausse a été observée (2016: 21 UDI parmi les nouveaux patients séropositifs et 9.77% de séropositifs déclarées parmi les UDHR recensés par RELIS) alors que les offres nationales en matière de réduction des risques et dommages sont fort développées et diversifiées. D'autres États membres de l'UE ont également signalé des flambées récentes de VIH parmi les populations de consommateurs de drogues injectables (UDI) (OEDT, 2016).

Dans ce contexte, un groupe d'experts a travaillé sur cette question afin de comprendre les raisons et les réponses possibles. La récente augmentation de la consommation de cocaïne par injection semble expliquer en partie ce phénomène. Une plus grande offre de cocaïne sur le marché, des injections plus fréquentes dues à des fenêtres d'effet plus courtes (par rapport à l'héroïne), des groupes d'utilisateurs marginalisés avec peu ou sans contact avec les services disponibles, ainsi qu'une proportion accrue de prostitution liée à l'usage de drogues sont d'autres facteurs supplémentaires en jeu.

Les données récentes de 2017 et 2018 suggèrent une **inversion de cette tendance** et indiquent une diminution du nombre (10 en 2017, contre 21 en 2016) et de la proportion (9.9% en 2017 et 21.4% en 2016) d'UDI parmi les nouveaux séropositifs diagnostiqués dans le pays.

La **prévalence de l'infection à l'hépatite C** parmi les usagers de drogues semble s'être stabilisée à un niveau élevé: 54.7% des UDHR ont déclarés être infectés par l'hépatite C (RELIS, 2017) et 75.8% des consommateurs par injection-vie ont eu un test sérologique positif pour l'hépatite C (Devaux et al., 2017).

La concrétisation des plans d'action consécutifs a été accompagnée d'une baisse discontinue mais tangible du taux de **décès par surdosage** au Grand-Duché de Luxembourg (2017 : 8 cas).



Exprimée en nombre de cas de surdoses par rapport à la population générale du Grand-Duché de Luxembourg, cette proportion correspondait à 5.9 décès par surdose pour 100.000 habitants âgés entre 15 et 64 ans en 2000 (2007 : 5.67). En 2017, 1.9 surdoses aiguës pour 100.000 habitants ont été enregistrées, représentant une tendance décroissante. Les données médico-légales de 1992 à 2017 confirment que la quasi-totalité des décès impliquaient la consommation d'héroïne et de substances prescrites dans un contexte de polyconsommation.

Pour les victimes, il s'agissait d'une femme et de 7 hommes en 2017 et l'âge moyen au moment du décès a connu une hausse discontinue mais sensible sur les dernières vingt années (1992 : 28.4 années, 2016 : 41.1 années et 2017 : 41.5 années). Bien que la moyenne d'âge ait augmenté, le nombre de victimes âgées de moins de 20 ans est resté relativement stable. En 2017, la victime la plus jeune était âgée de 25 ans au moment du décès, tandis que la plus âgée avait 53 ans.

Une majorité confirmée de 87.5% (60% en 2016) de victimes était de nationalité luxembourgeoise. Une analyse détaillée des cas de victimes de surdoses fatales depuis 1994 a été effectuée dans le cadre d'études à grande échelle dont les résultats ont été publiés entre 2013 et 2015 (Origer et al., 2014, 2015)⁵.

CONSÉQUENCES SOCIALES ET MESURES DE RÉINTÉGRATION

Les corollaires sociaux de l'usage de drogues et de la dépendance y associée sont multiples et se répercutent aux niveaux familial, professionnel, financier et légal.

Le niveau d'enseignement des usagers recensés est pour la plupart faible et incomplet. Leur situation résidentielle affiche toutefois une amélioration longitudinale. Si en 1995, 31% des usagers de drogues disposaient d'un logement stable, cette proportion se situe actuellement autour de 65% (ce qui est comparable à l'année 2016 : 67%), et peut en partie être le mérite d'une série de projets d'aide au logement pour personnes dépendantes mis en place dans le cadre des plans d'action « drogues ». Les chiffres les plus récents tendent cependant à confirmer que même si l'offre en logements encadrés pour la population visée continue à être développée, la demande pour ce genre de logements s'est accrue également sur la toile de fond de la situation économique plus difficile des dernières années.

Le **taux d'inactivité professionnelle** (60%) parmi la population cible tend à stagner. La majorité des consommateurs de drogues indexés dépendent de l'aide sociale (allocations de chômage ou de retraite, etc.) et le revenu minimum garanti (RMG) constitue la **principale source de revenus des UDHR** (37.4% en 2017). Cependant, la proportion d'UDHR professionnellement actifs présentant une situation d'emploi stable est restée assez inchangée les dernières 4 années et les activités illégales en tant que revenu principalregistrent une tendance à la baisse depuis 2013.

MESURES DE RÉDUCTION DES RISQUES

Le **nombre de contacts enregistrés par les structures d'accueil bas-seuil et de réduction de risques** a connu un accroissement remarquable depuis 2013 (124.048 contacts). En 2017, 164.806

5 Origer, A., Lopes da Costa, S. & Baumann, M. (2014). Opiate and cocaine related fatal overdoses in Luxembourg from 1985 to 2011: A study on gender differences. *Eur Addict Res*, 20(2), 87-93. DOI: 10.1159/000355170
Origer, A., Le Bihan, E. & Baumann, M. (2014). Social and economic inequalities in fatal opiate and cocaine related overdoses in Luxembourg: A case-control study. *Int J Drug Pol*, 25, 911-915. DOI: 10.1016/j.drugpo.2014.05.015
Origer, A., Le Bihan, E. & Baumann, M. (2015). A Social Gradient in Fatal Opioids and Cocaine Related Overdoses? *PLoS ONE*, 10(5), e0125568. DOI:10.1371/journal.pone.0125568

contacts ont été enregistré par les différents services de réduction de risques (2016 : 150.937). Environ 54% des clients de la salle de consommation national (Abrigado) appartiennent à la classe d'âge 35-44 ans. Approximativement 16% des clients sont des femmes.

Depuis la mise en place du **programme national d'échange de seringues**, on notait une augmentation continue du nombre de seringues stériles distribuées jusqu'en 2006. Entre 2006 et 2013 on assistait à une tendance à la baisse. En 2017 une nouvelle hausse marquée s'observait (2017 : 437.946 / 1996 : 76.259). Le taux global de retour de seringues usées a augmenté pendant la période de référence et se situe actuellement à 92% (94% en 2016). Un nombre croissant d'injecteurs se procurent leurs seringues auprès de structures spécialisées suivies des pharmacies.

INDICATEURS DE RÉDUCTION DE L'OFFRE⁶

Saisies de substances illicites au niveau national

D'importantes variations au niveau de l'évolution des **quantités saisies** s'observent depuis le début des années 90 et ceci pour presque tous les types de produits. Une analyse longitudinale fait apparaître une tendance générale à la baisse des **quantités saisies**⁷ d'héroïne, de cocaïne et de cannabis entre 2006 et 2013, affichant toutefois une nouvelle hausse pour le cannabis et la cocaïne à partir de 2014. Dans l'ensemble, les quantités de cocaïne saisies sont restées élevées ces dernières années, tandis que les quantités de cannabis saisies ont atteint un nouveau pic en 2017.

Nonobstant les quantités de cannabis et de cocaïne saisies, **le nombre de saisies** a augmenté de façon discontinue depuis 1990 en ce qui concerne le cannabis et depuis 2010 pour la cocaïne, alors que le nombre de saisies d'héroïne a eu tendance à diminuer depuis 2010 avec une légère reprise à partir de 2014.

Aucune saisie de **crack** n'a été rapportée à ce jour par les instances répressives bien que les associations de terrain rapportent la pratique du *free-basing* / *cocaine cooking* par certains usagers. En ce qui concerne la cocaïne, un total de 226 saisies ont été signalées en 2017 par la Police Judiciaire. Les premières saisies de **substances de type ecstasy** (MDMA, MDA, etc.) ont été enregistrées en 1994 et les quantités saisies au niveau national affichent une nette tendance à la hausse depuis 2014. L'année 2016 représentait un record des quantités de MDMA saisies. En 2017, toutefois, la quantité de pilules de MDMA saisies a diminué à nouveau.

Mesures judiciaires et pénales

Le nombre de **procès-verbaux** pour motifs d'infraction à la loi modifiée de 1973 est passé de 2.546 en 2010 à 3.385 en 2015, alors qu'il a diminué au cours des deux dernières années (2.624 en 2016; 2.525 en 2017). En ce qui concerne le nombre respectif de **prévenus**, on note une évolution similaire à celle du nombre de procès-verbaux. En 2017 furent enregistrées 183 **arrestations** (2016: 234) pour motifs d'infraction à la loi modifiée de 1973.

Le nombre total de personnes impliquées dans des infractions pour possession de drogues a suivi une tendance à la hausse jusqu'en 2015 et a connu une première diminution au cours des deux dernières années (2000: 1.758; 2012: 1.782; 2013: 2.066; 2014: 2.779; 2015: 3.345; 2016: 2.566; 2017: 1.969).

⁶ Sauf indication contraire, les données présentées se rapportent à l'année 2017. A défaut d'autres indications, les données entre parenthèses se rapportent à l'année 2016.

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



La population des prévenus se compose de 86% hommes, proportion qui variait entre 79% et 90% durant les dix dernières années. 808 prévenus nouveaux ont été enregistrés en 2003 et 1.047 en 2017. Le **pourcentage de prévenus mineurs** (< 18 ans) parmi les premiers auteurs a connu une tendance à la hausse qui est confirmé par les chiffres les plus récents (11.2% en 2014, 9.7% en 2015; 10% en 2016; 12.4% en 2017 contre 4.9% en 1994). Le cannabis est la principale substance impliquée dans les premières infractions.

Depuis 1998, les personnes originaires de pays autres que le Luxembourg (63.6% en 2017 ; 59% en 2016) ont représenté la majorité des prévenus (50-68%). En 2017, 53% des cas enregistrés sont des **premiers auteurs**, une proportion relativement élevée comparée aux années antérieures (32% en 2015 et 37% en 2016). Les données statistiques fournies par l'administration pénitentiaire pour l'année 2017 font état de 974 (962 en 2016) nouvelles entrées dont 26% (249 en 2017 ; 306 en 2016) pour infraction(s) à la loi modifiée du 19 février 1973 (Code : DELIT-STUP); une proportion qui représentait 42.6% en 1996.

DISPONIBILITÉ ET QUALITÉ DES DROGUES ILLICITES AU NIVEAU NATIONAL

La production nationale de drogues illicites est jugée très limitée en termes de quantité et de qualité. Au cours des deux dernières années, aucun laboratoire clandestin de drogues n'a été démantelé. Selon les données fournies par la Police Judiciaire et par l'ensemble des unités décentralisées de la Police Grand-Ducale (sections de recherche), la grande majorité des drogues illicites consommées au Grand-Duché de Luxembourg sont originaires des Pays-Bas (production de cannabis et transit d'autres drogues) suivis de la Belgique (transit et production d'ecstasy et d'amphétamines) et du Maroc (production de cannabis). **La disponibilité de cocaïne sur le marché national est élevée.** L'importation de cocaïne depuis l'Amérique latine s'effectue souvent par le sud de l'Europe (Espagne, Portugal) pour être acheminée ensuite via la France, la Suisse, l'Autriche et l'Allemagne en direction des Pays-Bas, tandis que l'héroïne continue à emprunter la route du Balkan (Roumanie et Bulgarie) ou des dérivés de celle-ci (Pologne, Turquie, Bélarusse). Le pays producteur principal reste l'Afghanistan.

Au cours des dernières années des réseaux de distribution mieux organisés ont vu le jour sur le plan national. L'expansion de ces réseaux plus structurés a contribué à une hausse sensible de la disponibilité de drogues, particulièrement en ce qui concerne l'offre de cocaïne et de cannabis. Les nouvelles drogues synthétiques et produits associés (Legal highs) sont également à surveiller de façon rapprochée. Les stratégies et techniques de vente de drogues impliquent plusieurs acteurs avec des tâches bien définies afin de réduire les risques liés au trafic. Par ailleurs, les réseaux de vente œuvrent à délocaliser leurs points de vente vers des endroits moins visibles aux forces de l'ordre, tels qu'appartements privés, cafés ou des aires de repos autoroutières afin de rencontrer leurs clients à mi-chemin et de vendre des quantités brutes.

Au cours des dernières 10 années, **la pureté** de la cocaïne a baissé et une tendance générale mais discontinue à la baisse au niveau de la pureté moyenne de l'héroïne est observable pendant la même période. Il faut tenir compte des différences marquées entre les puretés maximales et minimales (en particulier pour le cannabis et la cocaïne), ainsi que de la concentration maximale élevée de THC dans les produits de cannabis saisis au Luxembourg ces dernières années.

Les prix de rue de l'héroïne, de la cocaïne et du cannabis connaissent des marges croissantes, ce qui est dû partiellement aux différences de plus en plus marquées de la qualité de l'ensemble des drogues de rue. Néanmoins, les prix ont été stables au cours des 5 dernières années. Le cannabis de rue (résine et herbe) est actuellement vendu au prix de 8 à 15 euros par gramme, le prix moyen par gramme de la cocaïne est actuellement de 95 € et celui de l'héroïne se situe autour de 55 €, ce qui témoigne d'une légère augmentation des prix de l'héroïne et de la cocaïne au cours des dernières années. Les prix des stimulants tels que l'ecstasy, la MDMA et les amphétamines varient entre 7 et 15 €.

Tous indicateurs de tendances confondus, les données les plus récentes suggèrent **une diminution de la prévalence des UDHR et une stabilisation de la prévalence des UDI**. Au cours de la dernière décennie un nombre croissant d'UDHR a commencé un traitement ou profite des offres bas-seuil et un nombre décroissant d'UDHR entre en contact avec les forces de l'ordre.

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

La qualité des drogues vendues sur les marchés illicites au niveau national a connu une dégradation importante, ce qui a eu comme conséquence une augmentation généralisée de la polyconsommation. Le nombre de victimes de surdosages mortels a diminué à 8 cas en 2017 (27 cas en 2007).

Bien que la prévalence UDHR récente témoigne d'une tendance à la baisse, certains indicateurs indiquent une marginalisation croissante de certains groupes d'utilisateurs. Une partie des UDHR peut ne pas être en contact avec les services de traitement/bas seuil (et éventuellement non plus avec les forces de l'ordre). En outre, il convient de surveiller de près les nouveaux phénomènes tels que l'ivresse précoce, le « binge drinking » chez les jeunes, le « cocaïne freebasing », l'injection de stimulants et l'utilisation de nouvelles drogues de synthèse (NPS) et de produits contenant ces dernières.

Les maladies infectieuses dont souffrent beaucoup d'usagers de drogues et particulièrement les UDI demeurent un phénomène préoccupant. Les taux d'infection à VIH parmi les UDHR ont été faibles et stables de 2000 à 2008, mais ont montré une tendance à la hausse en 2009 et 2010 pour se stabiliser à nouveau autour de 3 à 5% entre 2011 et 2014. Cependant, en 2015 et 2016, une nouvelle augmentation (8% et 9%) a été enregistrée concernant la proportion d'UDHR infectées par le VIH, bien que le nombre de seringues distribuées aux UDI par le biais du programme national d'échange de seringues ait atteint un niveau record en 2017. En outre, la proportion d'UDI dans les nouveaux cas de VIH était en hausse depuis 2014. Les données de 2017 et 2018 suggèrent toutefois une première inversion de cette tendance.

La prévalence de l'hépatite C n'a cessé d'augmenter entre 2000 et 2008, mais a légèrement diminué en 2009, 2010 et 2012 pour augmenter à nouveau en 2014. En 2017, la proportion d'UDHR infectés par l'hépatite C s'est stabilisée à un niveau élevé. Des résultats de recherche basés sur des tests sérologiques suggèrent des taux d'infection d'hépatite C supérieurs à 70% et même plus élevés chez les populations carcérales en 2007 (Origer et Removille, 2009) et d'environ 75.8% chez les UDI-vie (usagers de drogues injectables – au cours de la vie) en 2017 (Devaux et al., 2017).

Le marché illicite de drogues au niveau national se caractérise par des techniques de vente et de stratégies de distribution plus agressives ce qui est notamment dû à une collaboration plus perfectionnée entre des multiples groupes criminels ayant des tâches/fonctions spécifiques. Dans ce contexte on peut observer que les points de vente sont devenus moins visibles pour les forces de l'ordre, p.ex. des appartements privés ou des bars. La disponibilité de cocaïne sur le marché national est élevée et croissante et la consommation de cocaïne et de MDMA / ecstasy chez les jeunes semble également augmenter. Le nombre de saisies de cannabis, de cocaïne et de MDMA a augmenté au cours des dernières années, bien que seuls le cannabis et la cocaïne témoignent également d'une augmentation des quantités saisies. Une attention particulière doit aussi être portée sur les différences accrues observées dans les puretés minimales et maximales des drogues de rue ainsi qu'à la concentration maximale du THC au niveau des saisies de cannabis les dernières années. Les différences de qualité des drogues de rue ont tendance à augmenter ce qui suggère des mécanismes plus diversifiés de distribution et qui pourrait expliquer les variations de prix importantes observées au cours des dernières années. L'ensemble des indicateurs disponibles suggère par ailleurs que les consommateurs de drogues illicites s'approvisionnent de plus en plus sur le marché national. Généralement, les prix des drogues



illicites ont affiché une légère tendance à la hausse au cours des dernières années. Le nombre d'infractions à la législation liées aux drogues et le nombre de prévenus a légèrement diminué en 2017 par rapport aux années précédentes.

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

Les plans d'action nationaux en matière de drogues et d'addictions ont permis de disposer de moyens financiers supplémentaires. Si la prévention primaire est considérée comme primordiale, les mesures d'intervention précoce ont été développées. Des efforts importants ont également été déployés pour diversifier les offres de soins et, enfin, les mesures de réduction de risques ont été considérablement diversifiées. Les offres de logement et les programmes de réintégration ont par ailleurs contribué à améliorer les situations socioprofessionnelles, comme en témoignent les dernières données RELIS. Le traitement de substitution et les offres à bas-seuil ont été diversifiés et décentralisés et continuent de l'être.

Les mécanismes de coordination ont été renforcés entre les ONG et les autorités nationales et des mécanismes d'évaluation sont en place. Il a été procédé à une deuxième évaluation externe du plan d'action drogues et addictions (2010-2014). Les résultats ont été intégrés, ensemble avec les recommandations issues d'une série de groupes de travail d'experts nationaux et de résultats d'enquêtes auprès des usagers/clients, dans l'élaboration de la nouvelle stratégie drogues et addictions et plan d'action 2015-2019, qui a son tour sera soumis à une évaluation externe dont les résultats seront intégrés dans l'élaboration du prochain plan d'action national 2020-2024.

SUMMARY

ANNUAL NATIONAL REPORT ON THE STATE OF THE DRUGS PROBLEM (Edition 2018)

DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

In 1999, the government entrusted the Ministry of Health with the overall coordination of drug-related demand and risk reduction actions. This led to the creation of the National Drug Coordinator's Office in 2000.

The 2009 governmental programme has set the framework for the elaboration of the third national strategy and action plan (2010-2014) for the fight against drugs and addictions. **The national strategy and action plan 2010-2014** relied upon the priorities of the Ministry of Health and a sustained collaboration with field actors and civil society. In order to optimize its impact, the new action plan has taken into account relevant issues from EU and EC treaties, **the EU anti-drugs strategy 2005-2012** and the **EU drugs action plans 2009-2012**. The elaboration of the new **national drugs action 2015-2019** has built upon the outcome of an **external evaluation** of the previous action plan. The general aim of the national strategy and action plan is to contribute to a high level of protection in terms of public health, public security and social cohesion.

The national drug strategy relies on **two pillars**, namely on demand reduction and supply reduction and on **four transversal axes**: 1. Risk, damage and nuisance reduction, 2. Research and information, 3. International relations and 4. Coordination mechanisms. The national drug coordinator, jointly with the Interministerial Committee on Drugs (ICD), follows up and steers the implementation process of the national drugs action plan.

The **global budget of the Ministry of Health** granted to drug demand reduction related services and programs has increased from 2,066,000.- EUR in 2000 to 13,994,013.- EUR in 2018, thus witnessing a progression rate of 577%.

EPIDEMIOLOGICAL INDICATORS

Globally, the UNODC (2018) estimates that 275 million people aged 15 to 64 years used at least one illicit substance during the past year, revealing approximatively 5.6% of the global population from this age group. High-risk drug use (HRDU) affects about 31 million people worldwide, and among these 10.6 million are intravenous drug users. The UNODC estimates that 1 in every 8 intravenous drug users is HIV+.

Cannabis remains the most widely consumed illicit psychoactive substance worldwide (192 million people), and its consumption represents a slight increase compared to former estimations of 2009. The use of amphetamine-type stimulants reached 34 million people. The prevalence of "ecstasy" (21 million people) has decreased compared to 2009 data. The number of opiate users has increased and currently situates around 19 million people.

According to the European Drug Report 2018 (2016 data), published by the EMCDDA, more than 92 million people (between 15 and 64 years-old) in Europe have used an illicit drug at least once in their lifetime. Positive evolutions are observed in the decline of new heroin users, the decrease of the number of people who inject drugs, and the stabilisation of the use of cannabis. On average, the use of cocaine has slightly increased in European Union (5.1% reported in 2017 and 5.2% reported in 2018), while some countries are particularly affected by this development. The number of people in treatment remains high (1.4 million



of Europeans in 2015 and 1.3 million in 2016) and the HIV infection associated to drug use is decreasing. Amphetamines and ecstasy remain the most widely used synthetic stimulants in Europe. Recent data suggest, however, a stable and declining use of amphetamines by young adults.

Concerning cannabis, it is estimated that around 1% of European adults use cannabis daily or nearly on a daily basis. In 2016, 14.1% of young Europeans aged 15 to 34 years consumed cannabis during the past year.

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

At the micro-geographical level, tendencies observed in the Grand-Duchy of Luxembourg reflect those observed in the EU with however local prevalence variations.

National drug prevalence in the general population

Drug prevalence in school population and in the general population

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

The controlled substances most often used in Luxembourg after cannabis were cocaine and XTC type substances, whereas national use prevalence rates situate below the EU average. Male users showed higher prevalence rates of cannabis use than female users. The first use of illicit substances occurs most often in age group 15 to 19 years with the exception of heroin and cocaine, which occur most often in age group 20 to 24 years (first use of ecstasy is reported equally between 15-19 and between 20-24 years).

In terms of surveys targeting younger populations, serial school survey data (HBSC 2006 – 2014) reveal a stable trend in the prevalence of various illicit drug use from 2006 to 2014. The majority of the common illicit drugs follow a declining or stable lifetime prevalence trend with the exception of "abuse of psychoactive medicines" and LSD witnessing an increase. Opiates' use in school-aged children has been consistently low over the last decade.

Even though cannabis is still the most used illicit drug by youngsters aged 13 to 18 years, a slight decline has been observed from the beginning of the 21st century as far as lifetime prevalence is concerned. Currently, it is estimated that 17.1% (17.4% in 2010 and 22.6% in 2006) of national youngster aged 15 have already used cannabis at least once during lifetime (HBSC, 2014). Recent cannabis use prevalence rates (last 12 months) have been stable between 2006 and 2014 and current cannabis use prevalence (last 30 days) has been increasing moderately during the same period.

Data on institutional contacts and drug treatment demands

The annual **number of HRDU person-contacts** indexed by national institutions figured 5,285 in 2017 (multiple counts included⁸) (2002: 4,701).

In total, 2,383 users have been indexed by national specialised **drug demand reduction (DR)** agencies, and 2,318 drug law offenders by **supply reduction (SR)** agencies in 2002. In 2017, the same agencies have indexed 2,992 and 2,293 persons, respectively. Overall, the number of persons showing drug-related contacts with demand reduction (DR) agencies has been discontinuously increasing, showing a peak in 2015. Since 2016, an important decrease of contacts registered by supply reduction (SR) agencies has been observed. Worth mentioning is also the decrease between 2011 and 2013 of national low threshold agencies' contacts. Successive increases, however, have been observed 2014 onwards.

Socio-demographic profile of HRDU

In 2017, the **male/female ratio** of the HRDU population set at 77/100. Over the last decade the proportion of indexed non-native HRDU has been showing strong variations but marked increases in 2015 (58%) and in 2016 (63%) compared to a rate of non-native citizens in the national population of 47.7% (1st of January 2017). A decrease towards 38% of non-natives HRDU was observed in 2017. The population of non-native drug users largely consists of Portuguese citizens (39% of total number of non-native HRDU), followed by French citizens (18%).

The **mean age** of indexed HRDU has been evolving from 28 years and 4 months in 1995 to 38 years and 6 months in 2017. The mean age of male HRDU has been increasing faster than for females with the exception of the year 2017 for which data indicate average older female HRDU. The proportion of HRDUs aged 40 and more has been increasing over recent years, while the proportion of HRDUs aged 30 years and less has been witnessing a general decreasing tendency. Even though average data from 2017 suggest that native and female users are younger than non-natives and male users respectively, these differences are not statistically significant.

Worth mentioning is also the overall increase of the average age of fatal overdose victims during over the last 20 years (1992: 28.4 years; 2016: 41.1 years; 2017: 41.5 years).

HRDU prevalence and consume trends

National data are provided by serial prevalence studies on HRDU aged between 15 and 64 years performed in 1997, 1999, 2000, 2007, 2009 and 2017 (Origer, 2012⁹, 2017). According to the latest serial drug use prevalence study (Origer, 2017) performed on 2015 data, the national prevalence of **HRDU** situates around 2,250 persons. A decreasing trend in the HRDU prevalence rate in the national population aged 15 to 64 years has been observed from 2003 onwards. A similar evolution occurred also for **Injecting Drug Use (IDU)** prevalence since 2009. The prevalence rate of **Opioid Use (OU)** was estimated for the first time on 2015 data at 4.46 per 1,000 inhabitants aged 15-64 years, which equals to approximately 1,700 opioid users.

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

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



Injecting heroin and cocaine use associated to **polydrug use** have been reported being the most common consume pattern in HRDU. The injecting consumption route has been progressively decreasing among HRDU. The proportion of IDUs decreased from 62% in 2009 to 40.8% in 2017. In 2016, cocaine as primary drug reached a high level (17%) similar to the ones observed in 2014 (19.9%) and 2015 (19%). The use of cocaine as primary drug among HRDUs increased and reached 21% in 2017.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use represented 32.8% in 2016, while this number decreased in 2017. However, it is important to note that, in 2017, the coverage of data collected by the cannabis specialised treatment agencies decreased significantly. Hence, this result should be considered with caution and be followed during coming years. **Amphetamine** type substances and ecstasy related treatment demands are low, which, however, does not inform on their prevalence in general population as RELIS data refer to HRDU and not to the overall population of recreational drug users. The proportion of **polydrug use** decreased from 2011 to 2014 (54%). Since then, it has been discontinuously increasing and reached 76% in 2017.

DRUG-RELATED TREATMENT

The number of adult outpatient clients and hospital-based treatments tends to increase, while the number of adult inpatient treatment demanders have been decreasing slightly at national level. Since 2010, the number of substitution treatment demanders has been stabilising and the number of contacts in low threshold facilities has been decreasing from 2010 to 2013 (2010: 140,093; 2012: 127,080; 2013: 124,048) and again increasing since 2014 (2014: 131,375; 2015: 142,054; 2016: 150,937 contacts). In 2017, the number of contacts in low threshold facilities increased to 164,254.

Furthermore, approximately 27% of the RELIS respondents (yearly data on number and characteristics of treatment demanders) have been first treatment demanders, all national treatment centres included. A clear trend towards an increase in the proportion of OST patients aged 40 years or more (54.7%) can be observed, and 51.3% of OST patients are natives.

HEALTH CORRELATES AND RESPONSES TO CONSEQUENCES

The **HIV/AIDS prevalence**¹⁰ in HRDU was fairly stable until 2014 according to RELIS (self-reported) data and according to the data on the proportion of IDU in newly diagnosed HIV cases from the National Laboratory of Retrovirology. In 2016, however, an important increase concerning HIV prevalence among HRDUs was observed. More specifically, from 2004 to 2013, this proportion varied between 4% and 6% (RELIS self-reported data) and between 2 and 8 cases of IDUs in new HIV patients (data from the National Laboratory of Retrovirology). From 2014 onwards, an increasing trend was observed (2016: 21 IDUs in new HIV patients and 9.77% of self-reported HIV infections among HRDUs), although national harm reduction offers are highly developed and diversified. Other EU member states have also reported recent HIV outbreaks in IDU populations (EMCDDA, 2016).

In the context of this outbreak, an expert group worked on this issue in order to understand reasons for this increase and formulate possible responses. The recent increase in cocaine injections seems to be part

10 Origer, A., & Schmit, J.-C. (2012). Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. *Journal of Epidemiology and Community Health*, 66, 64-68. doi: 0.1136/jech.2009.101378

of the bigger picture. Higher availability of cocaine, more frequent injections due to shorter effect-windows compared to heroin, marginalised user groups with no or poor service contact, as well as an increased proportion of drug use related prostitution in new HIV cases are some additional factors at play.

Recent data from 2017 and 2018 suggest a trend inversion and reveal a decrease in the number of new IDUs diagnosed with HIV (10 in 2017, whereas 21 in 2016) and thus in the respective proportion of IDUs among new HIV infected people (9.9% in 2017 and 21.4% in 2016).

The **prevalence of HCV (hepatitis C)** in drug users seems to have stabilised at high level: in 2017, 54.7% of HRDUs reported being infected by HCV (RELIS, 2017) and 75.8% of lifetime injectors revealed a positive HCV serology test (Devaux et al., 2017).

The implementation of the 2005-2009 and 2010-2014 action plans has been accompanied by a discontinuous but significant overall decrease of fatal **overdose cases** in the Grand Duchy of Luxembourg (2017: 8 cases).

In terms of number of overdose cases in the general population of the Grand Duchy of Luxembourg, this proportion figured 5.9 overdose deaths per 100,000 inhabitants aged 15 to 64 years in 2000 (2007: 5.67 cases per 100,000 inhabitants). In 2017, 1.9 overdose deaths per 100,000 inhabitants aged 15 to 64 years have been registered, showing a decreasing tendency. Forensic data from 1992 to 2017 show that the most frequently involved substances in drug-related deaths are heroin and prescription drugs consumed in a polydrug use context.

From all drug-related death cases reported in 2017, 7 victims were male and one female in 2017. The mean age of victims has been showing a discontinued increase over the past 20 years (in 1992: 28.4 years; in 2015: 41.1 years; in 2017: 41.5 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years has remained relatively unchanged. The youngest victim was 25 years old and the oldest was 53 at the moment of death.

As regards the nationality of overdose victims, 87.5% (67% in 2015) were natives. A detailed description of fatal overdose victims since 1994, as well as the gender impact in overdose victims, have been analysed by extensive studies which results have been published between 2013 and 2015 (Origer et al., 2014, 2015)¹¹.

SOCIAL CORRELATES AND SOCIAL REINTEGRATION

Social correlates of problem drug use are manifold and touch upon family, professional, financial and legal areas.

The educational levels of HRDU are low and mostly incomplete. The **residential status** of the latter has improved over the last years. In 1995, 31% of the drug users reported a stable accommodation; currently the proportion situates at 65%, comparable to the year before (2016: 67%). The overall improvement may be partly due to various accommodation and housing offers for addicted people set up in the framework of the national drug action plan. Recent figures tend to confirm that although specialised accommodation offers have been developed, the current economic situation has created an even higher demand for this type of housing.

11 Origer, A., Lopes da Costa, S., & Baumann, M. (2014). Opiate and cocaine related fatal overdoses in Luxembourg from 1985 to 2011: A study on gender differences. *Eur Addict Res*, 20(2), 87-93. DOI: 10.1159/000355170
Origer, A., Le Bihan, E., & Baumann, M. (2014). Social and economic inequalities in fatal opiate and cocaine related overdoses in Luxembourg: A case-control study. *Int J Drug Pol*, 25, 911-915. DOI: 10.1016/j.drugpo.2014.05.015
Origer, A., Le Bihan, E., & Baumann, M. (2015). A Social Gradient in Fatal Opioids and Cocaine Related Overdoses? *PLoS ONE*, 10(5), e0125568. DOI:10.1371/journal.pone.0125568



The **unemployment rate** (60%) tends to plateau. The majority of indexed drug users rely on social welfare (social aids, unemployment or pension benefits), and the Guaranteed Minimum Income constitutes the **primary source of revenue** of HRDU (37.4% in 2017). However, the proportion of active respondents reporting a stable job situation (e.g. long-term contract) has been stable over the last 4 years and illegal activities as main revenue have witnessed an ongoing downward trend since 2013.

HARM REDUCTION ACTIVITIES

The **number of contacts** indexed by national low-threshold agencies has been increasing markedly since 2013 (124,048). In 2017, 164,806 contacts have been registered by various national harm reduction services (2016: 150,973). Approximately 54% of clients from the national drug consumption room (Abrigado) are aged between 35 and 44 years. Around 16% of the Abrigado clients are females.

The number of **syringes** distributed in the framework of the national needle exchange programme peaked in 2006 and has been decreasing discontinuously until 2013. In 2017, however, a marked increase and new peak have been observed (2017: 437,946 / 1996: 76,259). Return rates of used syringes have been increasing during the referred period and reached 92% in 2017 (94% in 2016). An increasing majority of injectors procure their syringes in specialised agencies followed by pharmacies.

LAW ENFORCEMENT INDICATORS¹²

Seizures of illicit substances at the national level

Great variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency in heroin, cocaine and cannabis (herbal and resin) seizures¹³ between 2006 and 2013, followed by a new increase of cocaine and cannabis seizures from 2014 onwards. Overall, quantities of seized cocaine have remained high in the past years, whereas the quantity of seized cannabis reached a new peak in 2017.

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

Crack (cocaine-base) seizures have not been reported to date by national authorities, although freebasing is reported by field agencies. With regard to cocaine, a total number of 226 seizures was reported in 2017 by the National Judicial Police. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994 and seized quantities increased 2014 onwards. The year 2016 stands for an historical peak in MDMA quantities seized. In 2017, however, the quantity of seized MDMA pills decreased again.

Drug law offenders and prison sentences

The **number of police records** for presumed offences against the modified drug law of 1973 went from 2,546 in 2010 to 3,385 in 2015, while it has been decreasing afterwards (2,624 in 2016; 2,525 in 2017).

¹² If not specified, data refer to 2017. Figures in brackets refer to 2016 if not otherwise specified.

¹³ Non-transit drugs destined to the national market

A similar evolution has been observed with regard to the **number of drug law offenders**. In 2017, 183 **arrests** (234 in 2016) for presumed drug offences have been reported.

The total **number of persons** involved in drug possession offences has followed a global upward trend until 2015 to witness a first decrease in the past two years (2000: 1,758; 2012: 1,782, 2013: 2,066; 2014: 2,779; 2015: 3,345; 2016: 2,566; 2017: 1,969).

The population of drug law offenders is composed of 86% **males**, a proportion that has been varying between 79% and 90% during the past decade. Regarding total numbers of **first drug law offenders**, 808 were reported in 2003 and 1,047 in 2017. Moreover, the **percentage of minors** (< 18 years) among first drug law offenders has been increasing which is confirmed by the most recent figures (11.2% in 2014, 9.7% in 2015; 10% in 2016; 12.4% in 2017 compared to 4.9% in 1994). Cannabis remains the main drug involved in registered first drug offences.

Since 1998, **non-natives** (63.6% in 2017; 59% in 2016; 56% in 2015; 50% in 2014; 48% in 2013) have been representing the majority of drug law offenders (50-68%). In total, 53% of the registered cases were **first drug law offenders**, a proportion that is fairly high compared to previous years (37% in 2016; 32% in 2015). National **prison data** of 2017 refer to 974 (962 in 2016) new admissions of which 26% (249 in 2017; 306 in 2016) were related to drug law offences; a proportion that represented 42.6% in 1996.

PROFILE OF THE NATIONAL DRUG MARKET

The national production and culture of illicit drugs appear to be irrelevant in terms of quantities and quality. Over the past two years, no clandestine drug-manufacturing laboratory has been dismantled at the national level. According to observational data provided by the Judicial Police and all decentralised national police units, a majority of illicit drugs consumed in the G.-D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (transit and ecstasy and ATS production) and Morocco (cannabis production). **Cocaine availability on the national market is high** and originating from Latin America and mostly transits South of Europe (Spain, Portugal) to reach the Netherlands via France, Switzerland, Austria and Germany. Heroin follows the main Balkan route and its derivate (Poland, Turkey, Belorussia).

In recent years, more organised distribution networks have been developing nationally. The expansion of these distribution networks by criminal groups thus contributed to a significant increase in drug availability, and particularly in the supply of cocaine and cannabis. Dealing and selling techniques involve several actors and drugs to minimise traffic-related risk. Moreover, it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible for police as for instance private flats, bars or motorway rest areas in order to meet their clients halfway and sell gross quantities.

Over the last 10 years, **purity** of cocaine has been generally decreasing and average heroin purity has also been following a discontinuous downward trend. Attention has to be paid to the striking differences in maximum and minimum purities (especially for cannabis and cocaine) as well as to a high maximum concentration of THC in cannabis products seized in Luxembourg in recent years.

Prices move within increasingly broader ranges for heroin, cocaine and cannabis, which is partly due to increasing differences in quality levels of street drugs. Nevertheless, prices have been stable over the last 5 years. Typical street retail cannabis (resin and herbal) is currently sold for 8-15 € per gram, the average price for cocaine is currently around 95 € and heroin around 55 € per gram, indicating a slight increase in heroin and cocaine prices over the past years. Prices of stimulants such as ecstasy, MDMA and amphetamines have been varying between 7-15 €.



MOST RELEVANT TRENDS

Overall, available indicators suggest a **decrease in HRDU prevalence rates over recent years**. Furthermore, results from latest prevalence studies suggest that **IDU prevalence has stabilised**. Over the last decade, an increasing number of HRDU entered treatment or use low-threshold offers and fewer were in contact with law enforcement agencies.

Injecting opiate and cocaine use combined (polydrug use) is the predominant HRDU pattern. However, recent data suggest that the inhalation mode (chasing) is becoming increasingly popular, whereas fewer people tend to inject drugs.

The overall quality of street drugs decreased, which resulted in an overall increase of polydrug use. The number of acute drug deaths decreased to 8 cases in 2017 (27 cases in 2007).

Although current HRDU prevalence appears to follow a declining trend, some indicators point at an increasing marginalisation of certain groups of users. Part of the HRDUs may thus not be in contact with treatment and/or low threshold agencies (and eventually neither with law enforcement). Additionally, new phenomena such as early drunkenness, binge drinking in youngsters, cocaine freebasing, stimulants' injection and use of new synthetic drugs and products containing the latter must be monitored closely since they may have a relevant impact of HRDU incidence in the future.

There is also concern about infectious diseases in drug users and particularly in IDUs. HIV rates in HRDUs have been low and stable from 2000 to 2008, but showed an increasing tendency in 2009 and 2010, to stabilise again around 3 to 5% between 2011 and 2014. In 2015 and 2016, however, an increase (8% and 9%) was observed concerning the proportion of HRDUs infected by HIV, although the number of clean syringes provided to IDUs via the national needle exchange programme reached a record level in 2017. Also, the proportion of IDUs in newly detected HIV cases has been increasing since 2014. 2017 and 2018 data suggest, however, a first trend inversion.

The prevalence of hepatitis C has been increasing continuously from 2000 to 2008, slightly decreasing in 2009 and 2010, as well as in 2012 to increase again in 2014. In 2017, the proportion of HRDUs infected by hepatitis C has been stabilised at high level. Former and recent research results based on serological testing suggested HCV infection rates of over 70% and even higher prevalence rates in prison populations in 2007 (Origer & Removille, 2009) and around 75.8% among lifetime injectors (Devaux et al., 2017).

The national drug market is led by more aggressive selling and distribution strategies as well as improved strategies of trafficking involving 'multiplayers' with specific tasks. A tendency to move selling points to locations or settings less visible for police as for instance private flats or bars is also observed in this context. Cocaine availability on the national market is high and growing, whereas consumption of cocaine and MDMA/ecstasy among younger people tends to increase as well. The number of seizures of cannabis, cocaine and MDMA have been increasing over the past years, though only cannabis and cocaine equally show a rise in seized quantities. Attention has finally to be paid to the striking differences in maximum and minimum purities of street drugs as well as to a historically high maximum concentration of THC in cannabis samples seized over the last years. Quality ranges of street drugs tend to increase which suggest more diversified distribution mechanisms and may explain the important price variations observed during recent years. Available indicators suggest that users increasingly acquire illicit drugs on the national market. Drug prices tend to increase slightly the past years. The number of drug law offences and offenders have decreased slightly in 2017 compared to previous years.

The most relevant developments at the **response** side result from the implementation of the national drug strategy and its associated action plans. Over the last years, counselling and specialised care networks have been further developed, which had as a positive and documented consequence that HRDU start treatment at an early stage of their drug career.

National action plans on drugs and addictions have allowed disposing of additional financial resources. If primary prevention is considered most important, there have been improvements in early intervention measures. Major efforts have also been made in the diversification of care offers and finally harm reduction measures have been significantly developed. Housing offers and reintegration programmes have obviously contributed to improve socio-professional situations as documented by latest RELIS data. Substitution treatment and low-threshold offers have been diversified and decentralised and continue to be so.

Coordination mechanisms have been reinforced between NGOs and national authorities, and evaluation mechanisms are in place. A second external evaluation of the national drugs action plan has been performed and outcomes have been integrated together with recommendations from a series of national expert groups and outcomes of users/clients surveys in the elaboration of the drugs strategy and action plan 2015-2019. The drugs strategy and action plan 2015-2019 will, in turn, be submitted to an external evaluation. Its results will be incorporated into the development of the 2020-2024 national action plan.



PART A:

NEW DEVELOPMENTS AND TRENDS

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

INTRODUCTION

Given the complex nature of drug use and its correlates, national drug policies are based on shared political competencies and responsibilities. Furthermore, in terms of intervention strategies, the more holistic concept of addictive behaviour has gained in importance and influences increasingly policy debates. This tendency is reflected by the enlargement of ICD (Inter-ministerial Committee on Drugs) competences and its increased external visibility as well as the general framework set by the new national drugs strategy 2015-2019 on addictions (and not exclusively on illicit substances' related problems).

The governmental programme 2013¹⁴, has foreseen to further develop the national drugs action plan and specifically refers to the decentralisation of care and harm reduction structures, to the creation of a heroin assisted treatment programme and to the extension of post-therapeutic offers. In 2014, the Netherlands Institute of Mental Health and Addiction, the "Trimbos Institute", performed an 'External evaluation of the Governmental Strategy and Action Plan 2010-2014 of Luxembourg regarding the fight against drugs and addictions' as a critical analysis of the implementation of the National Drug Action Plan.

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

GENERAL LEGAL FRAMEWORK¹⁵

Drug legislation and recent drug-related laws

The basic national drug law, namely: '*Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie*'¹⁶ regulates both, the selling of controlled medicaments and the fight against drug addiction and dates back to the 19 February 1973. It has been last amended by the law of 27 April 2001¹⁷. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of treatment and harm reduction measures, namely, drug substitution treatment, needle exchange and shooting galleries (state accredited and, in addition to article 13 of the Grand ducal decree of 30 January 2002 (see below), Heroin Assisted Treatment (HAT).

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

15 Legal texts prevail on selectively produced summaries. The integral national legislation on drugs and drug addiction is available under: <http://www.emcdda.europa.eu/eldd>

16 Official gazette A 1973, p.319

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

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

The legal access to medicinal cannabis was granted by the law of July 20th 2018 amending the law of February 19th 1973 concerning the commercialisation of medical substances and the fight against drug addiction. The new 2018 law defines the non-application of the 1973 law to: a) persons detaining and consuming "medicinal cannabis"; b) doctors prescribing "medicinal cannabis" and c) pharmacists delivering "medicinal cannabis". The law of July 20th 2018 further specifies that "cannabis for medical purposes" can be obtained if the following conditions are fulfilled:

- The patient is:
 - suffering from serious illness, in advanced or terminal phase, associated to chronic pain;
 - suffering from cancer treated by chemotherapy inducing nausea/vomiting;
 - suffering from muscle spasms related to multiple sclerosis;
- Medicinal cannabis is prescribed by physicians who have completed a specific a training on "cannabis for medical purposes", and exclusively according to the rules of prescription defined in the regulation of the law implementation;
- "Cannabis for medical purposes" can only be delivered by hospital pharmacies.

The prescription rules for medical cannabis indicate that eligible patients need to have Luxembourgish nationality to be resident in Luxembourg, or to be beneficiary of the Luxembourg health insurance.

An evaluation of the implementation of this measure on the national level is foreseen after two years including assessing the possibility of selling the prescribed medical cannabis by all pharmacies and the introduction of training for doctors.

Grand Ducal Decrees

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

- Grand ducal decree of **4 March 1974** regarding certain toxic substances
- Grand ducal decree of **20 March 1974** regarding certain psychotropic substances
- Grand ducal decree of **26 March 1974** establishing the list of controlled narcotics
- Grand ducal decree of **8 May 1993** regarding commerce of narcotics and psychotropic substances
- Grand ducal decree of **6 February 1997** regarding substances listed in schedules III and IV of the UN Convention on psychotropic substances of 21 February 1971
- Grand ducal decree of **13 February 2007** on the surveillance and commerce of drug precursors¹⁹

The full text of the current basic national drug law as well as recent decrees can be accessed through the following web sites: <http://www.legilux.public.lu> or <http://emcdda.europa.eu/eldd>.

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

19 Official gazette A 2007 (Adoption: 30/01/2004, Entry in force: 13/02/2004). See also ELDD. Règlement grand-ducal du 30 janvier 2004 modifiant le règlement grand-ducal modifié du 2 février 1995 relatif à la fabrication et à la mise sur le marché de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes.



CHANGES IN 2012:

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

- MDPV (3,4 méthylène-dioxy-pyrovalerone)
- Salvia Divinorium (Salvinorine A)
- Myragyna Speciosa, Kratom (Myragynine, 7-Hydroxymyragynine)

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

CHANGES IN 2013:

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

- MDMC(Methylamphetamine).

CHANGES IN 2014:

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

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

CHANGES IN 2015:

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

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

20 Règlement grand-ducal du 21 juillet 2012 modifiant :

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

Official gazette A 157, p.1888 (Adoption: 21.07.2012, Entry in force: 30.07.2012)

21 Règlement grand-ducal du 29 janvier 2013 modifiant :

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

(Adoption: 29.01.2013. Entry in force: 01.02.2013)

22 Règlement grand-ducal du 24 janvier 2014 modifiant :

l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;
(Adoption: 24.01.2014. Entry in force: 30.01.2014)

23 Règlement grand-ducal du 19 juin 2015 modifiant :

l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;
(Adoption: 19.06.2015. Entry in force: 17.07.2015)

CHANGES IN 2016:

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

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

CHANGES IN 2017:

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

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

CHANGES IN 2018:

The grand-ducal decree of 2018²⁶ puts the following substances under national control:

Carfentanil	Méthyl 1-(2-phényléthyl)-4[phényl(propanoyl)amino]pipéridine-4-carboxylate;
Ocfentanil	N-(2-Fluorophényl)-2-méthoxy-N-[1-(2-phényléthyl)pipéridin-4-yl]acétamide;
Furanylfentanyl	N-Phényl-1-N-[1-(2-phényléthyl)pipéridin-4-yl]furan-2-carboxamide;
4-Fluoroisobutyrfentanyl (4-FIBF, pFIBF)	N-(4-Fluorophényl)-2-méthyl-N-[1-(2-phényléthyl)pipéridin-4-yl]propanamide;
Tetrahydrofuranylfentanyl (THF-F)	N-Phényl-N-[1-(2-phényléthyl)pipéridin-4-yl]oxolane-2-carboxamide;
Acryloylfentanyl	N-(1-phénéthylpipéridine-4-yl)-N-phénylacrylamide;
4-Fluoroamphétamine (4-FA)	1-(4-Fluorophényl)propan-2-amine.

Laws implementation

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

24 Règlement grand-ducal du 9 juin 2016 modifiant l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes. (Adoption: 09.06.2016. Entry in force: 22.06.2016)

25 Règlement grand-ducal du 12 octobre 2017 modifiant :
 1. l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ;
 2. l'annexe du règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants. (Adoption: 12.10.2017. Entry in force: 19.10.2017)

26 Règlement grand-ducal du 18 juillet 2018 modifiant :
 1. l'annexe du règlement grand-ducal modifié du 26 mars 1974 établissant la liste des stupéfiants ;
 2. l'annexe du règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes. (Adoption: 24.08.2018. Entry into force: 28.08.2018).



Drug-related offences are covered by the law (concerning the sale of medicinal substances and the fight against drug addiction) of 19 February 1973 (hereinafter referred to as 'the 1973 law') that was modified by the law of 27 April 2001.

Even though the 1973 law does not specifically provide for alternative measures to prison for drug-addicted law offenders, the following options exist.

In accordance with article 23 of the 1973 law, cases involving personal use of drugs (individually or in a group) and/or cases involving offences against article 8 of the 1973 law are dropped if the offender, before the illegal use was disclosed, undertook treatment for drug addiction. Moreover, the public prosecutor can offer the offender the option of voluntary treatment of his/her addiction.

According to the terms of article 24 of the 1973 law, when preliminary charges are brought for personal use of drugs and when it is established that the offender is the subject of medical treatment, the investigative judge may order treatment for drug addiction at the request of the prosecutor or the accused person.

Article 25 of the 1973 law makes provision for the juvenile court to refer an addicted minor to treatment.

Article 26 of the 1973 law provides for the courts to order a drug addict to undergo treatment, in which case the verdict can be postponed. If the accused person meets all conditions imposed by the courts, the charges for illegal use may be dropped.

The above measures are only available to drug users and no other categories of offenders.

In addition to the special measures set forth in the 1973 law, the courts can still avail of the reformed sentencing measures or of any of the extenuating circumstances which are an option for all offences, as outlined in the Code of Criminal Law and the Code of Criminal Investigation. The extenuating circumstances outlined in Articles 73 to 79 of the Code of Criminal Law allow the judge the option of ordering community service or a fine, or even to forgo sentencing in favour of a police fine (between EUR 25 and 248).

Articles 619 to 634 (1) of the Code of Criminal Investigation allow the judge the option of either postponing the verdict, with/without a trial period, or suspending the sentence, with/without probation and with a trial period.

The law of 27 April 2001²⁷ modifying the basic drug law of 19 February 1973 by decriminalising cannabis use (without aggravating circumstances), and enhancing the differentiation of penalties according to the type of drug offences and the nature of controlled substances involved and the grand ducal decree of 30 January 2002²⁸ on substitution treatment, have largely contributed to increase the congruity between drug legislations and prosecution routines. Also, current drug legislation and prosecution policies put higher priority on drug dealing and trafficking than on drug consumption and promote harm and risk reduction measures. The creation of a national supervised drug consumption room in 2005 is a sound example of this holistic approach.

As a legal principle, the reaction to an offence committed by a drug user must be proportional to the harm it aims to prevent. In fact, as long as a drug addicted person remains a simple user, any damage caused to himself/herself and the legal response remains minimal as long as public order is not greatly disturbed.

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

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

However, if the drug user causes harm to others, the response will become firmer according to the seriousness of the offence.

In practice, the median expected sentence varies by drug type and quantity. Indeed, cannabis substances are less harshly punished with median expected penalties of 1 year and 6 months for 1 kg and 3 years for 10kg. For amphetamines, the expected sentences range from 1 year and 9 months for 100g and 3 years for 1 kg. More severely punished, cocaine and heroin trafficking median expected sentences are 2 years for 100g and 3 years for 1 kg.²⁹

In 2017, 25% of all the confirmed prison sentences were related to offences against the national drug legislation (22% male and 26% female). It should be noted, however, that from 2014 to 2015, the proportion of drug-related offences in female offenders increased from 7% to 20%. This proportion, however decreased again in 2017 (10.6% females).

NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

Coordination mechanisms

The coordination of drug demand reduction, risk reduction and related research is a competence of the Ministry of Health. Since 2000 a National Drug Coordinator, appointed by the Minister of Health, has been mandated with the overall coordination (including inter-ministerial coordination) in the domains of drug-related demand and harm reduction and represents Luxembourg at the international level. Supply reduction and international cooperation aspects remain a competence of the Ministry of Justice and the Ministry of Foreign Affairs respectively.

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

The National Drug Coordinator is also the head of the national delegation within the Horizontal Working Party on Drugs (EU Council) and the national Permanent Correspondent within the Pompidou Group (Council of Europe). Furthermore, he has been nominated chair of the national substitution treatment surveillance commission in 2010 and is member of the national HIV/AIDS surveillance commission as well as of the steering committee of the *Fund against the fight of certain forms of criminality* and the consultative committee of the *Œuvre Nationale de Secours Grande-Duchesse Charlotte*.

²⁹ EMCDDA. (2017). *Technical Report: Drug trafficking penalties across the European Union, A Survey of expert opinion*. Lisbon, Portugal: EMCDDA.



National plan and strategy

Having taken into consideration the EU drugs strategy 2005-2012, the EU drugs action plan 2009-2012, the national strategy and drugs action plan are meant to contribute to a high level of health protection, public security and social cohesion and rely on two policy pillars, namely supply reduction and demand reduction. More precisely, it is designed to contribute to reduce initiation of drug use, to develop and maintain diversity and quality in care and treatment offers, to tangibly reduce drug use prevalence in the general population as well as health and social damage generated by illicit drug use and drug trafficking.

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

Overall, the national strategy and drugs action plan are meant to contribute to a high level of health protection, public security and social cohesion and rely on two policy pillars, namely supply reduction and demand reduction. More precisely, it is designed to contribute to reduce initiation of drug use and addictive behaviours, to develop and maintain diversity and quality in care and treatment offers, to tangibly reduce drug use prevalence in the general population as well as health and social damage generated by illicit drug use and drug trafficking. Priorities of the Action Plan include general and indicated prevention, diversification and decentralization of care offers, the further development of substitution treatment, specific offers for aging drug users, supervised housing offers, the fight against infectious diseases among drug users and new psychoactive substances.

Furthermore, the 2015-2019 national action plan³⁰ includes, in addition to international cooperation and research, information, evaluation (retained by the EU action plan), two more crosscutting themes: coordination and harm, risk and nuisance reduction. Luxembourg considers the latter two activity fields to be essential and of transversal nature.

The 2015-2019 governmental drugs strategy has built upon a more holistic approach than the previous ones. It addressed addictive behaviour as a whole and not only illicit drugs and drug addiction. Thus, alcohol, tobacco and psychotropic pharmaceuticals dependence as well as addictive behaviour not associated with substance use are now an integral part of a unique strategy. Specific action plans have been conceived or are currently under preparation in order to integrate the framework of a global national policy on addictions.

Operational objectives are as follows:

1. To contribute to the maintenance of individual and collective well-being.
2. To increase means for action and to improve coordination mechanisms and synergies between available resources in order to guarantee their best possible use.
3. Reduce the burden for the community by promoting a rational culture of investments, allowing to generate sustainable achievements.
4. To adequately update drug-related legislation and other regulatory instruments according to emerging evidence on drugs and drug use pattern as well as on commercial strategies that are building upon new opportunities created by new consumer trends.
5. To increase the knowledge base on drugs and addictive behaviour by promoting research and the broadest possible diffusion of objective information to the general public and specific target groups.
6. To consolidate mechanisms that allow to critically analyse actions and achievements, and by doing so, improve drug policy making, action planning and implementation.

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

The national plan lists some **60 separate actions** associated to a clear definition of tasks, involved management actors, financial requirements, deadlines and performance indicators. Some of the referred actions are submitted to a series of conditions to fulfil by the action manager in order to be proposed for financing. The action plan reflects priorities set by the government: primary prevention (4 projects), treatment and care (7), socio-professional reintegration (5), reduction of risks and damages (9), research, evaluation and information (8), supply reduction (18), coordination and international relations (9). Special focus is placed on primary prevention, offers of accommodation and housing, socio-professional reinsertion measures, diversification and access to therapeutic offers and quality management.

The selection of specific actions, projects or programmes has occurred on basis of a 6 criteria matrix including: pertinence, opportunity, feasibility, cost-benefice/quality factors, quality assurance mechanisms and measurability of results or impact.

The overall objective of the national action plan is to:

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

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

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

Implementation of policies and strategies

The outcome of a national drugs action plan highly relies on the way it has been elaborated. The successive action plans reflect the general strategy of the Ministry of Health in order to optimize the overall interventions in the fight against drugs and drug addiction in the light of stated priorities, assessed needs and available resources. It constitutes an open framework meaning that complementary projects can be included if required.

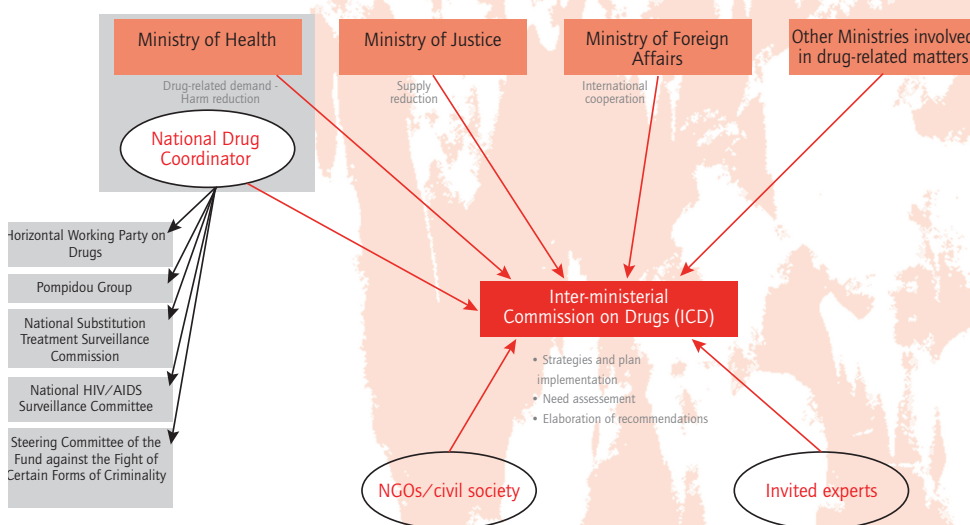
In 2014, in order to best meet current needs in the elaboration of the 2015-2019 action plan, the National Drug Coordinator has launched a fourth multilateral consultation process involving ministerial departments, specialised NGOs and civil society. A special working group, chaired by the Ministry of Health, performed a needs assessment and elaborated national recommendations focusing on specialised drug care and rehabilitation offers. A more restricted group composed of representatives of the Ministry of Health and the National Addiction Prevention Centre drafted the action plan in the framework of primary prevention strategies. The priorities set by the Ministry of Health were discussed and, if necessary, complementary measures were added. A consensus on priority rankings of listed actions has been reached among involved parties. Finally, all retained actions were structured in an output oriented way as follows:



1. Description/objective of action;
2. Responsibilities;
3. Budget;
4. Outcome;
5. Deadlines for outcome and evaluation.

The active involvement of specialised NGOs/civil society from the very start of the conceptualisation work and consensus making prior to the implementation phase have shown to be a major criterion to guarantee an effective implementation process. Summarily, one should stress that the multilateral involvement of competent actors and the fact that most agencies involved in the implementation process are financed and controlled by the centrally coordinating Ministry of Health highly promote the effectiveness of the national strategic model.

Fig. 1.1 Coordination summary chart



Evaluation of policies and strategies

The implementation progress of the drugs action plan has been on the political agenda since its start in 2000 and consequently the visibility of achievements was continuously high. Media also contributed to this enhanced awareness and activity boosting, especially since they have been able to identify a central personalised key actor in the person of the national drug coordinator. Another positive side effect of consecutive drugs action plans is an increased commitment of NGOs/civil society in the drug policies as they are involved from the very beginning of the process. The general public has equally welcomed the drug action plans since it enables them to follow up public efforts to fight a problem of great concern and to compare announced objectives with achieved actions.

Beside efforts made by all involved actors and networks, the positive outcome has also to be related to the considerable increase of the budgetary means allocated to the fight against drug addiction. An increase of 564% of the budget invested by the Ministry of Health in drug demand reduction occurred between 2000 and 2017.

Budgetary means invested allowed to increase resources in terms of primary prevention, to extend admission capacities of low-threshold services, to increase the number of post-therapeutic offers, to further regionalize ambulatory treatment offers, to improve technical control measures related to substitution treatment, to reduce risks and damages, especially related to synthetic drugs and the transmission of certain infectious diseases, endemic to the population of HRDU, to reduce the rate of drug overdoses and finally to promote research activities in the field.

Over the last 10 years the concept of implementation follow-up, evaluation and external evaluation strategies have gained in importance in the field of drugs and drug addiction. In the beginning of 2010, the Minister of Health jointly with the National Drug Coordinator has presented the new drug strategy and action plan 2010 – 2014. The referred action plan is based on the evaluation outcome of previous action plans and the assessment of current and future needs. In this context and for the first time nationally, a final external output and progress evaluation of the national drug strategy and action plan 2005-2009 has been performed in 2009 by the Netherlands Institute of Mental Health and Addiction, the “Trimbos Institute” (Trautmann & Braam, 2009).

In 2014, the drugs strategy and action plan 2010-2014 were also evaluated by the Trimbos Institute (Trautmann & Braam, 2014). The contractual scope of the evaluation was a critical analysis of the implementation of the National Drug Action Plan 2010-2014. The aim was to serve policy relevant information to the stakeholders involved in making and implementing drug policy in Luxembourg. The following questions were addressed:

- **Priorities:** Does the Action Plan address in an appropriate way the priorities put forward by the different stakeholders, e.g. by clear problem definitions and clearly defined actions?
- **Conditions:** Were conditions given to realise the actions formulated in the Action Plan, e.g. by serving the necessary instruments and resources, and by dividing and defining the responsibilities and by facilitating cooperation between the different stakeholders? Has the existing coordination structure proved to be appropriate and efficient?
- **Results:** Did the implementation of the National Drug Action Plan result in the realisation of the envisaged actions?
- **Process:** Did the process of policy formulation and implementation go well (managed appropriately, allowing and taking-up input from all stakeholders, etc.)?

A mixed method was used combining survey questionnaires, face-to-face interviews and focus groups. Data triangulation method was chosen to take account of various data and information sources. All stakeholders (from ministries to specialised services) were involved in the reflexion process and had the opportunity to provide input.

In implementing the evaluation, the following guiding principles were applied:

- The evaluation is based on reliable and verifiable facts/results;
- The evaluation process is transparent to all stakeholders;
- All relevant parties are invited to participate in the evaluation process;
- All these parties must feel free to express their opinions;
- The evaluation is meant to formulate concrete recommendations that could lead to improvement of the quality, efficacy and efficiency of the Luxembourg drug policy;
- The evaluation does not take a stand in the political debate in Luxembourg.



The external evaluation of was based upon an assessment of the achievements of the National Drug Action plan 2010-2014 and a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis.

Over the 60 actions listed in the plan, 45 out of them (74%) were fully implemented and most of the outcomes were judged as "positive".

The full outcome of the evaluation have been published and is publically available³¹.

The main limitations in the realisation of the evaluation were the limited budget and the limited time frame allocated to this activity. The method selected for the evaluation was thus optimised according to these limitations.

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

Main recommendations of the evaluation report:

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

Other drug policy developments: Initiatives in Parliament and civil society

Petition regarding the legalisation of the recreational use of cannabis:

In 2018, a public petition regarding the legalisation of recreational use of cannabis gained the critical number of signatures to allow for a public debate in the Parliament, which led each political party to state a position towards the legalisation of cannabis for recreational purposes before the legislative elections that took place in October 2018. The new governmental program 2018-2023 mention the intention of

31 Trautmann, F. & Braam, R. (2014). *Evaluation of the national drug action plan (2010-2014) of Luxembourg*. Utrecht, the Netherlands: Trimbo Instituut.

the government to elaborate a dedicated legislation of recreational cannabis, which could include under conditions yet to be defined, depenalisation or even legalisation of recreational cannabis for the personal needs of the major residents. Main dedicated objectives are to reduce the illicit market, the mental and physical dangers linked to its use and to fight crime at the level of supply.

Special topics addressed by the Inter-ministerial Group on Drugs (IGD) in 2018 were:

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

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

- New HIV infections in PWID, partly due to the increase of cocaine injections and new responses – outreach offers further developed in 2017 and 2018;
- Recreational drug use and drug testing facilities in festive settings;
- Regulation on New Psychoactive Substances in the light of amendments at EU level (i.e. EU directive and amendment of EMCDDA regulation);
- Alcohol and cannabis use in the general population with special focus on youngsters.

ECONOMIC ANALYSIS³²

Public expenditures

The fight against drugs is multidisciplinary. Thus, in Luxembourg 11 ministries and 13 departments are involved to a different extent in the enforcement of national drug policies. As in most EU Member states, the structure of the national state budget does not allow for a drug budget allocation analysis exclusively based on labelled expenditures. Following are some of the preliminary problems one typically is confronted with in a public expenditure study:

- Budget lines may be generic (legal & illegal drugs), aggregated (addiction prevention), over inclusive (social solidarity) or unidentifiable (others);
- Apportionment of budgets may not be provided;
- Difference between provisional budget, voted budget and final expenditure (provisional budget often more detailed than voted budget);

32 See related chapter in Part B



- Expenditures may be annual, multiannual, unique, ordinary, extraordinary, etc. If they occur during the study reference year, they should be included even though they might give a biased picture of average or routine expenditures, especially when they are important (e.g. investments in real estate)³³;
- In terms of follow-up: budget lines may be restructured, integrated or divided over time;
- In the field of public health, expenditures may result from direct state financing or social security reimbursement;
- Lack of clarity due to national mixed (Multi-ministries) financing (e.g. Public research Centres – multi projects' financing) or National & EU & International shared financing;
- Eligibility of cooperation projects vs. variability of yearly contributions;
- Assessment of impact of general education and educational interventions (e.g.) on DDR impossible.

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

In order to tailor and fine tune a methodology that fits the national context and which is in line with the work plan of the EMCDDA, a national study on direct economic costs of drug policies and interventions has been performed from 1999 to 2002 and refers to data from 1999 (Origer 2002 b). (*Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies*). In the framework of 2006 EMCDDA contractual requirements, an update of the Origer 2002 study has been performed. A detailed description of the methodology applied in 2002 can be consulted in the original study. The same methodology has been applied for the present and other yearly updates.

METHODOLOGY

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

The constituent concepts are defined as follows:

DIRECT: Excluding 'costs of indirect consequences' (e.g. loss of income, taxes) and 'non quantifiable costs' (e.g. loss of welfare) as well as expenditures related to the acquisition of illicit drugs by the consumer himself.

ECONOMIC: Monetary impact and not social impact (costs) or loss of life quality e.g.

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

COSTS: Expenditures and not revenues created by illegal drug market.

NATIONAL DRUG POLICIES: Public finances and not private expenditures or investments.

DRUG-RELATED TREATMENT: '*... any activity that directly targets individuals who have problems with their drug use and which aims to improve the psychological, medical or social state of those who seek help for their drug problems. This activity often takes place at specialised facilities for drug users, but may also occur in the context of/in general services offering medical and/or psychological help to people with drug problems*' (EMCDDA, 2000). The harm reduction approach directly targets drug addicted persons and aims to improve their psychological, health and social state or situation. In the national understanding, drug-related treatment therefore also includes harm reduction interventions.

The applied methodology refers to the concepts of the '**Cost of Illness**' (C.O.I.) approach. **COFOG and REUTERS** classifications were applied as recommended by the EMCDDA. The following techniques have been applied and combined according to existing contexts:

- Analysis of state budget and provisional state budget;
- Clarification meeting with involved financial authorities;
- Qualitative interviews;
- Analysis of activity reports of ministerial departments and NGOs;
- Analysis of state conventions and financial statements of specialized NGOs;
- Detailed financial breakdown and budget apportionment provided on demand by a series of institutions (NGOs, Social Security, Hospitals).

Main data sources:

- Laws and projects of law regarding the budget of revenues and expenditures of state;
- Annual ministerial activity reports;
- Activity reports of specialised agencies;
- State conventions with NGOs;
- Annual financial statements of specialised NGOs;
- Statistical outputs and financial breakdowns of the CNS.

Main reference documents:

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

Ministère de la Santé. (2017). *Rapport d'activités 2016*. Luxembourg: Ministère de la Santé.

Ministère de la Santé. (2005). *Stratégie et plan d'action national en matière de lutte contre les drogues et les toxicomanies 2005 – 2009*. Luxembourg: Ministère de la Santé.

Ministère de la Santé. (2009). *Stratégie et plan d'action national en matière de lutte contre les drogues et les dépendances 2010 – 2014*. Luxembourg: Ministère de la Santé.

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

Ministère de la Santé. (2015). *Stratégie et plan d'action gouvernementaux 2015–2019 en matière de lutte contre les drogues d'acquisition illicite et les addictions associées*. Luxembourg: Ministère de la Santé.

Origer, A. (2002). *Etude du coût économique direct des interventions publiques et de la politique en matière d'usage illicite de drogues au Grand-Duché de Luxembourg. Séries de recherche n°4*. Luxembourg: Point focal Luxembourgeois de l'OEDT – CRP-Santé.



Origer, A. (2010). *Update of direct economic costs of national drug policies in 2009. National Report on the state of the drugs problem in the Grand Duchy of Luxembourg*. Luxembourg: Point Focal Luxembourgeois de l'OEDT – CRP-Santé.

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

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

Table 1.1 provides an synopsis overview of labelled and non-labelled drug-related public expenditures in the field of drug prevention, treatment and harm reduction. In case an attributable proportion key was required, a detailed description of the calculation procedures is provided in the last column.

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

7. Ministry of Justice	S7.2/12.370 0.30 TOX PROGRAMME: Care and treatment programme for drug addicts in prison	826,800.-	<i>Extracted from the national state budget 2012</i>
10-11 Ministry of Education [...]	S 11.4 12.301 08.30 Drugs prevention campaigns in schools	2,000.-	<i>Extracted from the national state budget 2012</i>
14 /44 Ministry of Health	S 14.1/33.013 05.23 – 33.015 05.23 Staff and operational costs of specialised drug agencies and the NFP EMCDDA conventionned by state (40% non-specialised)	7,584,373.-	<i>Extracted from the national state budget 2012</i>
	S 14.1 12.311 05.10 Provision of drug injection material in the framework of the national NEP	750,000.-	<i>Idem</i>
	S 14.2 12.301 05.20/12.301 05.20 Toxicological surveillance of drug addicts	200,000.-	<i>Idem</i>
	I52.000 05.22 Construction, and maintenance of drug treatment facilities.	100.000.-	<i>Idem</i>
	I52.002 05.22 Participation in equipment costs of drug treatment facilities.	50.000.-	<i>Idem</i>
14.1 Directorate of Health	S 14.1/33.014 05.23 Staff and operational costs of drug related activities of the National Aids counselling Centre	210,326.-	25% of total budget of the centre: average proportion of PLWHIV/ AIDS infected via IDU in clients

17 Ministry of Social Security*	S 17.2 Staff, operational and mission costs for agents in charge of drug treatment referral abroad	80,000.-	Estimation by MSS based on analysis of work/mission/career
22/55 Ministry of Public Works	Maintenance work and equipment on/in buildings occupied by specialised NGOs (not covered by other budgets)	40,000.-	<i>Extracted from the national state budget 2012</i>
TOTAL LABELLED DRUG DEMAND REDUCTION EXPENDITURES: 9,483,499.-			

NON LABELLED EXPENDITURES

Health/Social Insurance

A. OST (Opioid substitution treatment)

Reimbursement of prescription substitution drugs (methadone, buprenorphine, etc.) (net patients' contribution excluded)	515,343.-	Detailed breakdown by the National Health Insurance Funds
Reimbursement of pharmacies fees generated by substitution medication preparation /delivery	35,080.-	Detailed breakdown by the National Health Insurance Funds
Reimbursement of medical counselling costs related to substitution prescriptions	215,800.-	Number of substitution prescriptions X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)

B. Inpatient hospital drug treatment

Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification)	2,358,510.-	ICD-10, F11, F12, F14, F16, F18, and F19 hospital episodes X average cost per episode (see study report 1999)(adjusted CNS data)
Medical counselling costs associated to hospital treatment episodes	205,000.-	Number of medical consultations X reimbursed fees according to duration of stay

C. Drug treatment abroad

Reimbursement of drug treatment costs abroad/ e.g. residential therapy or therapeutic offer unavailable in Luxembourg	1,479,000.-	Year-adjusted breakdown provided by CNS
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D. Inpatient therapeutic treatment extra-hospital

829,933.-	Institution specific budget of 2001 adjusted for salary costs and inflation
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E. Drug treatment costs subsidised by Min. Health

239,444.-	Budgetary section 14.0.34.011: Breakdown of real costs generated by drug treatment not covered by the CNS
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<u>F. Cost of HIV/AIDS treatment provided to patients infected via IDU</u>	510.000.-	Number of HIV/AIDS patients infected via IDU x yearly average cost of HIV/AIDS treatment X reimbursable proportion
<u>G. Estimation of state revenue loss from low renting prices for real estates provided to specialised NGOs</u>	240,000.-	Yearly sum of differences between paid rent and market value rent.
TOTAL NON LABELLED DRUG DEMAND REDUCTION EXPENDITURES: 6,388,110.-EUR		
TOTAL DEMAND REDUCTION EXPENDITURES 2012: 16,231,609.- EUR		

* Ministry of Social Security (Health expenditures)

HIV/AIDS treatment (IDU related infections and health costs)

For HIV/AIDS treatment rates the following calculation formula has been applied:

- A: Total number of registered PLW HIV/AIDS infected via IDU (diagnosis reporting) (status: alive)
(if available: Total number of PLW HIV/AIDS infected via IDU X mortality rate of target population) (higher precision (if available): Total number of PLW HIV/AIDS in treatment during year X that might be provided directly by central social security department)
- B: Average cost of HIV/AIDS treatment/ year
- Total cost of PLW HIV/AIDS IDU Treatment = A X B

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

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

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

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

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

Ministry / Department	Budget /Title	Budget / Expense (EUR)	Attributable proportion	COFOG 1	COFOG 2	SECTOR
01 Ministry of Foreign Affairs and Immigration	S. 01.7 Staff, operational and mission cost related to drug related issues	21,400.-	Estimation by MFA based on analysis of work and mission reports and career of involved agents	Gf01	Gf0101	S1312
07 Ministry of Justice	S. 07.0 Staff, operational and mission cost of MJ related to drug related issues	25,000.-	Estimation by MJ based on analysis of work / mission / career	Gf03	Gf0306	S1312
	S. 07.1. 0 Staff, operational and mission cost of judiciary services (courts, etc.) related to drug related issues	1,250,000.-	Total cost of judicial services x proportion of drug offences affairs (based on ad hoc register)	Gf03	Gf0303	S1312
	S. 07.2 Prison drug related expenditures	10,802,430.-	Total prison budget x proportion of drug law offenders in total prison population	Gf03	Gf0304	S1312
	S.07.4 Police drug related expenditures	1,200,000.-	Dedicated staff, operational and mission costs (Special drug units 100%)	Gf03	Gf0301	S1312
		3,780,000.-	+ Assessment by Police Directorate based on analysis of job descriptions and related operational costs	Gf03	Gf0301	S1312
12/13 Ministry of Family, Social Solidarity and Youth	S. 13.1 / 12,140 06. 32 Information campaigns on drugs	15,000.-	Internal budget breakdown	Gf10	Gf010	S1312
	S. 13.1 / 11.000 11.00 Staff, operational and mission costs of MF related to drug related issues	22,700.-	Estimation by MF based on analysis of work / mission / career	Gf10	Gf1004	S1312



14 Ministry of Health	S 14.0 Staff, operational and mission cost of MH related to drug related issues	25,000.-	Estimation by MH based on analysis of work / mission / career	Gf07	Gf0704	S1312
<i>14.1 Directorate of Health</i>	S 14.1 / 33.014 05.23 Staff and operational cost of National Aids counselling Centre	191,341.-	25% of total budget: average proportion of PLWHIV/AIDS infected via IDU in clients	Gf07	Gf0702	S1312
<i>14.2 Public Health Laboratory</i>	S 14.1 / 11.000 05.00 / 12.010 05.00 Staff and mission costs of Directorate of Health allocated to drug related issues	250,000.-	Dedicated staff to drug issues + Estimation by MH based on analysis of work / mission / career	Gf07	Gf0704	S1312
	S 14.2 / 11.000 05.20 Staff, operational and mission costs of Laboratory related to drug related issues	25,000.-	Estimation by Laboratory based on analysis of work / mission / career	Gf07	Gf0704	S1312
17 Ministry of Social Security	S 17.2 Staff, operational and mission costs for agents in charge of drug treatment referral abroad	75,000.-	Estimation by MSS based on analysis of work / mission / career	Gf07	Gf0704	S1312
<i>Health / Social insurance</i>	A. Substitution treatment					
	- Reimbursement of prescription substitution drugs (methadone, buprenorphine, etc.) (Net, patient's contribution excluded)	647,604.-	Detailed breakdown by National Health Insurance Fund (CNS)	Gf07	Gf0701	S1312
	- Reimbursement of pharmacies fees generated by substitution medication delivery	32,913.-	Number of substitution prescriptions (- free prescription JDH) X prescription fees (50% counselling & 50% prescription renewal) X % reimbursed by health insurance (95%)	Gf07	Gf0701	S1312
				Gf07	Gf0702	S1314
	- Reimbursement of medical counselling costs related to substitution prescriptions	404,790.-	Detailed breakdown by National Health Fund (CNS) (extrapol.)	Gf07	Gf0703	S1314

B. Inpatient hospital drug treatment

- Reimbursement of inpatient hospital drug treatment costs (e.g. detoxification) (2007)	2,876,498.-	ICD-10: F11, F12, F14, F15, F16, F18 and F19 hospital episodes (CNS) (extrapol.)	Gf07	Gf0706	S1314
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C. Drug treatment abroad

- Reimbursement of drug treatment costs abroad (e.g. residential therapy or specialized therapeutic offers not available in Luxembourg)	1,220,000.-	Extraction from the generic state budgetary section 14.0.34.011	Gf07	Gf0703	
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D. Drug treatment costs subsidised by Min. Health

	75,000.-		Gf07	Gf0702	
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E. Cost of HIV/AIDS treatment provided to patients infected via IDU

	1,927,000.-	Number of HIV/AIDS patients infected via IDU in treatment x yearly average cost of HIV/AIDS treatment (+/- 20,000.- EUR) x reimbursable proportion		Gf0703	
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TOTAL A	Non-Labelled Public drug-related expenditures	24,866,676.-			
TOTAL B	Labelled Public drug-related expenditures (not detailed)	13,571,807.-			
TOTAL A+B	Non-Labelled + Labelled public drug-related expenditures	38,438,483.-			

Source: Origer, 2010

Note: JDH = Fondation Jugend- an Drogenh llef

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

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



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

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

Source: Origer 2002/2009

Budget

The NFP follows up the annual budgetary evolution by means of the most accessible and specific indicator, which is the annual budget of the Ministry of Health allocated to drug-related activities. Table 1.6 shows the budgetary progression since the implementation of the first drugs action plan in 2000 and Table 1.7 summarises the annual progression of budget of the Ministry of Health and human resources allocated to NGOs specialised in drug demand reduction.

Table 1.6: Annual budget of the Ministry of Health allocated to drug demand reduction activities 2000 – 2018

Year	2000	2005	2011	2012	2014	2015	2016	2017	2018
Budget (EUR)	2,066,000.-	6,196,000.-	8,321,620.-	8,590,033.-	10,949,211.-	12,349,000	12,519,993	12,987,138	13,994,013
Cumulative progression rate	Reference year	200%	303%	316%	430%	498%	506%	529%	577%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour les exercices 2000-2017. Volume 1. (Ministère des Finances, 1999-2018)

Table 1.7: Annual progression of the budget of the Ministry of Health and human resources allocated to specialised drug-related demand reduction NGOs 2004 – 2018

Budget Year	2004	2006	2009	2011	2013	2014	2015	2016	2017	2018
Budget (EUR)	5,771,000.-	6,584,000.-	7,991,583.-	8,321,620.-	9,531,000.-	10,949,211.-	12,349,000.-	12,519,993.-	12,987,138.-	13,922,211.-
Annual progression rate	Reference year	6.27%	9.65%	4.13%	10.9%	14.8%	12.8%	1.4%	3.73%	7.2%
Annual cumulative progression rate	Reference year	14.09%	38.48%	44.20%	65.15%	89.73%	114%	117%	125%	142.46%
Dedicated human resources Full Time Equivalent (FTE)	59.5	69.25	83.75	88.75	110.75	111.75	117.25	121.25	121.501	128
Annual progression rate	Reference year	16.39%	20.94%	5.97%	9.93%	0.90%	4.92%	3.41%	0.21%	5.35%
Annual cumulative progression rate	Reference year	16.39%	40.76%	49.16%	86.13%	87.82%	97.06%	103.78%	104.20%	115.13%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour les exercices 2006-2018. Volume 1. (Ministère des Finances 2004-2018)

Funding arrangements

Funding of drug-related interventions is centralised at state level. There exist no specific regional or local funding mechanisms. Few drug prevention activities are subsidised by council districts on an ad hoc basis. Respective ministries or governmental departments, according to their attributions, are coordinating the creation, the implementation and the funding of required infrastructures. Governmental departments directly rely on the state budget while NGOs involved in drug treatment or research activities have either signed a so-called '**convention de collaboration**' with concerned ministries or are financed or co-financed on basis of regular subventions. A governmental delegate follows-up activities and functioning of a given NGO by attending a 'coordination platform'.

The funding of the drug action plan is subject to an annual budgetary decisions' process. Specific local projects designed by non-governmental actors requiring external financial support are generally submitted to respective ministries or to other national funding sources (Fund Against Certain Forms of Criminality, Oeuvre de Secours Grande-Duchesse Charlotte, Foundations, private funds, etc.) or international bodies (EU, EMCDDA, etc.).

Economic costs

Origer (2002) assessed **the direct economic costs of policies and interventions in the field of illicit drug** use referred to year 1999. An update of the Origer 2002 study has been performed according to data for 2007 and results have been presented in the earlier 2008 edition of the national drug report.

A chapter dedicated to methodological aspects of drug-related expenditures estimations in Luxembourg has been published in an EMCDDA Insight publication in 2017. Regarding the European Union, it is estimated that over 1 million people receive treatment for drug-related problems every year. With shrinking public budgets, increasing pressure on health systems, changes in the drugs used and the need to provide on-going care to chronic cases, the real cost of drug treatment in Europe remains largely unknown. The EMCDDA Insight publication on "Drug treatment expenditure: a methodological overview" presents the current practices used for estimating drug treatment costs in order to help fill the knowledge gap (EMCDDA, 2017).

In 2006 and 2014, the STATEC (Central service of statistics and economical studies) published **studies estimating the economic impact of the illegal drugs related activities in Luxembourg** (Statec, 2006, 2014). These studies were carried out within the framework of a European project intended to improve the comparability and the coverage of national accounting. Results were presented in the 2009 edition of the national report. Results of the 2014 study may be retrieved from:

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



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

INTRODUCTION

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

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

Prevalence estimations on drug use in the general population are based on data collected in more (e.g. schools) or less (general population: age group 15-64 years) targeted and representative samples of the national overall population. According to the most recent less targeted survey (EHIS, 2014)³⁴, cannabis and its derivatives are by far the most common illicitly used psychoactive substances in the national population, followed by cocaine and Amphetamine Type Stimulants (ATS). Cannabis use in youngsters has been decreasing and stabilized subsequently since the beginning of the 21st century, according to latest school surveys, but still shows the highest prevalence regardless age categories, whereas the prevalence of other psychoactive drugs varies according to age and data collection setting factors. Most recent school survey data presented in the present report stem from the HBSC studies from 2010 and 2014. HBSC data since 2006 has been revised by the University of Luxembourg, being responsible for the scientific coordination of the HBSC study in Luxembourg. By using the same underlying criteria in the data cleaning and data analysis, this revision provides comparable data for the waves 2006, 2010 and 2014.

DRUG USE IN THE GENERAL POPULATION

**General population survey on health status, healthcare use and health determinants
(European Health Interview Survey – EHIS)**

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

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

EHIS covers the following topics:

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

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

The target of 4,000 participants was reached by the end of 2014. On December 31, 2014 the number of participants reached 4,118 from which 4,004 questionnaires were considered valid.

EHIS is a cross-sectional population-based survey, based upon a health data questionnaire of the resident population of the Grand-Duchy of Luxembourg. The methodology of EHIS was developed by 28 Member States of the European Union (see methodological manual EUROSTAT).

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

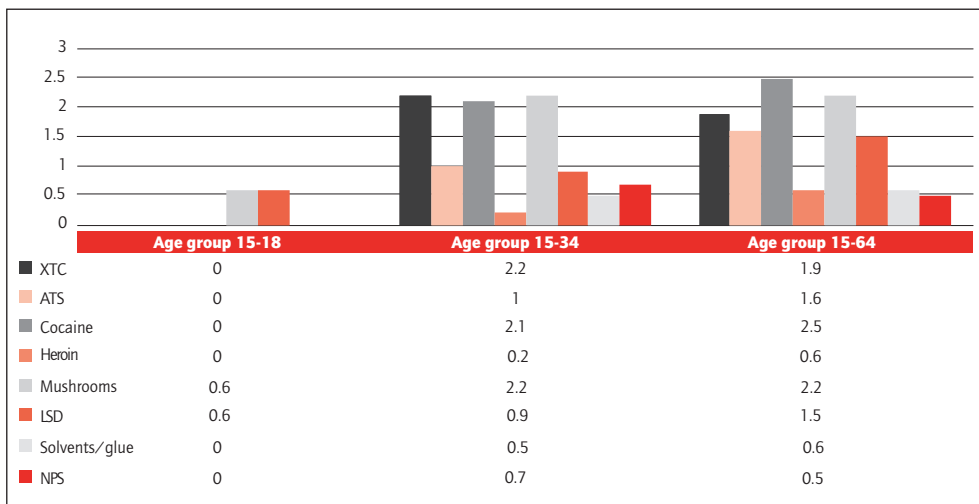
Illicit drugs' and NPS' use are not mandatory items of the basic EHIS questionnaire. A drug-related data protocol based on EMCDDA requirements and the EMQ (European Model Questionnaire) has been elaborated and tested jointly by the NFP and the LIH. The target for illicit and new psychoactive substances'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



SUMMARY OF MAIN RESULTS:

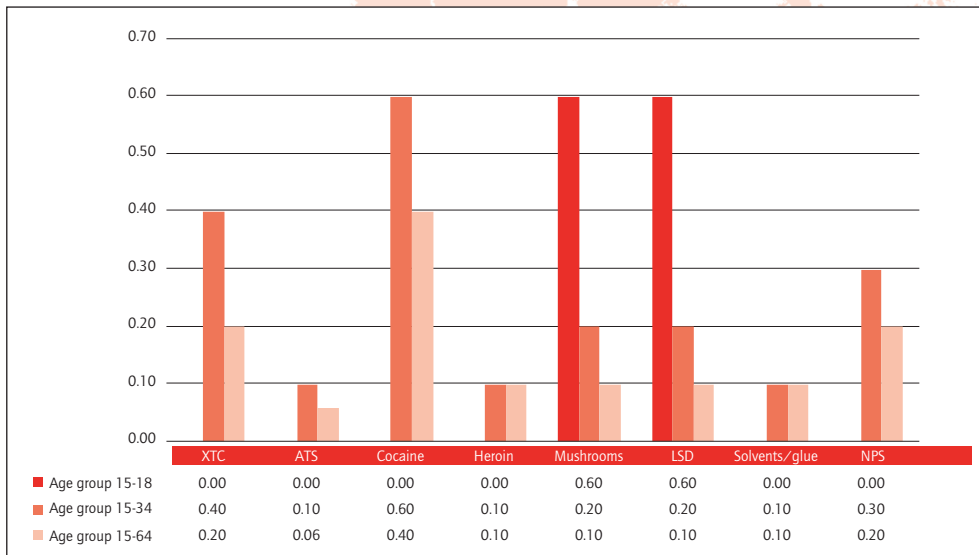
1. Prevalence of psychoactive substances' use in the general population (EHIS, 2014)

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



Source: EHIS, 2014

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



Source: EHIS, 2014

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



Source: EHIS, 2014

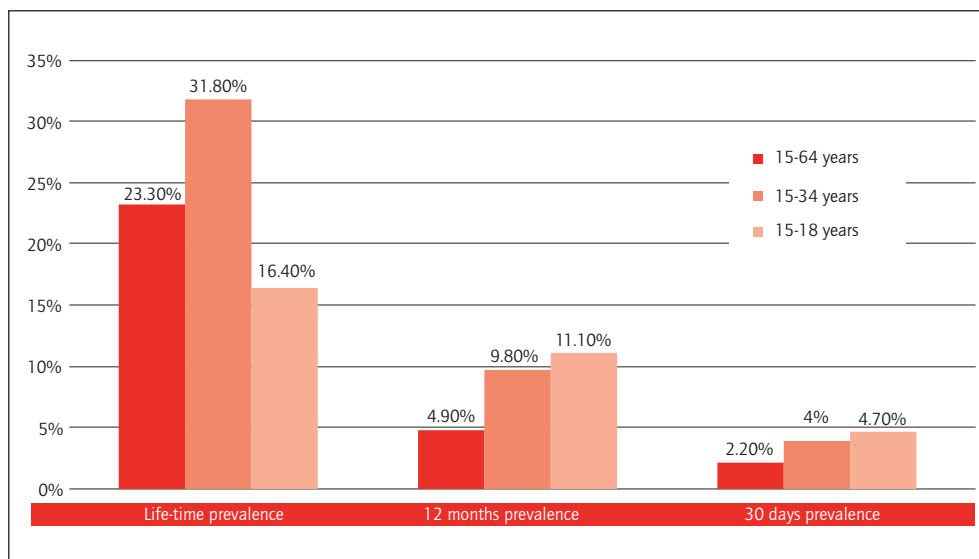
Summarily, national prevalence rates of illicit psychoactive substances, all levels and all age ranges included, appear to be fairly low with regard to EHIS data. A comparative analysis shows that national prevalence rates tend to situate around and often below currently observed EU mean averages. As far as current (last 30 days prevalence) and recent (last 12 months prevalence) use is concerned, this can be observed for all substances. In particular, for the age group 15-34 years old, last 12 months prevalence of cocaine and ecstasy (XTC) are 0.6% and 0.4% respectively, while the EU average for these substances are 1.9% and 1.8%, respectively.

2. Prevalence of cannabis use in the general population (EHIS, 2014)

Regarding prevalence of cannabis use, Figure 2.4 highlights LTP, LYP and LMP split by age groups. Overall, these data show that 31.8% of young adults (15-34y) have used cannabis at least once during lifetime, 9.8% have used it last year and 4% have used it last month. The highest LTP is observed in this group, while the highest LYP and LMP occur among the youngest group (15-18y), with 11.1% of the youngest reporting having used cannabis last year and 4.7% having used it last month.



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



Source: EHIS, 2014

The overall (15-64y) national lifetime prevalence for cannabis rate (23.3%) is below the EU average based on most recent and available results from surveys within the EU (26.3%) (EMCDDA, 2017). The last 12 months prevalence (15-34y) is 9.8% (EHIS, 2014) which is also markedly below the 14% EU average (EMCDDA, 2017). Substances most often consumed in Luxembourg after cannabis are cocaine and XTC type substances, even though prevalence rates of recent use of the latter situate below the EU average.

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

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

Source: EHIS, 2014

National prevalence data on cannabis show higher rates for male users compared to female users at all levels (all prevalence rates and age groups). Gender differences in cannabis use are important, and more pronounced though in younger subpopulations and with regard to recent use (Table 2.1).

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

	15-64 Y			15-34 Y			15-18 Y		
	T	M	F	T	M	F	T	M	F
Cannabis (105 ³⁵ /3,421 ³⁶)	35.8	38.5	33.7	54.7	58.9	51.8	53.0	54.9	52.7
XTC (163/3,421)	4.7	6.5	3.4	8.1	11.3	5.9	7.3	7.1	7.5
ATS (173/3,421)	3.5	4.8	2.5	4.9	6.9	3.5	1.8	1.4	2.2
Cocaine (161/3,421)	7.6	9.5	6.0	11.1	13.6	9.3	6.1	2.9	8.6
Heroin (177/3,421)	2.7	3.5	2.2	2.7	3.7	2.0	3.7	1.4	5.4
Mushrooms (168/3,421)	4.4	5.8	3.3	7.5	10.7	5.3	3.6	5.7	2.2
LSD (174/3,421)	3.0	4.2	2.0	4.8	6.9	3.3	4.9	4.3	5.4
Solvents/glue (176/3,421)	1.0	1.3	0.9	1.1	1.7	0.8	0.6	0.0	1.1
NPS (177/3,421)	1.4	1.8	1.0	2.1	2.8	1.7	4.9	5.7	4.3

Source: EHIS, 2014

In age groups 15-34 years and 15-64 years, male respondents do more often know other people using drugs, compared to their female pairs. In age group 15-18 years, female respondents show higher rates for XTC, ATS, cocaine, heroin and LSD. Cannabis use in persons known by the respondents is most prevalent followed by cocaine (Table 2.2).

Table 2.3: Mean and median age of first use

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

Source: EHIS, 2014

35 Missing values

36 N



Solvents and glue appear to be the first of listed psychoactive substances ever used by respondents, followed by LSD and cannabis. On average, female respondents report earlier first use of most substances, compared to their male counterparts, except for heroin, cocaine and magic mushrooms (Table 2.3).

Table 2.4: Age distribution of first substance use

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

Source: EHIS, 2014

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

Other targeted population surveys

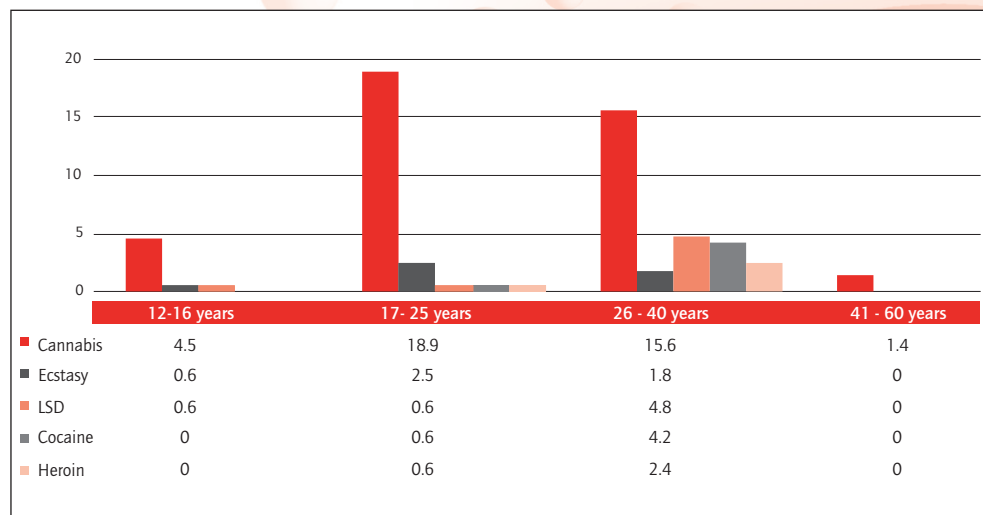
A primary prevention pilot project at community level was launched by the CePT in 1995. In 2000, 13 council districts participated in this project. In the framework of this project a non-representative survey on drug use in the general population (reference 1: "Fischer 1999 study") was conducted.

REFERENCE 1

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

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

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



Source: Fischer & Krieger, 1999

A second survey conducted by the CePT was published in 2000 (Fischer, 2000). Even though cannabis consumption was the main subject of the study, several other substances have been taken into account. The samples have been drawn on the one hand from a cinema visitor's population in Luxembourg City (ref.:2.1) and on the other hand from a population of six council districts (ref.:2.2).

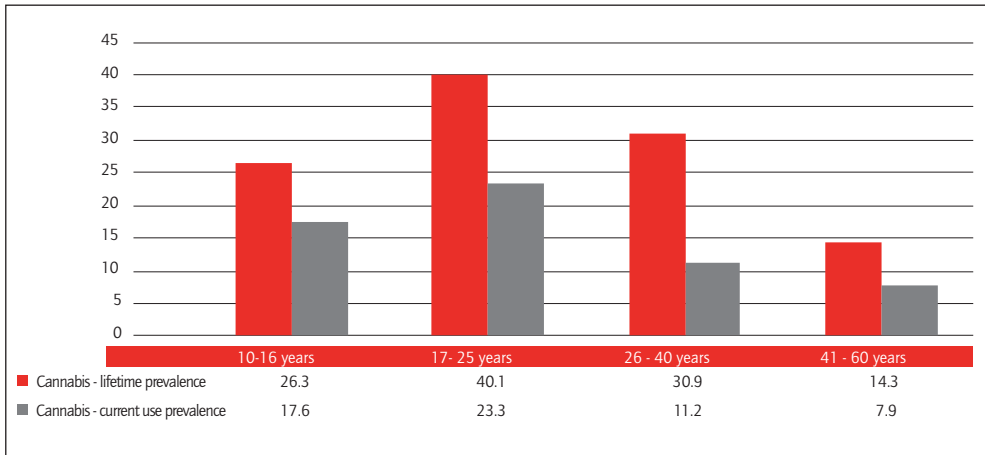
REFERENCE 2.1

Fischer U. C. (2000). *Cannabis in Luxemburg – Eine Analyse der aktuellen Situation*. Luxemburg: CePT. **EN:** Cannabis in Luxembourg

Year of data collection	1999
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	Cinemas in Luxembourg-City
Age range	15-64 years
Data coll. Procedure	On-site interviews
Sample size	991 valid cases
Sampling procedure	Random sampling of cinema customers
Remark	Detailed results of both surveys are provided in EMCDDA standard tables



Fig. 2.6 Current and lifetime prevalence of cannabis use according to age: Cinema sample (valid %)



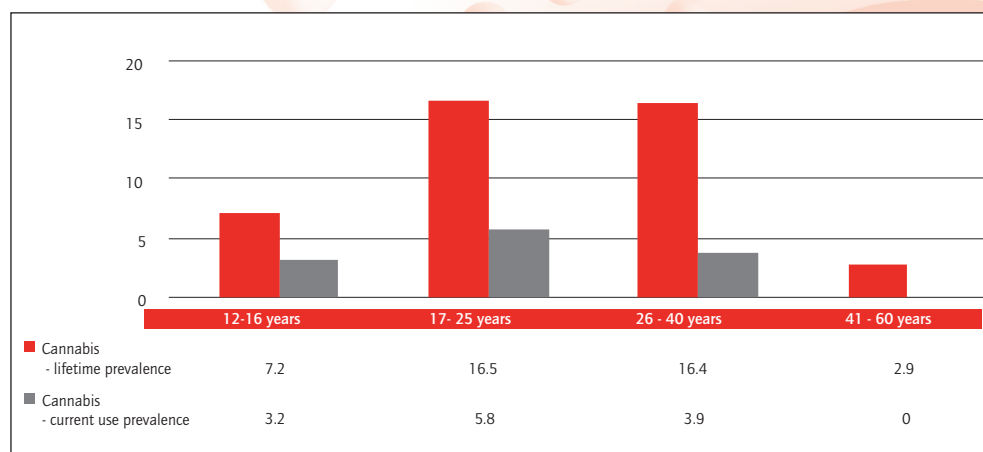
Source: Fischer, 2000

REFERENCE 2.2

Fischer U. C. (2000). *Cannabis in Luxemburg – Eine Analyse der aktuellen Situation. Luxemburg: CePT. EN.: Cannabis in Luxembourg*

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

Fig. 2.7 Current and lifetime prevalence of cannabis use according to age sample: Council districts (valid %)



Source: Fischer, 2000

As can be seen in Figures 2.6 and 2.7, cannabis prevalence rates show relevant differences according to type of recruitment settings. The sample recruited in cinema settings reveals higher prevalence rates of cannabis use than the sample recruited in council districts (these differences are observed for both lifetime and current use and for all age groups).

DRUG USE IN THE SCHOOL AND YOUTH POPULATION

LIFETIME PREVALENCE: SCHOOL POPULATION

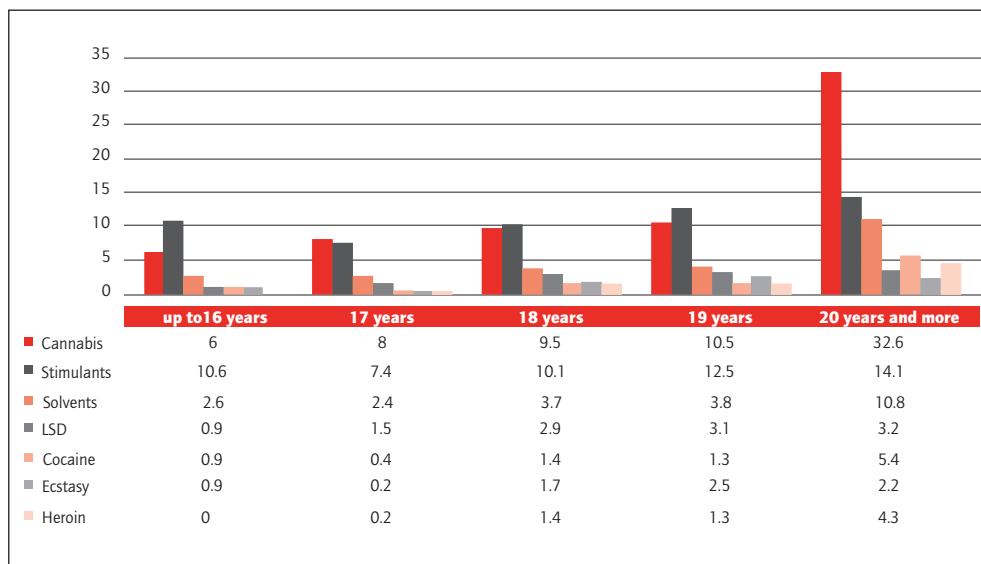
REFERENCE 1

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

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



Fig. 2.8 Lifetime prevalence of drug use according to age (valid %)



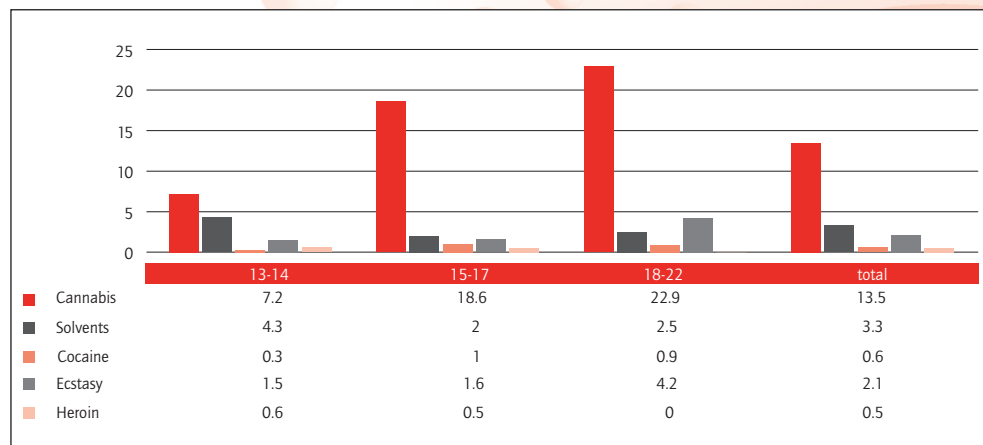
Source: Matheis et al., 1995

REFERENCE 2

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

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

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



Source: Meisch., 1998

REFERENCE 3

HBSC Study (2006 / 2010 / 2014). *Health Behavior in School Aged Children*.
 Université du Luxembourg, Ministère de l'Education Nationale de la Jeunesse et des Sports, Ministère de la Santé, Luxembourg.
EN.: Health and Health Behaviour in School Aged Children.

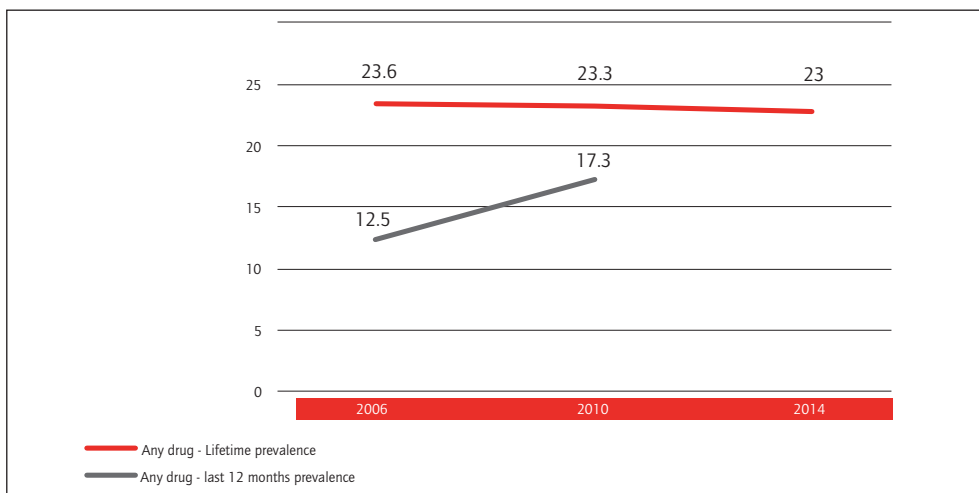
Year of data collection	2006 / 2010 / 2014
Single/repeated study	Repeated study (intended each 4 years)
Context	Health and Health Behaviour among Young People – WHO cross-national study
Area covered	Nation-wide, representative
Type of school	Secondary schools
Age range	11-18 years (drug-related questions from 13-18 years)
Data coll. procedure	Anonymous self-administrated questionnaires in school classes
Sample size	7,000 – 8,000
Response rate (M,F,T)	Over 95 %

Methodological note:

It is important to note that changes have occurred regarding the HBSC data reported (Reference 3). In order to provide comparable serial data, the University of Luxembourg (methodological coordinator of the project since 2015) recalculated the prevalence indicators (life-time, last 12 months and last 30 days prevalence) from 2006 to 2014. The data presented here were computed under the same statistical assumptions and criteria, and hence are comparable.



Fig. 2.10 Lifetime and last 12 months prevalence of any drug (valid %) (HBSC, 2006, 2010 and 2014)

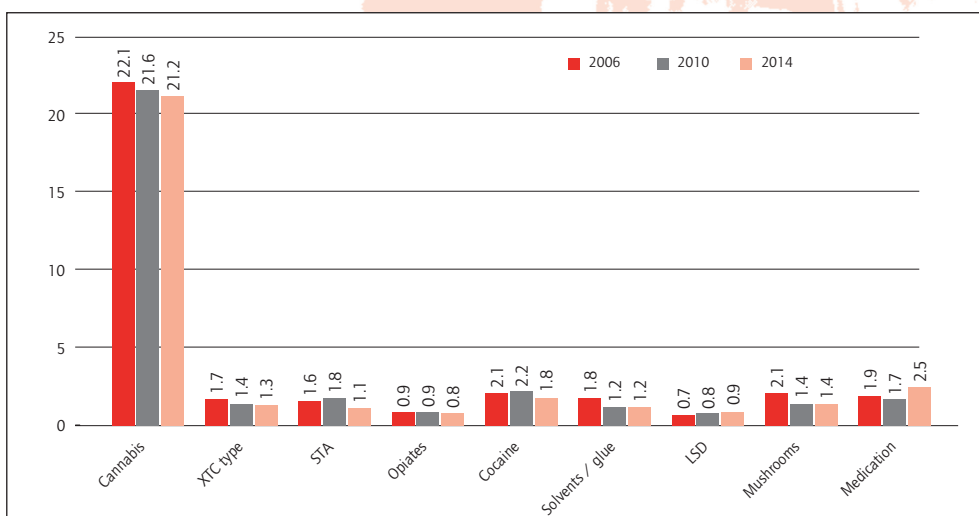


Source: HBSC, 2006-2014

Note: The sample's age range was 13-18 years; HBSC 2014 does not include a question on last 12 months prevalence of any drug.

Data from HBSC (since 2006) suggest that the number of school-aged youngsters using illicit drugs at least once in a lifetime has been stable (varying from 23.6% in 2006 and 23% in 2014). However, the number of school-aged youngsters having used drugs recently (in the last 12 months) increased from 2006 (12.5%) to 2010 (17.3%). Due to changes in the 2014 HBSC questions, last 12 months prevalence data are not available (Figure 2.10).

Fig. 2.11 Lifetime prevalence of drug use according to type of drug. Total school population aged 13-18 years (valid %) (HBSC, 2006, 2010, 2014)

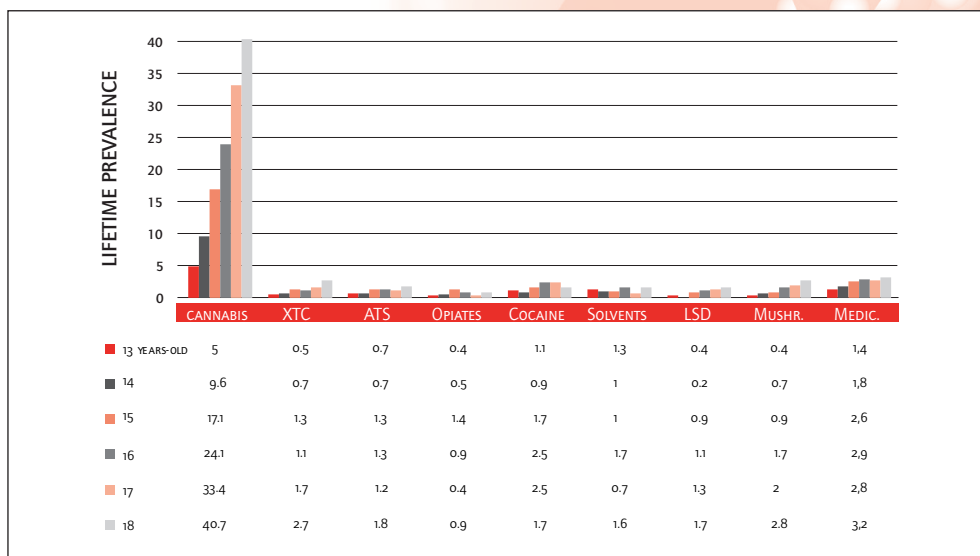


Source: HBSC, 2006-2014

Note: The sample is representative of the total school population. The sample's age range was 13-18 years

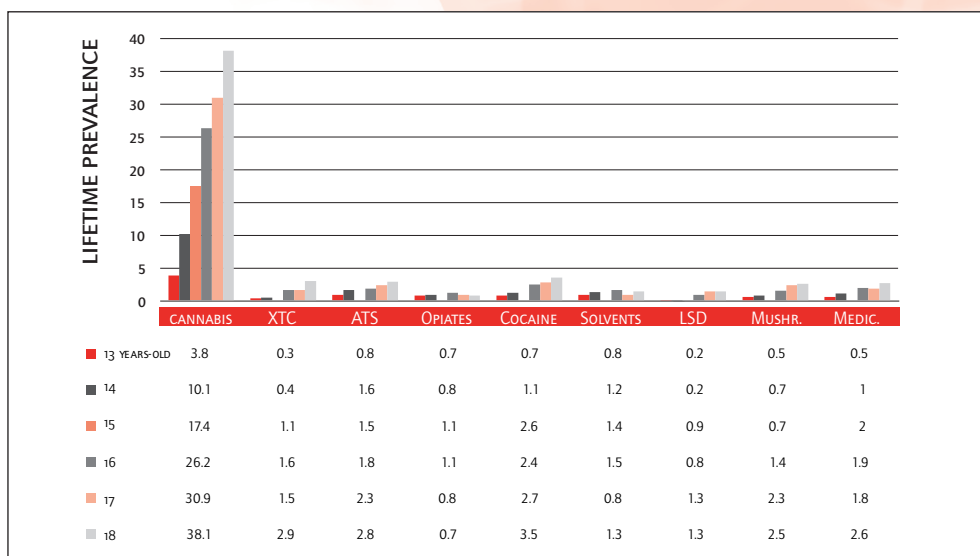
Considering lifetime prevalence (LTP) rates (Figure 2.11) by specific drug use, HBSC show a general decrease or stabilisation of the number of youngsters (13-18 years) using illicit drugs at least once in their lives, between 2006 and 2014. More precisely, LTP of cannabis, ecstasy/XTC, amphetamines, opiates and cocaine use has decreased and, LTP of solvents and mushrooms use has remained stable. The only exceptions concern "abuse of medication to get high", which LTP has increased from 1.9% to 2.5% in 2014, and LSD, which has slightly increased from 0.7% to 0.9% in 2014.

Fig 2.12 Lifetime prevalence of drug use according to age and type of drug (valid %) (HBSC, 2014)



Source: HBSC, 2014

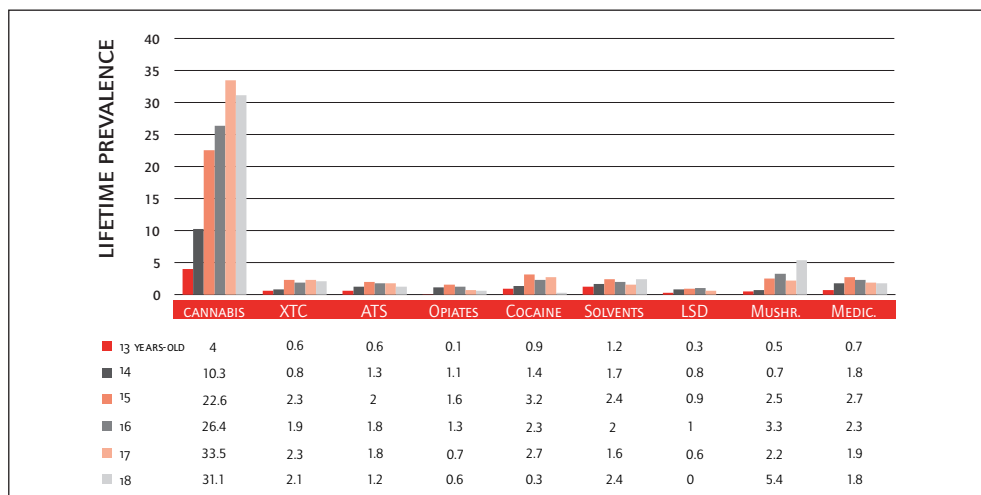
Fig 2.13 Lifetime prevalence of drug use according to age and type of drug (valid %) (HBSC, 2010)



Source: HBSC, 2010



Fig 2.14 Lifetime prevalence according to age and type of drugs (valid %) (HBSC, 2006)

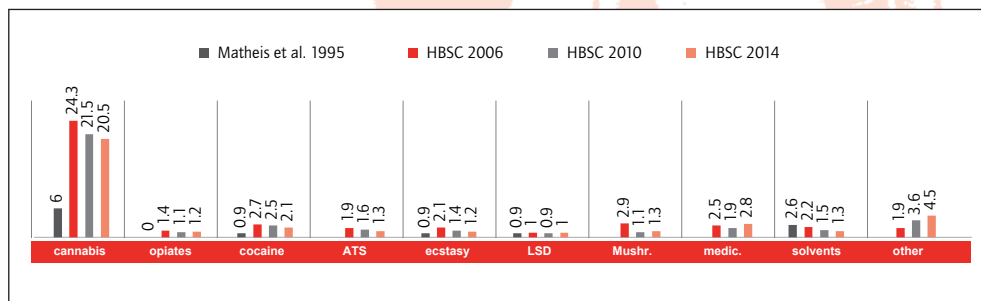


Source: HBSC, 2006

A comparison of serial HBSC data from 2006 and 2014 reveals that cannabis prevalence rates are the highest regardless of age and year of survey. During the referred period, lifetime cannabis use appears to be increasing for the older (18 years-old group), while it is decreasing among the 15 year-old group.

A comparison of the more recent surveys (2010 and 2014) indicates that, while lifetime consumption of amphetamines (ATS) decreased from 2010 to 2014 for all age groups, the lifetime "abuse of medication to get high" increased in all ages; this increase is relevant since the consumption more than doubled for the youngest (13 years old). LSD consumption is stable for some age groups (14, 15 and 17 years old) or in an increasing trend for others (13, 16 and 18 years old). Finally, the variations observed for ecstasy, opiates, cocaine, solvents do not indicate relevant changes regarding their lifetime prevalence.

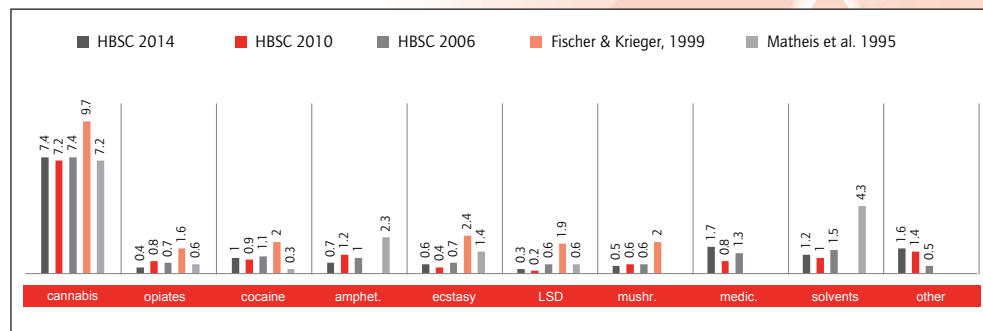
Fig 2.15 Longitudinal lifetime prevalence of several illicit drugs (age group 15-16 years-old)



Source: Matheis et al., 1995; HBSC, 2006-2014

When looking specifically into age groups, data from HBSC and previous studies (Matheis et al., 1995) suggest that, among 15-16 years-old, lifetime consumption of illicit drugs has been, in general, decreasing since 2006, with the exception of "abuse of medication to get high" and "other drugs", which presented the highest prevalence in 2014 ("medication" – 2.8% and "other drugs" – 4.5%) (Figure 2.15).

Fig 2.16 Lifetime prevalence of several illicit drugs (age group 13-14 years old)



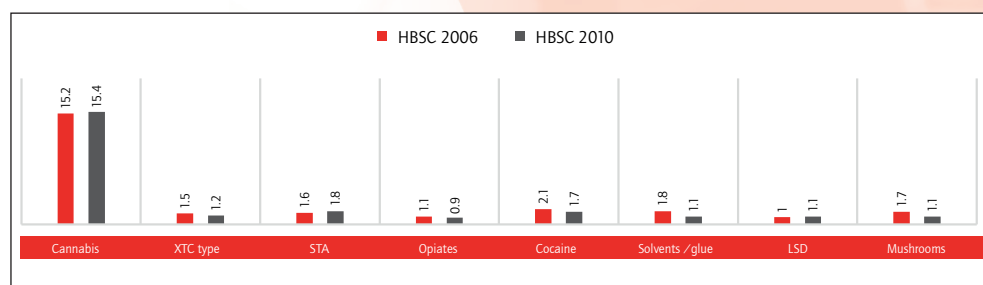
Source: Matheis et al., 1995; Fischer & Krieger, 1999; HBSC, 2006-2014

Note: HBSC data are directly comparable (similar methodology and statistical criteria used in the prevalence calculations)

The HBSC surveys (2006 / 2010 / 2014), the Fischer study (1999) and the serial surveys by Matheis et al (1985/95) provide trends in lifetime prevalence between 1995/1999 and 2014 applied to age groups 13-14 (in the case of HBSC) and in 13-16 (for the Fischer and Matheis studies). Compared to the end of the 20th century, most recent data from HBSC surveys indicate decreasing lifetime prevalence rates for all substances with the notable exception of medication and other drugs, which appear to be increasing for both 13-14 (Figure 2.16) and 15-16 year old (Figure 2.15) groups.

LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

Fig 2.17 Last 12 months prevalence of drug use according to type of drug. Total school population aged 13-18 years (valid %)



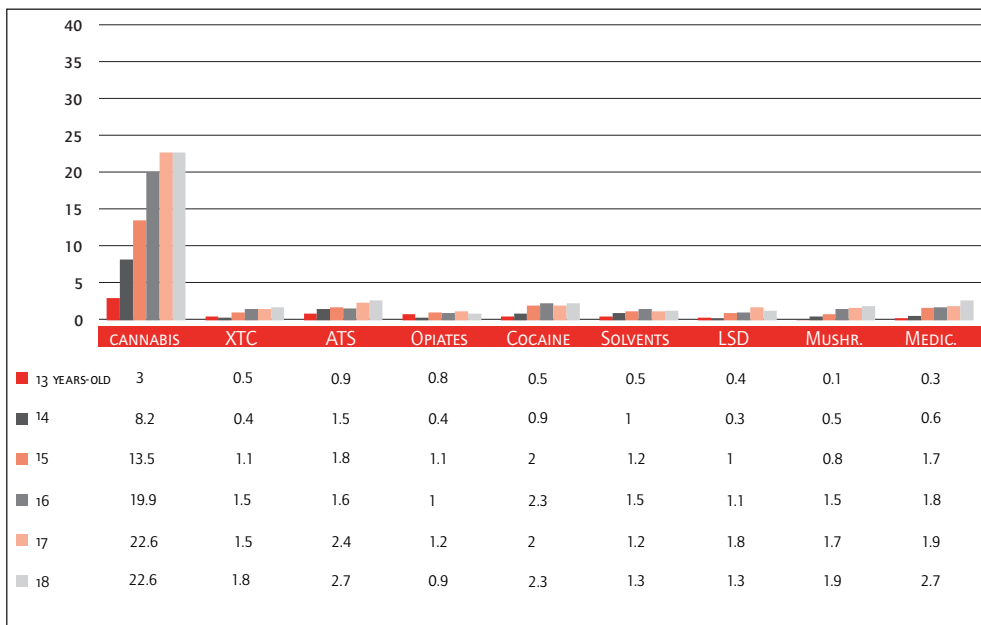
Source: HBSC, 2006-2010

Note: The sample was representative of the total school population. The sample's age range was 13-18 years.

Between 2006 and 2010, recent (last 12 months) consumption of ecstasy, opiates, cocaine, solvents mushrooms decreased while the consumption of cannabis, amphetamines and LSD slightly increased. Note: The data presented dates from 2010 since HBSC 2014 edition only includes last 12 months prevalence of cannabis use.



Fig 2.18 Last 12 months prevalence of drug use according to type of drug and age (valid %) (HBSC, 2010)



Source: HBSC, 2010

The most recent data available (HBSC, 2010) confirm highest rates for cannabis use (last 12 months) followed by stimulant type amphetamines, cocaine and abuse of medication to get high in schoolchildren aged 13 to 18 years. Recent consumption tends to reach the highest pick at 18 years old except for opiates, solvents and LSD.

Table 2.5: HBSC 2006 / 2010 / 2014: Trend analysis according to age and type of drug (last 12 months prevalence)

	13			14			15			16			17			18		
HBSC / Year	2006	2010	2014	2006	2010	2014	2006	2010	2014	2006	2010	2014	2006	2010	2014	2006	2010	2014
Cannabis	3.2	<u>3</u>	<u>2.3</u>	7.8	8.2	<u>7.2</u>	18.0	<u>13.5</u>	17.1	19.5	19.9	<u>19.7</u>	20.4	22.6	24	16.9	22.6	26.4
XTC	0.7	<u>0.5</u>		1.6	<u>0.4</u>		2.9	<u>1.1</u>		2.1	<u>1.5</u>		1.9	<u>1.5</u>		3.2	<u>1.8</u>	
ATS	1.0	<u>0.9</u>		1.9	<u>1.5</u>		3.0	<u>1.8</u>		2.6	<u>1.6</u>		1.3	2.4		2.6	2.7	
Opiates	0.5	<u>0.8</u>		1.8	<u>0.4</u>		2.3	<u>1.1</u>		1.9	<u>1</u>		0.8	1.2		2.0	<u>0.9</u>	
Medic.	0.8	<u>0.3</u>		2.3	<u>0.6</u>		3.5	<u>1.7</u>		2.6	<u>1.8</u>		2.0	<u>1.9</u>		2.4	2.7	
Cocaine	1.3	<u>0.5</u>		2.3	<u>0.9</u>		4.4	<u>2</u>		2.9	<u>2.3</u>		2.2	<u>2</u>		4.1	<u>2.3</u>	
Glue / solvents	1.1	<u>0.5</u>		2.5	<u>1</u>		3.0	<u>1.2</u>		2.5	<u>1.5</u>		2.1	<u>1.2</u>		1.8	<u>1.3</u>	
LSD	0.6	<u>0.4</u>		1.3	<u>0.3</u>		1.9	<u>1</u>		1.6	<u>1.1</u>		1.0	1.8		1.8	<u>1.3</u>	
Mushrooms	0.4	<u>0.1</u>		1.6	<u>0.5</u>		2.8	<u>0.8</u>		3.2	<u>0.8</u>		2.2	<u>1.7</u>		4.4	<u>1.9</u>	

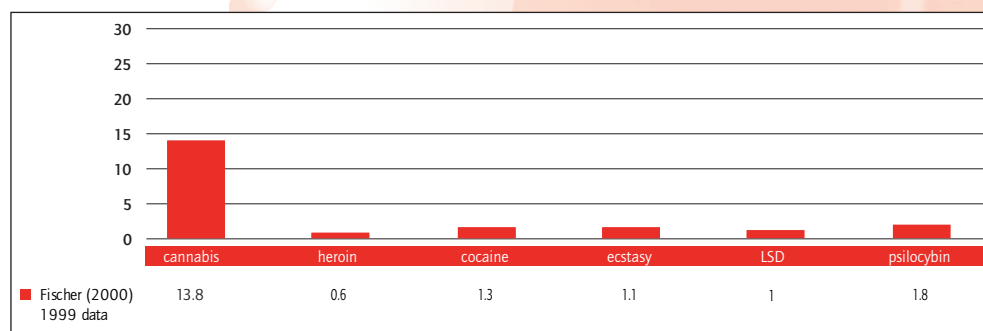
Source: HBSC, 2006-2014

Note: Downward trend 2006 - 2014 - upward trend 2006-2014

Serial HBSC surveys (2006, 2010, 2014) provide last 12 months national prevalence figures among 13 to 18 years aged schoolchildren. 2014 data are limited to cannabis use though. Among scholars with ages comprised between 13 and 16, consumption of all the substances, except cannabis, appeared to be in a decreasing trend. However, cannabis, amphetamines, opiates, medication and LSD showed an increased in the referred observation period.

LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

Fig. 2.19: Last 30 days prevalence according to type of drugs: school population - 13-20 years



Source: Fischer, 2000

REFERENCE 4

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

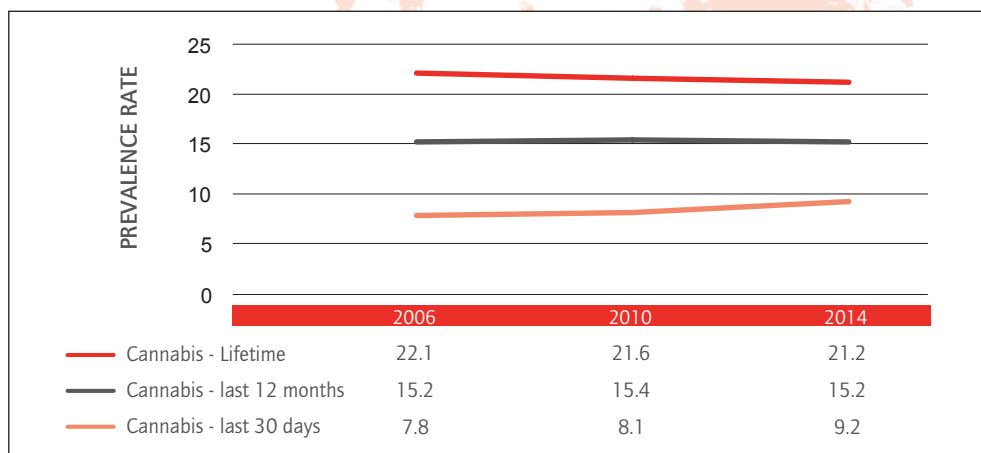
Year of data collection	1999
Single/repeated study	Single
Context	Cannabis prevalence
Area covered	Nation wide
Type of school	2 nd and 6 th years of secondary schools
Age range	13-20 years
Data coll. procedure	Self-administrated questionnaires
Sample size	562
Sampling frame	Schools selected on basis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



Fischer (2000) provides last 30 days prevalence figures for 13 to 20 year old schoolchildren. Cannabis and ecstasy prevalence figure 13.8% and 1.1%, respectively. Heroin, cocaine and LSD prevalence rates are close to last 12 months prevalence rates. Gender breakdowns are currently not available. HBSC surveys did not include questions on last 30 days use of different drugs, except for cannabis. Last 30 days cannabis use is addressed below.

IN-DEPTH DATA ON CANNABIS USE PREVALENCE IN SCHOOL-AGED CHILDREN³⁷

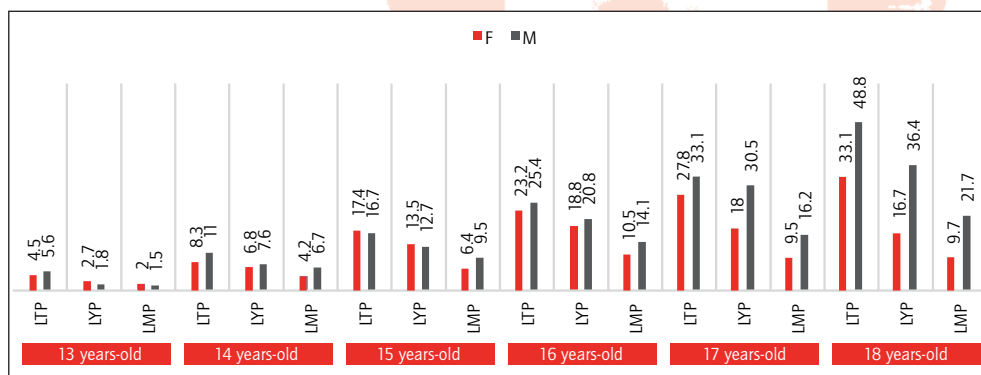
Fig. 2.20: Lifetime, last 12 months and last 30 days prevalence of cannabis use. Age 13-18 years (valid %)



Source: HBSC, 2006-2014

An analysis of HBSC data from 2006 until 2014 indicates that the lifetime and last 12 months prevalence of cannabis use have been stable during this period. The last 30 days consumption has slightly increased.

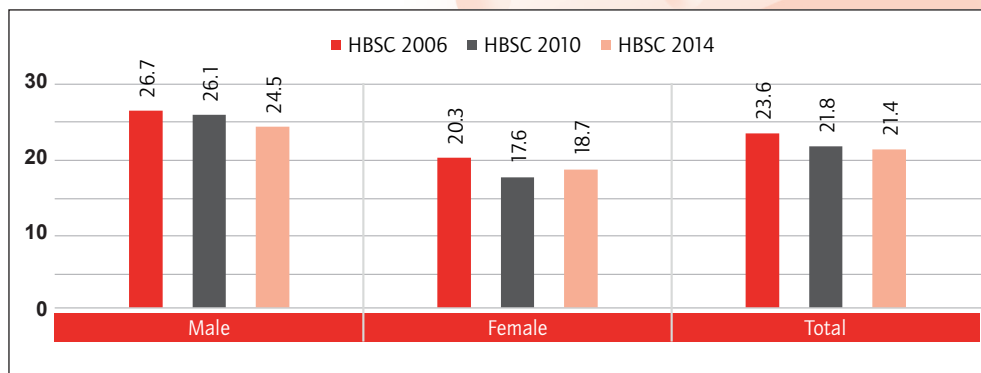
Fig 2.21: Cannabis prevalence rates according to gender and age (HBSC 2014 data)



Source: HBSC, 2014

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

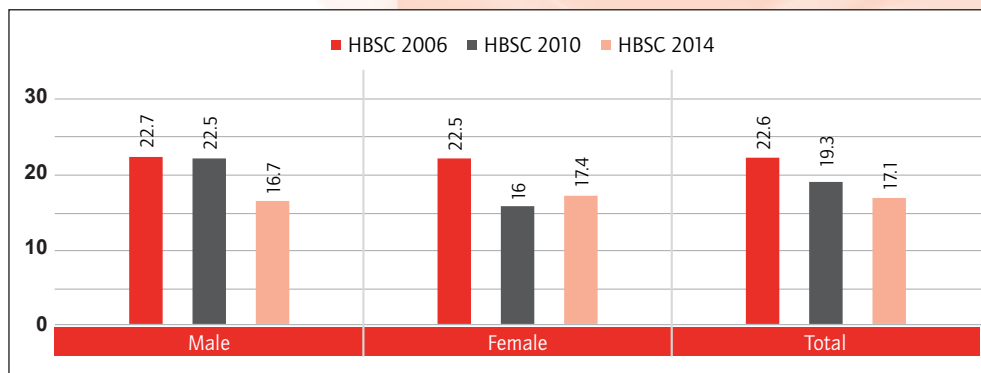
Fig 2.22: Yearly comparison of lifetime prevalence of cannabis use according to gender. Age 13-18 years old (HBSC, 2006, 2010, 2014)



Source: HBSC, 2006-2014

Overall, lifetime prevalence of cannabis use has slightly decreased for men and slightly increased for women.

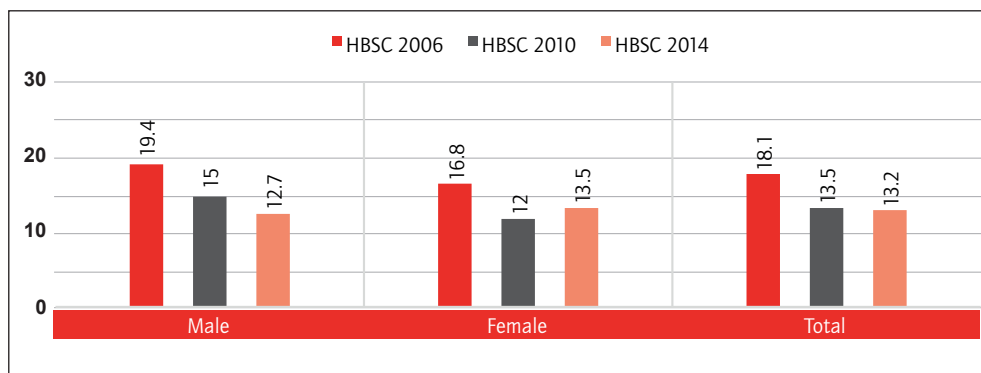
Fig 2.23: Yearly comparison of lifetime prevalence of cannabis use according to gender. Age 15 years old (HBSC, 2006, 2010, 2014)



Source: HBSC, 2006-2014

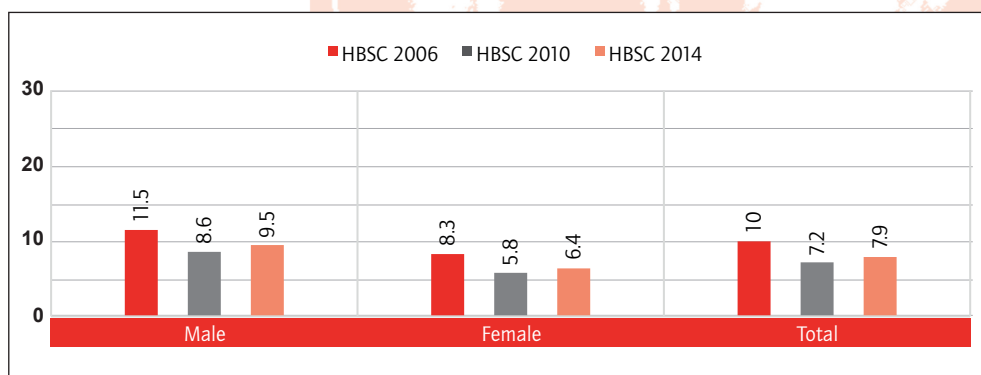


Fig 2.24: Yearly comparison of last 12 months prevalence of cannabis use according to gender. Age 15 years old (HBSC, 2006, 2010, 2014)



Source: HBSC, 2006-2014

Fig 2.25: Yearly comparison of last 30 days prevalence of cannabis use according to gender. Age 15 years old (HBSC, 2006, 2010, 2014)

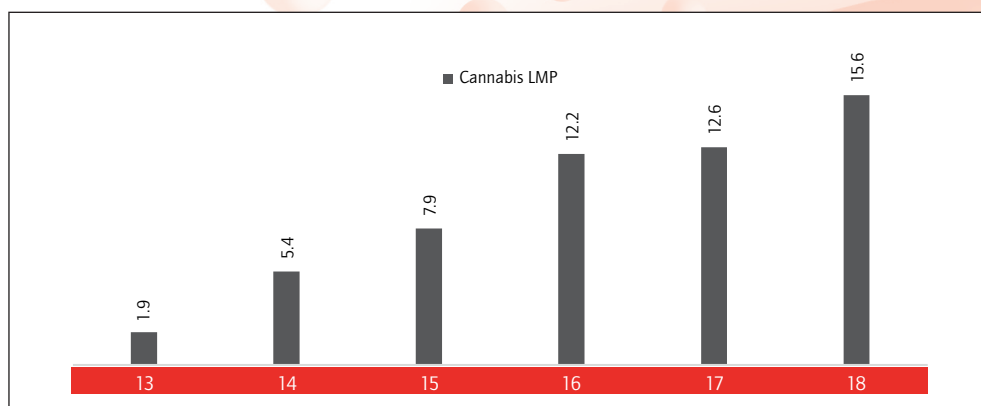


Source: HBSC, 2006-2014

Among pupils aged 15 years old, gender differences have been observed in the evolution of lifetime, last 12 months and last 30 days prevalence of cannabis use. Lifetime, recent and current use of cannabis among female youngsters increased between 2010 and 2014, but is still below the 2006 prevalence rates. Among men, lifetime and recent consumption show a decreasing trend, while current consumption increased compared to 2010 while not reaching the values observed in 2006.

Until 2010, male pupils tended to present greater prevalence figures than females. However, 2014 results are somewhat surprising as they suggest that females present a greater lifetime and recent (last 12 months) cannabis consumption than male.

Fig 2.26: Last 30 days prevalence (LMP) of cannabis use according to age (valid %) (HBSC 2014 data)



Source: HBSC, 2014

Current consumption increases progressively between 13 and 18 years-old.

DRUG USE AMONG TARGETED GROUPS

In 2007, the National EMCDDA focal point published the results of action research on HIV and hepatitis infections in drug users (Origer and Removille, 2007).

REFERENCE 5

Origer, A., & Removille, N. (2007). *Prévalence et propagation des hépatites virales A,B,C et du HIV au sein de la population problématique de drogues d'acquisition illicite*. Luxembourg: Point Focal OEDT / CRP-Santé.

EN: Prevalence study on HIV, HCV, HBV and HAV in HRDU in Luxembourg

Year	2007
Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence national PDU population
Area covered	In- and outpatient drug agencies and national prisons
Type sample	Random sampling during 8 months in 2005
Age range	> 17
Data coll. Procedure	Anonymous self-administrated questionnaires and serological testing
Sample size	366
Sampling frame	Random sampling
Response rate (M, F, T)	33.96%

MAIN RESULTS:

- 67.21% of HRHRDU reported at least 1 prison stay during the last 10 years
- of which 56.1% report drug use in prison
- of which 54.3% report IDU in prison



Furthermore, a study on *"Drug addiction in the working environment: Prevalence of use of psychoactive substances use and its relationship to high-risk occupation and stress"* (Krippeler & Kittel, 2011)³⁸ has been published in April 2011. The aim of the study was to explore the prevalence of licit and illicit psychoactive substances use among employees aged between 18–39 years in the private sector in the G.D. of Luxembourg as well as its relationship to high-risk occupations and other potential risk factors in occupational settings (e.g. high-stress tasks). For this purpose, a self-administered questionnaire containing validated tools from the EMCDDA concerning street drugs, the AUDIT-C for alcohol use and the Siegrist Effort-Reward-Imbalance questionnaire on stress were distributed during occupational medical check-ups during June and July 2008. Alcohol, cigarettes, amphetamines, cocaine, heroin, ecstasy, LSD and psychotropic drugs use were investigated together with socio-demographic and professional factors. Among the 1358 respondents, 8.4% consumed illicit substances, cannabis accounting for 8.2%. High-risk occupations are significantly related to illegal substance use. Age (young), gender (men), smoking and family situation (bachelor living alone) show the same relationship. No effect was found for stress on illicit drug use while there was a significant effect on alcohol and prescription drug use in bivariate analysis only.

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

Q12. Have you used cannabis yourself?				
	Yes – in past year	Yes – but more than one year ago	No, I have never used	Don't want to answer
LU	7 (7)	18 (10)	69 (77)	1 (2)
EU 28 (EU27)	10 (8)	14 (12)	69 (72)	0 (2)
Q3. In certain countries some new substances that imitate the effects of illicit drugs are being sold as legal substances in the form of – for example – powders, tablets/pills or herbs. Have you ever used such substances?				
	No, I have never used		Yes, I have used such substances	
LU	93 (93)		7 (7)	
EU 28 (EU27)	92 (95)		8 (5)	

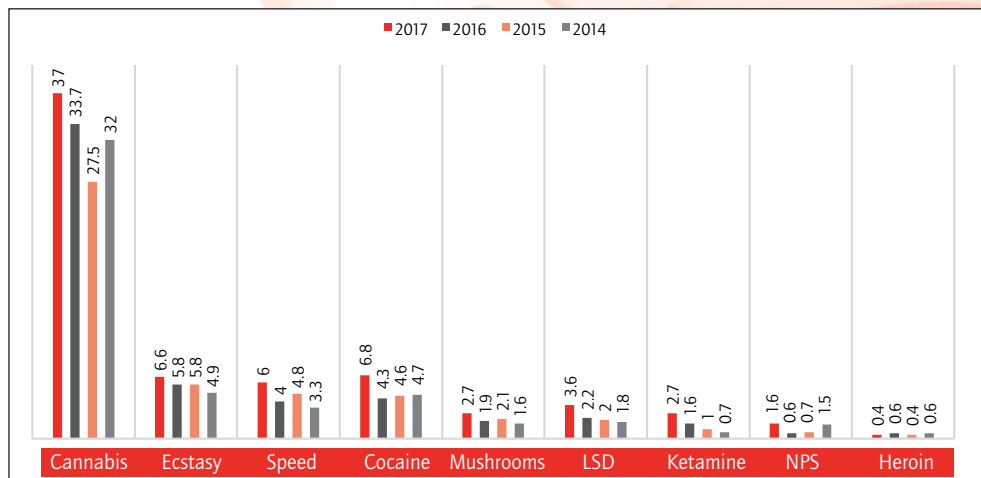
Source: Flash Eurobarometer N°401, 2014

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

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

38 Krippeler, S., & Kittel, F. (2011). Toxicomanies en milieu professionnel : prévalence de l'usage de substances psychoactives et sa relation avec le poste de sécurité et le stress. *Archives des maladies professionnelles et de l'environnement*, 72 (2), 181-188.

Fig 2.27: Yearly comparison of the % of individuals reporting illicit substance in festivals



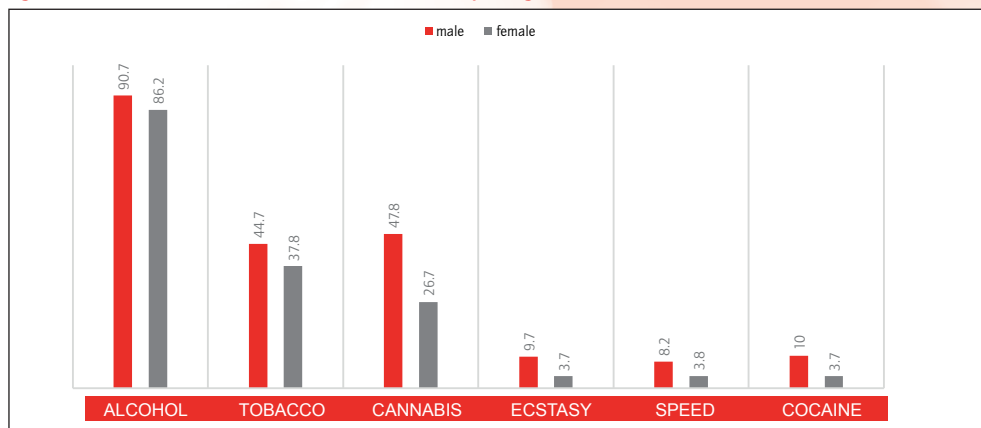
Source: Ducherer & Paulos, 2015; Ducherer & Paulos, 2016; Paulos, 2017; Paulos, Hagen, & Loverre, 2018

Drug use among partygoers is yearly assessed by the Pipapo project (4motion asbl). This project conducts a rapid assessment survey in festive settings in Luxembourg, notably it addresses the participants' drug use during the last two weeks. The main goal is to understand and have a current description of the public attending these events as well as to assess recreational drug use in festive contexts in Luxembourg.

Figure 2.27 shows the percentage of participants reporting recent use of drugs. A comparison of recent festive consumption since 2014 is presented. The number of participants varies across years: 3,679 in 2014; 3,676 in 2015; 1,806 in 2016 and 2,450 in 2017.

Overall results indicate that cannabis is the most frequently used substance and that its consumption has been progressively increasing – 32% in 2014 and 37% in 2017. In 2017, all other drugs ranged below 7% (cocaine being the second most consumed one by 6.8% of the respondents), while they did not exceed 5.8% in 2016 and 2015.

Fig 2.28: Gender differences in the % of individuals reporting substance use in festivals in 2017



Source: Paulos et al., 2018

Similarly, to 2016, 2017 data confirms that males report greater substance use in festive settings than females.



3. PREVENTION

INTRODUCTION

Capacity building, awareness raising and mobilisation of individual resources and promoting protective factors are the main benchmarks as far as national prevention strategies are concerned. Measures may target the general public or selective, specific or risk populations or communities.

The present chapter provides a summary of environmental, universal, selective and indicated prevention measures undertaken at the national level. More detailed information and examples of good practice can be found in the EDDRA / Best practice database of the EMCDDA under: <http://www.emcdda.europa.eu/themes/best-practice/examples>.

The **national drugs action plan 2015-2019** addresses primary prevention as a main intervention area in the fight against drug addiction. Prevention aims at reducing initiation to drugs, delaying the onset of drug use, and at encouraging protective actions and healthy lifestyles in the general population and in groups that are particularly at risk.

The priority areas of drug prevention according to the national action plan and the Interministerial Group on Drugs (GIT³⁹) are as follows:

- Interventions in school and youth environments, peer education.
- Prevention in homes for youngsters and socio-educative facilities;
- Demand reduction (by use of primary prevention strategies focusing on social-cognitions);
- Intervention in recreational and festive venues;
- Cannabis, alcohol, shisha and NPS use in youngsters and polydrug use in general;
- Mass media campaigns;
- Multidisciplinary training programmes and training of multipliers;
- Documentation, monitoring and evaluation strategies.

The national drug strategy and action plan 2015-2019 highlights that prevention programs should be developed and carried out by qualified public health and prevention experts. An agreement on sharing responsibilities between social and health services on the one hand and the police and the justice on the other hand is perceived to be important in order to ensure high standards of quality and efficiency in prevention.

Demand reduction policies focus on the development and implementation of primary prevention measures for the general population, and support structures and reintegration measures for high-risk drug users. In line with the principle adopted in the EU Drugs Strategy 2013-2020, primary prevention is preferred over treatment measures, whereas treatment is preferable to harm reduction measures. National priorities for reducing demand aim in particular:

- to improve the availability, accessibility and scope of effective and diversified measures to reduce demand, promote the use of good practices and exchange them, and develop and apply quality standards for prevention, early detection and intervention, harm and risk reduction, treatment, rehabilitation, social reintegration and healing;

39 GIT : "Groupe Interministeriel Toxicomanies"

- to improve the availability and effectiveness of prevention programs and raise awareness of the risks associated with the use of illicit drugs and other psychoactive substances.

The National Addiction Prevention Centre (Centre de Prevention des Toxicomanies, CePT), which has started its activities in 1995, covers drug addiction as well as the prevention of different types of addictive behaviour. Legally speaking the CePT is a foundation co-financed by the Ministry of Health. Education and training interventions in drug demand reduction are increasingly developed at the national level. A special department named '*Trampoline*' has been set up within the CePT, to ensure the development of training activities and instruments covering national needs. Target groups include children and young people but also professionals from the educative, social, psychological and medical fields as well as parents and other interested stakeholders such as Youth Centers or municipalities. More detailed information is available on the CePT website⁴⁰.

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

The overall coordination of drug prevention, counselling, treatment and low threshold interventions is within the competence of the **Division of Social Medicine, Dependence and Mental Health**⁴¹ and the **National Drug Coordinator's office**. The Division of Social Medicine, Dependence and Mental Health has coordination and financial control missions (supervision of financial contract implementation of subsidised NGOs) in the field of drug addiction and psychiatry. Furthermore, the National Drug Coordinator is responsible for the conceptualisation and the implementation of activities included in **national drugs action plans** (see 1.1).

ENVIRONMENTAL PREVENTION

Alcohol policies

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

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

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

⁴⁰ www.cept.lu

⁴¹ The Division of Social Medicine, Dependence and Mental Health was translated from the original French title "Division de la médecine sociale, des maladies de la dépendance et de la santé mentale".



Since the October 1 2007, the legal blood alcohol concentration is of 0.5 g/l (before 2007: 0.8 g/l). An alcohol level of 0.2 g/l in the blood for new drivers and professional drivers has also been introduced in October 2007. Similarly, in 2007, drink driving offences were set at four penalty points.

From June 1, 2015 onwards, penalties for drug driving offences were tightened⁴², with 6 penalty points (instead of 4) for drink-driving offences, and a fine between 500-10 000 euros, and/or 8 days-3 years of prison.

National Action Plan to Reduce Misuse of Alcohol Consumption

The « Plan d'Action Luxembourgeois de réduction du Mésusage de l'Alcool » is currently under development. Based on the European Action Plan Against the Harmful Use of Alcohol 2012-2020, the Luxembourg Action Plan for the Reduction of Alcohol Misuse will be part of the National Cancer Plan and of the national mental health strategy. It will focus on a reduction of the misuse of alcohol in Luxembourg and associated harm by creating favourable environments enabling the population to adopt healthy behaviours when consuming alcohol at all stages of life, protecting young people in particular, and organising a coordinated therapeutic and rehabilitating treatment of people showing alcohol misuse. The expected outcomes of the action plan are medium- and long-term effects to reducing alcohol-related morbidity and mortality, as well as societal impacts, and to develop a co-responsibility of the public authority and society to prevent the misuse of alcohol. Priority axes include health promotion and prevention, early detection of misuse of alcohol, and organisation of treatment and rehabilitation.

Campaigns and governmental programs to reduce alcohol misuse

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

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

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

A campaign 'Raoul: drink or drive' came out in 2012 with big hoardings along the main transport axis, small posters in cafes, pubs and discos, as well as a cinema spot. In 2014, the 'Raoul' campaign was reissued, while it was communicated through posters in bus shelters, and elsewhere.

The Ministry of Health introduced a new campaign in 2013 entitled '0% of alcohol during pregnancy and breastfeeding'.

42 Official gazette A-N° 92, Loi du 28 mai 2015. Circulation sur toutes les voies publiques. Loi du 22 mai 2015 modifiant: a) la loi modifiée du 14 février 1955 concernant la réglementation de la circulation sur toutes les voies publiques; et b) la loi modifiée du 6 mars 1965 concernant les taxes à percevoir sur les demandes en obtention des documents prescrits pour la mise en circulation et la conduite de véhicules, p. 1556-1557. Entry into force: 01.06.2015

In addition, the promotion of a fake campaign 'Lux Drink Drive' - a drive-in for alcoholic and non-alcoholic beverages was launched in 2014. The slogan 'your cocktails straight to your car'⁴³ was exposed with a picture of cocktails served from a drive-in window. The real purposes of this prevention campaign were revealed soon after the first promotion wave.

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

Luxembourg is also very active within the Pompidou Group of the Council of Europe to promote prevention of drug-related problems in work environments.

In 2017, from May 13 to 21, the first edition of the National Action Week 'Alcohol? Less is better!' took place. This week was organised by the Ministry of Health in collaboration with the Ministry of Sustainable Development, Infrastructure and Road Safety. The CePT contributed to this by carrying out various awareness-raising activities with the general public, particularly during the Health and Safety Day organised by the National Society of Luxembourg Railways (CFL) 'I see, I act', during the workshop entitled 'Von der Gewohnheit zur Abhängigkeit und zurück'. In addition, the information cards 2017 called 'the self-test' and '10 frequently asked questions about alcohol consumption' were addressed in public at this day. Another type of public awareness campaign was carried out at one Municipal Park through the transmission of prevention messages and the distribution of information materials produced as part of the campaign.

In 2017, in order to make the telephone counselling service (Fro No) offered by the CePT better known to the general public, a poster campaign was carried out at national railway stations in the cities of Luxembourg and Ettelbrück from 23 January to 12 February and from 05 June to 25 June 2017. In addition, a display campaign was conducted from 21 to 28 October 2017 in the Luxembourg City buses. Following this display campaign, there was a significant increase in the number of calls.

National activities and studies related to alcohol consumption

On 29 February 2012, the Ministry of Health organised together with the national working group on alcohol a congress with the aim of awareness raising and mobilization of potential partners in the framework of the national action plan on alcohol. This colloquium, with international experts in the field of alcohol policy, prevention projects and therapy, has addressed three main subjects: monitoring, prevention and therapy of medical and social consequences of excessive alcohol consumption.

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

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

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

43 Translated from the original French version "Emportez vos cocktails au volant"



To raise awareness on alcohol abuse at work, another conference was organised in Luxembourg in 2014. The Luxembourgish Chamber of commerce, in partnership with the Chamber of Trade and a supportive institution for enterprises (i.e. 'Guichet Unique PME'), organised a one-day conference entitled 'Alcohol and drugs at work'⁴⁴. This conference addressed policies in alcohol consumption at the workplace, including the preventive roles and responsibilities of employers and employees, and how to add an alcohol-relevant clause in a work contract.

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

Alcohol consumption at the workplace remains an important topic, as show the results from a former study conducted by the national Luxembourgish council on alcohol⁴⁵:

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

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

With regard to the consumption of alcohol (Currie, Zanotti, Morgan, Currie, de Looze, et al., 2012) the HBSC study suggested that 15% of the 15-year-old girls and 26% of the 15-year-old boys indicate that they drink alcohol at least once a week. In total, 17% of the 15-year-old girls declare that they had been at least twice drunken (lifetime), compared to 20% in boys.

In the 2014 HBSC study, students were asked if they had been drinking alcohol in the past 30 days. Of the 11-12 year-old students, 4% reported to have drunk alcohol in the past 30 days, whereas consumption raised to 68% among the age group of 17-18 year-old student. By the age of 16, boys and girls are similarly likely to drink alcohol. In the age group 17-18, male adolescents drank more alcohol than female adolescents (73% vs. 63% in the past 30 days). Older teenagers from wealthy families were more likely to drink alcohol than youngsters from low-income families (74% vs. 63%). In addition, the 15-18 year-old students of the secondary education consume more alcohol than the students of the secondary technical education. Compared to 15-year-old students from other countries, Luxembourgish students are less likely to have been drunk two or more times in their lives (Catunda, van Duin, et al., 2018).

44 Translated from the original title initially expressed in French as 'Alcool et drogues sur le lieu de travail'

45 Schackmann B. (2000). « Alcool et lieu de travail » *Guide pour responsables d'entreprise, cadres supérieurs, gestionnaires de ressources humaines, membres des comités d'entreprise et délégations du personnel (CNLA)*. Luxembourg: Ministère de la Santé, Direction de la Santé, Division de la Médecine préventive et sociale / Centre de prévention des toxicomanies (CePT).

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

Tobacco policies

The main objective of public health policies consists in the protection of the health of the citizens. The law of the 11th August 2006 specifies the following (Service central de législation, 2006):

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

The law of 11th August 2006 (Service central de législation, 2006) regarding the security and the health of the employees emphasizes that the employer has to take all possible measures to ensure and improve the protection of the physical and mental health of the workers. This includes appropriate measures to protect the employees effectively against the smoke resulting from tobacco consumption of others. The law encourages the employer to protect non-smokers from passive smoking at the work place. There are no mandatory instructions. In practice, the aim is to have working places without smoke, but not without smokers.

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

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

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

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

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



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

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

Seven strategies on three levels are included in this national tobacco plan:

Structural level

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

Behavioural level

- Prevention of tobacco consumption
- Assistance to stop smoking

General level

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

The Council of Government in its session of 16 December 2015 gave its principle agreement to an preliminary project of law transposing the Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC of the European Parliament; and modifying the modified law of 11 August 2006 regarding the anti-tobacco fight.

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

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

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

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

National Action Plan against Tobacco Use

The National Action Plan Against Tobacco Use that was developed in 2009 has been updated in 2016 ('Plan national de lutte contre le tabagisme 2016-2020'). The national action plan aims to prevent and reduce smoking and its morbidity and mortality by following three main objectives:

- Prevent tobacco consumption (to reduce the prevalence in young girls and boys, to delay the age of the first consumption and to stop the progression of tobacco consumption);
- Reduce tobacco use among current users (to promote objective information on the product, to pursue a change of behaviour in the long term and to stimulate detoxification treatment);
- Protect non-smokers from passive smoking (to protect the health and rights of non-smokers).

The global objective of the action plan is to protect youth, prevent smoking, and enhance smoking cessation by evidence-based interventions. Specific objectives are: a) sensitizing and motivating young people as well as the general population not to start smoking; b) reducing youth demand; c) "denormalizing" the image of the smoker; d) making tobacco products less attractive; e) providing a regulated approach for electronic vaping devices; and f) improving national policies regarding pricing and taxes on tobacco products.

Campaigns and governmental programs to reduce tobacco consumption

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

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

In 2015, a new anti-tobacco campaign launched by the Ministry of Health consisted of a contest on Facebook to conclude the phrase 'Everyone wins...' by indicating the gain to be won in case one quits smoking.

National studies and activities related to smoking

In the HBSC survey conducted in 2010 (Currie et al., 2012), 26% of the 15-year-old girls declared that they already smoked at the age of 13 (or younger), against 29% in boys. In total, 19% of the 15-year-old girls reported that they smoke at least once a week, versus 22% for boys.

The HBSC study 2014 revealed that among the 11-12-year-old students, 2% are smokers based upon self-assessment, whereas this proportion rises to just over one-third in the age group of 17-18 year-old students. By the age of 14, the proportion of regular smokers (i.e., they smoke at least once a week) is about the same for boys and girls. In the age group 17-18, 32% of male adolescents smoke regularly but only 23% of female adolescents. In the 'Enseignement Secondaire Technique', the proportion of regular smokers in all age groups is about twice as high as in the 'Enseignement Secondaire'. Half of the smokers started smoking at the age of 14, so early warning about the dangers of smoking should be provided (Kern, Heinz et al., 2018).



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

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

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

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

'The Insider' magazine (Cancer Foundation) further focusses on prevention of smoking behaviour, as well as by-product attributes that young people associate with smoking (i.e. 'smoking is cool'). This magazine is usually available at schools, medical doctor's offices and recreational areas.

UNIVERSAL PREVENTION

School

Addiction prevention programmes in schools are not mandatory. National drug prevention activities integrated within national school programmes have mainly resulted from **corporate actions** of different governmental and non-governmental actors: Ministry of Family and Integration – National Youth Service (SNJ), Ministry of Health - Division of Social and Preventive Medicine, Ministry of National Education – Service of Coordination of Research and of Pedagogical and Technical Innovations (SCRIPT)/Psychological Care and Educational Orientation Department (CPOS) and since 1995, CePT.

The **CPOS** is permanently represented in all secondary schools by at least one trained psychologist and several ad hoc teachers. In major schools, there are supplementary trained social workers. Among other tasks, they are supposed to detect, at the very early stage, problems or behaviours in relation to substance abuse. Drug and addiction topics are included in more general courses as for instance, hygiene or ethics, which might not be mandatory. Furthermore, the Grand-Ducal Police organises school courses for the 6th classes of primary school and 7th classes of secondary schools provided by specialized police teams out of regional police units and from the drug department of the Judicial Police.

CePTs' primary target group for addiction prevention measures in school settings are school staff: directorates, teaching staff, and psycho-socio-educational staff. This comprehensive group of actors is seen as an essential multiplier who can implement concrete measures in everyday school life with the final target group (students). Student-level offers for the CePT focus on project-related actions and actions (for example, prevention day, health weeks, thematic focus cycle, etc.). The CePT focuses on continuous, conceptual work (vs. punctual actions). Likewise, lectures on the subject of addiction prevention for parents are offered in the sense of involving all school partners. In addition to seminars, workshops and lectures, CePT offers project consulting and support for the school staff. In 2017, many schools made use of CePTs' offers, and ordered materials and consultations, for example to implement addiction prevention projects or used certain methods as well as didactic materials. On various school project days, the CePT participated in 2017 to present their work to students.

In 2000, the CePT started a pilot project called: 'D'Schoul op der Sich' (**School on quest**) in collaboration with the SCRIPT running for two years, which was evaluated in 2003. The aim of this participative project consisted in creating so-called prevention groups among all participating secondary schools in order to initiate a process of reflection on drug-related topics. Long-term concepts and concrete activities are being implemented on an ongoing basis (examples: prevention weeks, activities to improve well-being at school and improving the school climate). In 2017-2018, some secondary schools continued using the pilot project 'D'Schoul op der Sich'.

A further development stage has been reached in 2009 by the launch of the **CePToolbox**. This 'box' includes the necessary tools to understand and promote life competences of children and teenagers from 3 to 15 years and accompany them on their way to autonomy. The tools are designed for three age categories: 3-6, 7-11 and 12-15 years. The referred instruments are primarily meant to serve educators, pedagogues, psychologists and teachers to assist them in their professional activities. The CePT also offers trainings on how to use these tools. The CePT toolbox can be downloaded at <http://cept.lu/fr/trampoline/formations/materiel-didactique> (see also section family).

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



In 2016, the CePT took part in various school project days with workshops and performances for students in the context of a day of prevention at the Sportlycée 'Journée prévention' or special topic days: at the Lycée Classique d'Echternach 'COOLTOUR@LCE' or at the Lycée Technique pour Professions de Santé 'Health Virus Day'.

Coordinated by the Ministry of National Education-SCRIPT, a mobile interactive and prevention instrument called the 'Extra-Tour Sucht Lëtzebuerg' aiming to reach students aged 15 to 18 years in secondary school settings was further developed and adapted for instance to new trends such as shisha smoking. It was specifically designed for the Luxembourgish school settings by the German company *KomPass*. Interactive intervention modules are applied alternatively and allow the participation of 60 pupils. Currently the following thematic sessions are proposed:

- Tobacco – Lust for life;
- Dependence and pleasure;
- Life skills – Fit for life;
- Norms – New world;
- Alcohol – To win and to loose.

The current version of the 'Extra-Tour Sucht Lëtzebuerg' was initiated in 2009 by KomPass and a workgroup (SCRIPT, Ministry of Health, Ligue Médico-sociale, CePT). 'Extra-Tour Sucht Lëtzebuerg' was evaluated in 2012. In total, 107 questionnaires, mainly completed by class teachers and personal from the psychology and orientation department in different schools (SPOS⁴⁶), were analysed (return rate: 81%). The main results are described in the following summary:

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

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

Jointly with the STSJ, the CePT developed a brochure on cannabis especially designed for teachers and other professionals of the educational sector: **'School and cannabis – Recommendations for School staff'**. The Ministry of National Education-SCRIPT published the second edition 'The cannabis consumption

46 SPOS is an abbreviation for "Service de psychologie et de l'orientation scolaire", and refers to the psychology and orientation department in schools

among young people – a challenge for school staff' in October 2012. It includes epidemiological data, recommendations on early recognition, prevention and intervention means and information on existing networks⁴⁷.

A further component of the CePT's work is the promotion and implementation of addiction prevention projects in cooperation with schools and youth clubs. The project 'Still Allc%ol' ('**Nach ëmmer Allc%ol**') was developed jointly by the CePT, the National Theatre of Luxembourg (TNL) and SCRIPT for the secondary schools. The outcome was a theatre play, addressing prevention of alcoholism presented in secondary schools from January to March 2009 reaching approximately an audience of 1,300 persons. After the first edition in 2009, a new edition of the project 'Nach emmer Allc%ol' took place in November 2011. A DVD was produced by the Ministry of National Education in 2012, which is part of didactic material for alcohol prevention in school elaborated by the CePT as an educational workbook to be published by the SCRIPT.

The CePT elaborated an additional module in 2011, for the professionals acting in non-formal youth work and dealing with children and adolescents. The aim of this training was the communication with youngsters regarding psychoactive substances. The methods that professionals learned throughout the training are implemented in the CePT project "Act R.I.C.O." and in the "REBOUND" project as well.

The CePT acts within the scope of different basic trainings. Most of these modules are in the meantime well-established in the appropriate education structure for several years.

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

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

Also in 2015, a basic training in all day-school 'Sprongkraaft am Alldag' focused on fundamental principles in addiction prevention in young children in all day-school. Age specific needs and resources have been analysed with regard to prevention in school setting.

In the context of honorary office, a training course was conducted for youth leaders of the Luxembourgish Young Firefighters Association in the framework of their leadership trainings. Finally, trained police staff periodically visits various schools of the country, to inform students on drugs and their risks. These prevention officers meet yearly around 6,000 students. Moreover, the Luxembourgish Police has dedicated two sections on drug abuse prevention on their website, one for adults and parents, and one for adolescents and young people (Police Grand-Ducale, 2015).

In 2017, the CePT offered introductory courses on prevention of addictions at the Luxembourgish Police academy and at the University of Luxembourg.

47 http://cept.lu/?attachment_id=1343



Projects in School Settings in 2017

1. **Power-voll:** a prevention project implemented in primary schools

The project relies on the idea that addiction prevention should occur early in a child's life. Parents and family members support their children from the beginning so that addiction prevention aspects already play a major role in the everyday educational life. Elements include the attachment of parents to their children, their own role model function, communicating rules and limits, and increasing the resilience of the children. The school pursues, in addition to the teaching of knowledge, a similar mission as the parents by ensuring safe bonding and safe relationships, proper communicating rules, and teaching skills of resilience and making each child feeling accepted and valued. The project aims to strengthen and activate the resources of children. Children are given the opportunity to talk about their preferences; motives of consumption are inquired and possible behavioural alternatives are discussed for certain situations.

In the 4th year of elementary school, topics such as dealing with advertising, product placement and dealing with over-the-counter medications are presented to children. Simple models of addiction are discussed and moreover, substances such as alcohol and nicotine are discussed for the first time. 'Powerful' is about making children aware of and promoting their own strengths. This involves finding as many individual sources of well-being as possible through a healthy resource activation. 'Powerful' is an instrument that gives primary school teachers the opportunity to make children aware about their consumption patterns and to promote a reflective, balanced and responsible use of substances.

2. **Tom & Lisa:** a prevention workshop on alcohol for school classes (13-15 year old students)

This workshop has formerly been implemented on a large scale in Germany and revealed to be effective. In the context of universal prevention on the subject of alcohol, the prevention workshop 'Tom & Lisa' is introduced in Luxembourgish schools as a continuous preventive intervention. In preparation for this, the workshop should be organised independently by the schools. The program is suitable for grades 7 to 9. The moderators for the workshop 'Tom & Lisa' are trained and supported by the CePT, which guides the implementation in schools. The workshop is actually an interactive simulation in the preparation and simulation of the birthday party of Tom and Lisa. Tom and Lisa invite the class to plan and celebrate the party together. The students work in teams to prepare the party and celebrate the party the associated risks. The workshop consists of two modules, and in between students are asked to do an interview at home with their parents. The interview is neither evaluated nor graded. However, it serves to the family to exchange with regard to promoting attitudes, rules and risks of alcohol consumption. With regard to the implementation in Luxembourg, in 2017 a member of the CePT was certified as an Instructional Trainer for "Tom & Lisa". The program was adapted for implementation in Luxembourgish schools and pretested in some school classes.

3. **REBOUND:** Youth- and social work - A program for teenagers

Since 2016, a partnership has been set up between CePT, the FINDER Academy for Prevention and Experience-based Learning (Berlin) and MUDRA - Alternative Jugend- und Drogenhilfe e.V. (Nürnberg) to adapt the REBOUND curriculum, initially developed for school settings to promote social work with young people. It is a flexible and structured life skills addiction prevention program aimed at young people (14-25 years old). The project aims are to motivate young people to take an active part in discussions and become aware of risks. On the other hand, it is about encouraging teenagers to discover what it means to take a responsible approach towards alcohol and other drugs. In 2017, three working meetings and one pilot-seminar were held with the program partners to adapt the methods to the different settings and to prepare training courses for professional multipliers (pedagogues, psychologists, social workers, etc.) working in youth structures.

Projects in other settings

1. **Localize It!**: (Ref. 738055-Localize It!) Communal strategies to reduce alcohol consumption in adolescents and young adults (12-25 years)

The aim of this European project is to reduce excessive episodes of alcohol consumption. The kick-off meeting of the project was held in Luxembourg in May 2017. The project 'Localize It!' provides support for the development and implementation of strategies to reduce alcohol consumption at municipal level knowing the local social and cultural context. Thus, two municipalities were selected by the CePT, Mondorf-les-Bains and Dudelange. In 2017, the CePT conducted Rapid Assessment and Response (RAR) interviews with more than 40 local actors (20 interviews per municipality). The interviews provided an overview of individual local situations and allowed to raise awareness of the problem among the actors involved and to prepare local action plans (2018-2019).

2. **Click for Support - REALized**: (Ref. HOME/2015/JDRU/AG/DRUG/8857)

This European project is a continuation of the project 'Click for Support' (2014-2015) defining guidelines for the selective prevention of addictions that served as a basis for the 'Click for Support – REALized' project. The project (2017-2018) aims to develop web-based interventions and an App ("Mind Your Trip") that target young consumers (14-25 years) of new psychoactive substances. Following the kick-off meeting of the project in Belgium in February 2017, a first workshop brought together the project partners in Riga (Latvia) as well as external experts from Germany, Belgium, the Netherlands and representatives from the EMCDDA. The workshop focused on the phenomenon of NPS in Europe through the target group of young NPS users. The project partners have established national focus groups and an online questionnaire to collect information among the target groups.

CePT is member of the *Euro net*. *Euro net* is a European addiction prevention network which, by working on specific projects (e.g. 'Click for Support', 'Click for Support – REALized', 'Localize It!'), aims to develop European cooperation in addiction prevention. Within the framework of the network, knowledge and experience are being exchanged between locally, nationally and regionally active institutions and organisations. Through its projects, *Euro net* is particularly developing the use of peer education in addiction prevention. The projects are developed jointly and then implemented locally.

Trainings proposed in 2017

In 2017, the CePT provided various initial trainings. Most of these modules have been offered for several years. The initial training is an important pillar in the addiction prevention work of the CePT. The CePT offered four courses in the Luxembourg Police College in 2017. The goal of these courses are to get familiar with the offers of the CePT to be able to make use of them and to provide a differentiated insight into the topic of addiction prevention. Moreover, the CePT leads one elective course module 'Addiction prevention and social work' within the Bachelor's degree of Social Sciences and Education (BSSE) at the University Luxembourg.

Below are listed the trainings provided in 2017. We refer to the CePT's website for further information.

Small Drugs ABC - Questions and Answers (*Kleines Drogen ABC – Fragen und Antworten*)

Is the possession of small quantities of cannabis allowed in Luxembourg? May young people above the age of 16 drink high percentage alcohol? Is cocaine just a drug for fancy people? Is coffee also a drug? These and similar questions about drugs e.g. which psychoactive substances are highly prevalent in Luxembourg or what is meant by the term 'Legal Highs' were pursued in this seminar. The goal providing basic knowledge about drugs (and their consumption), and their (side-)effects among adolescents.



Motivational interviewing in consuming adolescents (*Motivierende Gesprächsführung bei konsumierenden Jugendlichen*)

During the training methods and strategies were presented in order to learn how to talk with young people about their use of legal or illegal drugs. In terms of content, the program focused on the concept of 'motivational interviewing'. The goal was to help the participants implementing targeted short interventions taking advantage of their educational "daily contacts" in order to promote a change in behaviour of young people. The training targeted school staff from secondary education schools. The training has been implemented in 2016 whereas in 2017, an evaluation of the training was done.

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

This training, also implemented in 2016, aimed at explaining cannabis consumption to adolescents and more specifically how to discuss it with young people. The emphasis was put on encouraging young people towards critical thinking on cannabis. This training was designed by the CePT and the SCRIPT for professionals at schools.

Cannabis Case 2.0 - Methods for Preventive Practice (*Cannabiskoffer 2.0 – Methoden für die präventive Praxis*)

This training focused on methods and exercises of the Cannabis Case 2.0. in order to discuss with youth the taboo and often trivialized topic of cannabis, hence how to involve this topic into a conversation. The Cannabis Case 2.0 is a further development of the interactive course 'Cannabis – Quo Vadis' (method case that can be borrowed from the CePT since 2012). It is conceived in a way that different methods can be put together as a 'kit'. The exercises are very flexible in their use and interactively structured.

Fit 4 Life – Addiction prevention differently (*Suchtprävention einmal anders*)

In addition to knowledge transfer, school-based addiction prevention focuses on life-skills methods. Meaningful addiction prevention in everyday school life, in addition to age-appropriate information on substances, draws on aspects of health promotion. The aim of this training was, for example, to learn concrete ways on how to implement search-preventive concepts and activities (exercises, methods, projects) in everyday school life.

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

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

Wednesday's seminars (*Séminaires du mercredi*) organised by the CePT

Now and then on the first Wednesday of the month, the CePT invites national and international experts to share their area of expertise with colleagues working in related sectors on a variety of topics in the context of addiction prevention. The topics are, in some way, connected to drugs and dependencies, as well as to health promotion. An external or internal expert conducts the seminars. Depending on the main topic, target groups are specialists from the social, psychological, psychological, medical or addiction-specific area.

In 2017, three Wednesday seminars took place.

- The first seminar consisted of 2 parts: First, Mrs. Angelika Kraus, graduate sociologist from the city of Saarbrücken, gave a presentation on "Recreational use of psychoactive substances among people above the age of 60". In this context, the following questions arose: Whether consumption habits of earlier life stages in old age are maintained or new ones are acquired? Which factors contribute especially to health risks if there is substance consumption in older age? Is there something like a conscious use of recreational drugs in older age? Which risk factors, risk behaviour patterns and risk groups are identifiable? A qualitative study in the framework of the Interreg IV-a project MAG-Net 2 tried to answer these questions. The results of this study were explained in this seminar. A second part of this seminar dealt with the problem of aging drug users. Subtitle: A social challenge! (Speakers: Employees of the JDH Fondation).
- Another seminar was dedicated to the "use of illegal drugs in pregnancy and breastfeeding", (Speaker: Prof. Dr. habil. Birgit Reime, Professor of Health Promotion, Furtwangen University, Germany). Prof. Reime discussed aspects such as the neonatal withdrawal syndrome, and the rooming-in project among addicted young mothers in Vancouver, Canada.
- The last seminar (Speaker: Thierry Lottin, psychologue clinicien, Direction du département de psychologie et personne ressource en alcoologie au CHS clinique psychiatrique Notre Dame des Angès à Liège, Belgium) dealt with the difference between recreational and festive alcoholic drinking and alcoholism.

Family

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

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

The CePT has developed a 'prevention box', targeting 3 to 6 years old children and including didactic material designed for potential multipliers as for instance teachers, parents and youth animators. In the past years, seminars on the 'prevention box' took place in different communities participating in the project of addiction prevention in local communities. Moreover, the CePT collaborates with the Kannerschlass Foundation, in the framework of the project 'Parents' School'. Due to its success, the CePT extended the 'prevention box' and published the CePTtoolbox in 2009, targeting three age categories: 3-6, 7-11 and 12-15 years.

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

A pilot projet called 'Power-voll' aimed for primary schools has been launched in 2017. The parents of school children received an information letter about this addiction prevention project and got involved in the evaluation of the initial phase of the project. The CePTtoolbox is used as a best practice toolkit in this framework.



Since 2013, the Ministry of Health has been promoting its campaign on alcohol consumption in pregnant women and young parents, named '0% of alcohol during pregnancy and breastfeeding'. The implementation took place in form of an information brochure in German and French, and was promoted through doctor's offices, pharmacies, health centers, and social institutions (Ministère de la Santé, 2013).

Since 2014, the Luxembourgish Police has shown increased initiatives in terms of drug prevention. Their information is mainly available for parents who would like to learn more about drugs, on the indicators and symptoms of drug use and abuse, the health consequences, the risks and crimes associated with drugs, and the relevant laws and policies (Police Grand-Ducale, 2015).

'To talk about drugs' is in parent information meeting where parents learn how they can keep the communication going with youngsters on the topics of alcohol, tobacco and cannabis. Besides parents, target groups also school directors and school staff. Information meetings are organised by the CePT on request.

Community

As most of drug-related interventions and strategies prevention in community settings are organised centrally and nationwide, projects are rarely initiated by the local community level without close collaboration of national authorities.

An earlier study by the Statec⁴⁸ on the overall perception of the presence of drugs in Luxembourg revealed that 35% of the general population have been directly or indirectly involved with drugs or drug resellers. In particular, 10% of residents are "frequently" in touch with drugs, or drug resellers, whereas 12% "occasionally", and 13% "quite rarely" (Statec, 2014). Nevertheless, local and regional communities do rarely dispose of a comprehensive addiction prevention strategy. Commonly, a given national agency initiates projects, defines the general intervention framework and seeks active collaboration with community authorities in order to meet local needs. At present, only one agency focuses on interventions in recreational settings, namely the CePT (community project⁴⁹).

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

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

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

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

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

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

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

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

Community-specific work: Youthwork

The CePT 'out of school' youth work was primary related to a conceptual approach to addiction prevention and intended to design guidelines for youth workers. In 2016, the CePT went beyond the conceptual work by fostering partnership with several Youth Centres. The project called "Act R.I.C.O" which stands for Reflected - Informed – Competent - Oriented aims to establish a positive festive and party culture with and among young people by developing a responsible attitude towards the use of alcohol and other drugs. In 2017, the CePT strengthened its partnership with eight Youth Centers of municipalities of the Region Moselle East in the context of the so-called 'Act R.I.C.O.' project. Additionally, a draft intervention guide 'Zum Umgang mit dem Thema Drogen- ein Handlungsleitfaden' has been developed together with Youth Centres to help professionals of youth structures to address the problem of drugs in their interventions with them. In this context, the CePT organised a series of discussion groups with young people on different substances (alcohol, tobacco, cannabis, NPS). Youth Center professionals have been offered the opportunity to attend CePT training courses, including motivational interviewing, basic knowledge of legal and illegal drugs, and the 'Cannabiskoffer 2.0'. Moreover, a youth peer education toolkit ('Charta für Drogenprävention bei Jugendlichen') was elaborated with the Red Cross Youth Centres to tackle drug issues with youngsters. In particular, the framework was enlarged to 8 Youth centres of the Moselle Region.



SELECTIVE PREVENTION IN AT-RISK GROUPS AND SETTINGS

At-risk groups

The Doctors without borders – Youth Solidarity (Solidarité Jeunes a.s.b.l.) was established in 2012 and focuses particularly on adolescents. The Service was renamed into "IMPULS - Aide aux jeunes consommateurs de drogues (Solidarité Jeunes a.s.b.l.)" in 2014. For more information, visit the official website (www.im-puls.lu).

In 2006, the Impuls service launched a new project called **CHOICE** in collaboration with the Ministry of Health, the Public Prosecutor's Department of Youth Protection and the Judicial Police- Drugs Unit, which is based upon a pilot project of 'early intervention of first drug offenders' (FreD) initiated by the Federal Ministry of Health and social security of Germany. The target group consists of youngsters aged 12 to 17 who entered in conflict with drug law. The overall aim of CHOICE is to offer youngsters an early and short-term intervention in order to prevent further development of drug abuse and drug addiction. An 'in-take' interview allows assessing whether a participation in the CHOICE project or an individual psychological follow up is indicated. A CHOICE group consists of four interactive sessions (6 to 8 participants) which provide information on drugs, legislation and treatment services, promote auto-reflexion, reinforcement of personnel skills and motivation to change attitudes towards drugs. In a first phase, the project is regionally limited to the judicial district of Luxembourg City. Police officers hand out CHOICE flyers to youngsters in breach with drug law including all information on the intervention and inform the Public Prosecutor's department of Youth Protection. The youngsters and eventually their parents contact the CHOICE team within two weeks and the latter inform the Public Prosecutor on the participation level. A certificate testifies the participation.

In 2014, the Impuls service enlarged the CHOICE to CHOICE18+ in order to be able to offer help and to youngsters between the ages of 18 to 21 years. The CHOICE 18+ program offers pre-suppression assistance and allows young participants aged 18 to 21 to avoid legal consequences, including registration in their criminal record or almoned. The Program conducts, in a targeted manner, three modules of awareness, training and self-reflection in groups and three individual sessions for young adults. Participation in the CHOICE 18+ program, or the development of a positive progress report by the therapist, after the care of the young adult, generally have extenuating circumstances with the prosecution and the court. It should be noted that similar programs do not exist at European level in the context of the decriminalization of first-time cannabis users.

In 2012, « Youth Solidarity » elaborated the intervention programme called "ProST – Programme for self-responsible drinking", a programme similar to the CHOICE programme, but specifically designed for alcohol misuse. The aim of the program is to increase the public's awareness of alcohol consumption among minors and offer systematic help to young at-risk, non-addicted people who have made themselves conspicuous by excessive alcohol consumption. This program originates from the 'Bundesmodellprojekt HaLT' of Villa Schöpfli (http://www.halt-projekt.de/), a project which aims at promoting at the municipal level the respect of the laws of the Protection of the Youth concerning the Sale of alcohol to minors during parties, in bars and shops. Moreover, the project offers support for young people who have been noticed by alcohol intoxication. The Impuls Service adapted this program to the Luxembourg context. Our service solicits partners such as high schools, courts and hospitals to establish close collaboration. This is to establish a network of exchange between the various services, to allow care and ongoing monitoring of these adolescents who have experienced alcohol intoxication.

In 2017, the Impuls service launched a new program called 'OPTION'. The 'OPTION' program is a specific therapeutic program that proposes adapted support measures for young drug users from the age of 18 and for whom non-reclusion remains possible. The originality of the program comes from the close collaboration

between the Impuls service and 'Comunità Emmanuel' of Lecce (Italy), which makes it possible to diversify the treatment by including the stationary therapies abroad. Future collaborations with other institutions abroad are also envisaged as part of the program development. The program targets young adults from the age of 18 with a police file of instruction, directed by the Parquet. Once the program is started, the IMPULS Service keeps the prosecutor informed of the evolution of the young person in full transparency for monitoring purposes. However, the young person can also apply for help/treatment on a voluntary basis. The IMPULS Service checks whether the young applicant does not have an open file with the Public Prosecutor's Office before implementing procedures for a stationary therapy abroad. In addition to providing help for young drug users, the Impuls service also recommends to include the family and/or parents in the therapeutic program.

In order to facilitate access to the offers from the Impuls service to young people, as to their parents, living in the north of the country, in 2017 the Impuls service opened a new office in the a city in north of the country (Ettelbrück).

In 2009, HIV Berodung Croix-Rouge, in collaboration with the Ministry of Health and the CHL, launched a project called '*DIMPS*' (Intervention mobile for the promotion of sexual health) in the framework of the national action plan on HIV and Aids 2006-2010. *DIMPS* is meant to inform on risk behaviour and provide free and rapid infectious disease testing in difficult-to-access populations. Among other interventions, rapid tests for HIV and HCV and HBV are proposed. Currently the *DIMPS* van visits low threshold drug agencies, gay meeting places, red light spots and asylum seekers facilities. Their services are free of charge⁵⁰, and can be booked on their website (www.dimps.lu).

In 2017, following the initiative of the ministry of health, the HIV Berodung service contributed to set up a project called 'Xchange/MOPUD' aimed at reducing new infections and screening new HIV and hepatitis C infections among drug users. The 'Xchange/MOPUD' is a joint project of the HIV Berodung service of the Red Cross, the JDH and the Abridado of the CNDS. The 'Xchange/MOPUD' van offers a needle exchange, as well as a possibility of HIV and hepatitis C screening on the car park in front of the main train station. The team consists of staff from the three associations and is present twice a week from 17h to 21h.

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

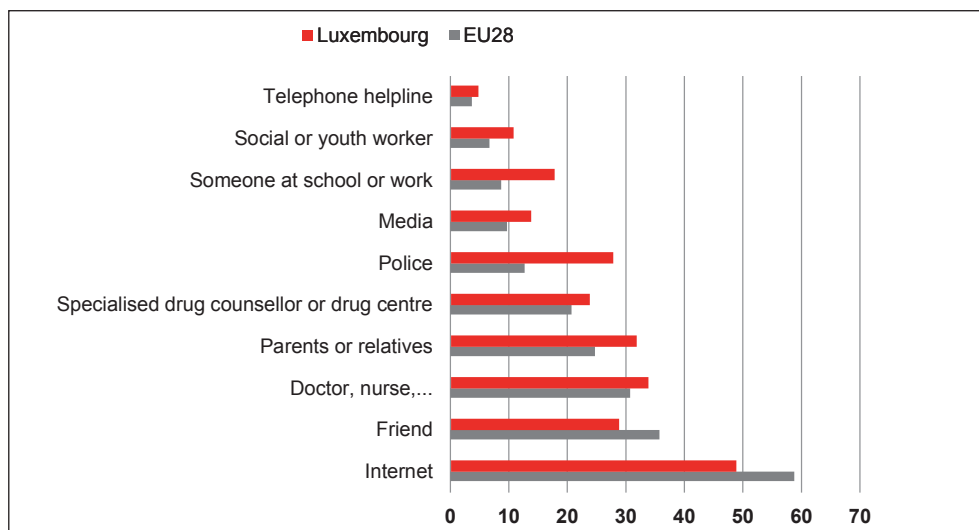
° Information on illicit drugs and drug use - Potential sources of information

Results from the previous 2008 and 2011 Flash Eurobarometer studies showed that **the internet** was the most popular source of information, with 59% (EU) (LU: 49%) of 15-24 year-olds, who said they would use the Internet when looking for general information about illicit drugs and drug use. The second preferred source were **friends** (EU: 36%; LU: 29%) and on third position, **a doctor, nurse or another health professional** (EU: 31%; LU: 34%). In the Luxembourgish sample, the internet was as well the first choice for information source on drugs, followed by doctor, nurse or other health professional in the second place and parents or relatives in the third place (32%).

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



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



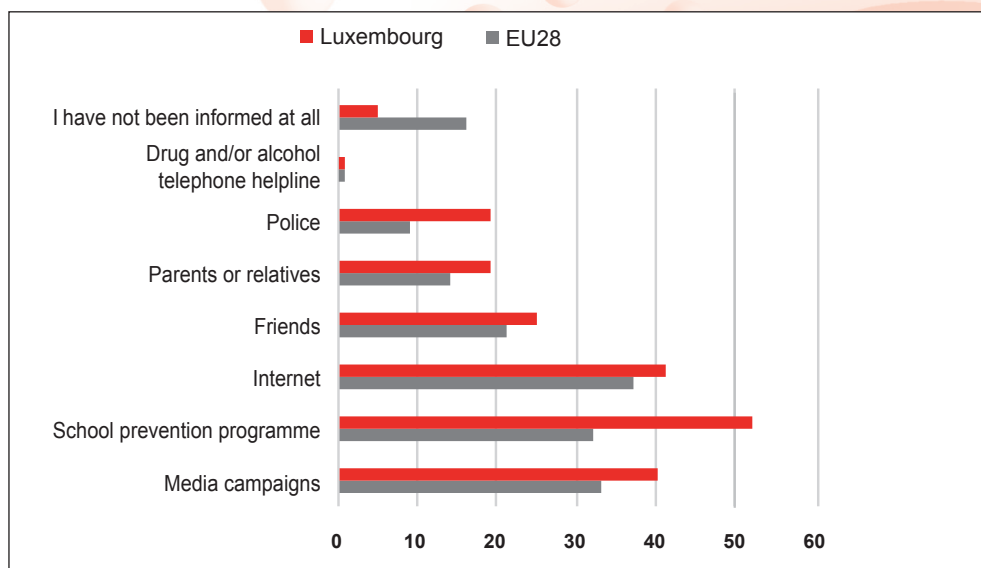
Source: Flash Eurobarometer 401, 2008 and 2011

° Information channels reaching youngsters in the past year

When asked through which information channels young people had been informed on the effects and risks of illicit drug use during the past year, 37% of respondents referred to **the internet** (LU: 41%), compared to 33% who reported **media campaigns** (LU: 40%) and 32% who mentioned **school prevention programmes** (LU: 52%). Twenty-one percent said they had discussed these issues with **friends** (LU: 25%) in the past year, and almost a sixth (14%) of respondents had been informed by their **parents or other relatives** (LU: 19%). A minority of respondents said they have been informed on effects and risks of drug use by **police** (EU: 9%; LU: 19%) or via **drug and/or alcohol helpline** (EU: 1%; LU: 1%). Finally, 16% of respondents reported **not to have been informed at all** (LU: 5%) about the effects and risks of illicit drug use in the 12 months prior to the survey.

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

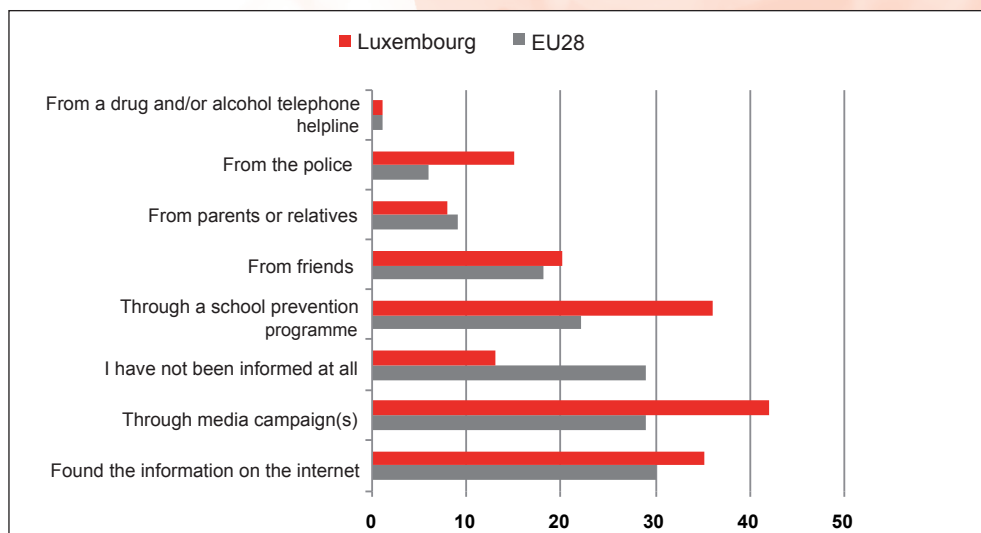
Fig. 3.2: Information channels used in the past year to be informed about the effects and risks of illicit drugs



Source: Flash Eurobarometer 401, 2008 and 2011

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

Fig. 3.3: Information sources about new substances



Source: Flash Eurobarometer 401, 2014



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

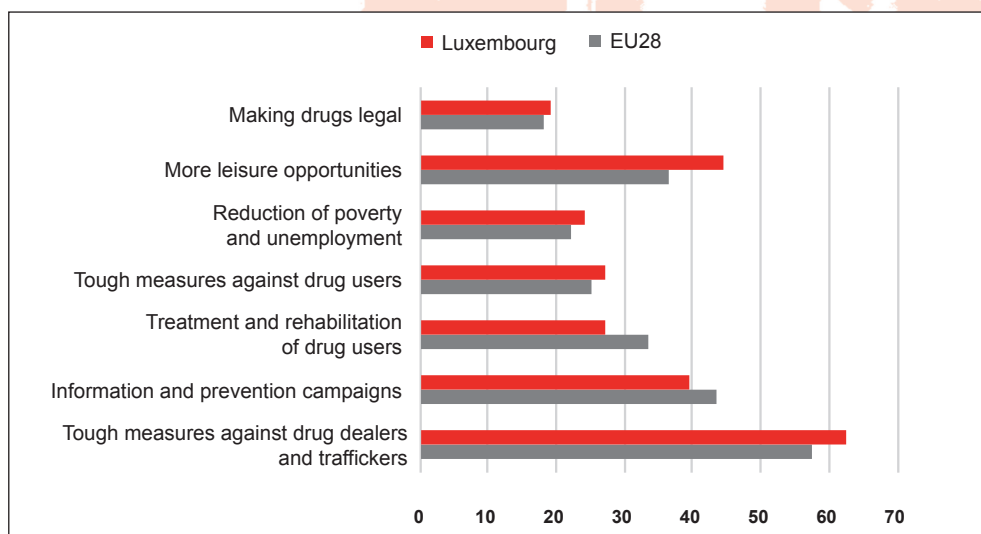
° How should drug problems be tackled?

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

As far as drug demand reduction is concerned, young people thought that other measures, such as prevention or treatment and rehabilitation of drug users, would be more effective than repressive measures. In total, 43% of respondents referred to **information and prevention campaigns** (LU: 39%) as one of the most effective ways of reducing drug problems; the **leisure opportunities** followed, with 36% (LU: 44%) of respondents choosing this as an effective measure and **treatment and rehabilitation** with 33% (LU: 27%). By comparison, **tough measures against drug users** were considered to be a valuable way of dealing with drug problems by a quarter of respondents (EU: 25% LU: 27%).

Reducing one of the possible primary causes of drug abuse – i.e. **poverty and unemployment** – was mentioned by 22% (LU: 24%) of interviewees. As in 2011, **legalisation of drugs** was thought to be the least effective way of fighting drug problems: 18% (LU: 19%) of young people, however, put forward this measure as one of the most effective ones.

Fig. 3.4: How should society's drug problems be tackled?



Source: Flash Eurobarometer 401, 2008 and 2011

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

At-risk families and aging drug-users

Since 2003, the JDH is running a parental project with the aim to provide psychosocial aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative capacities. This long-term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. An essential part of the project is outreach work. Meetings and interviews are held within the natural environment of the family (at home).

Moreover the CePT, in collaboration with JDH organised training courses for drug-dependant mothers in 2011 in order to build up their capacities as parent and improve mother-child relationship (Project: **O Mamm O Kanner**, which was renamed '**1,2,3, lass!**' '1,2,3, go!' in 2009). In 2012, the CePT finalised the train-the-trainer handbook for the parental project of JDH describing the topics and the methods of the courses. In 2013, preparation work for new sessions of the training courses took place in order to adapt the contents to the needs of this target group. In 2015, the CePT delivered a course for mothers in OST with children aged 0 to 6 years consisting of 7 modules focussing on the strengthening of self-esteem and dealing with the maternal role.

In June 2015, the JDH organised a conference on addictions among aging drug users in Luxembourg in the context of the European project "BERTRAD: Care for ageing people who use drugs". This conference focused on aging drug users. Another conference on the same topic was organised in 2018. The conclusions recommended the creation of specialised structures for aging drug users in the future. More information on the BERTRAD project can be found under the following link: <http://drogues.gencat.cat/en/details/Noticia/betrad-00002>.

Recreational settings

Youngster do spend an important share of their time in leisure, recreational or social activities and numerous programmes in recreational settings take place at the community level, church and youth organisations or sport-oriented clubs. The latter are not necessarily drug specific and as such difficult to list exhaustively.

Since its creation in 1995, the CePT has initiated projects in the field of active leisure organisation: art performances, theatre, and media supports (films, cartoons, etc.), seminars, ambulatory exhibitions, travel experiences, outdoor- and adventure education approach, etc. The CePT increasingly ensures the national coordination of such activities integrating the addiction prevention topic as one of the various components of **Health education**. The latter approach is believed to have more impact on youngsters (users and non-users) than a drug-centred approach. Indeed, human interactions in daily life situations as for instance adventure or sports activities are most adequate as a conceptual framework for the progressive integration of drug-related prevention initiatives.

In this respect, the demand reduction activities organised by the 'Mondorf Group' (joint initiatives of border regions of France, Germany, Belgium and Luxembourg) jointly with the CePT and SNJ combine a **non-drug-centred approach** with **intercultural components** in organising corporate leisure activities for youngsters from border countries based on the concept of '**adventure pedagogy**'. The annual '**adventure weeks**' do fit in a broader programme named 'Adventure pedagogy and primary addiction prevention'. With



prevention concepts of adventure and nature pedagogy or cultural approaches such as theatre pedagogy and music or art education, the activities primarily aim to provide the opportunity to youngsters to experience group dynamics, conflict management, limit and risk assessment as well as the feeling of solidarity within a group of socially and culturally different people. The programme further aims at the reduction of risk factors and the enhancement of protection factors, by focussing on youngsters and their environment, rather than on drugs and addiction. Regional teams specialised in drug prevention meet in autonomous working and training groups and report activities to the Mondorf Group.

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

Since May 2008, the CePT is an active member of several projects on the topic of health promotion and harm reduction in nightlife settings, as 'Democracy, Cities and Drugs II', the 'Club Health – Healthy and Safer Nightlife of Youth' (<http://club-health.eu>) project, or the 'Nightlife Empowerment and Well-being Implementation Project' (NEW-Net – <http://www.safernightlife.org/>). NEW-Net is a European network of community-based NGOs acting in the fields of health promotion and nightlife.

The main objectives of these networks and projects are to improve existing interventions reducing drugs related harm in nightlife and party settings and to facilitate their transferability, evaluation and implementation. In the NEWIP project, the CePT co-authored in 2013 guidelines on good practice standards when developing peer projects in nightlife settings (Noijen, Duschere, Schrooten, et al., 2013).

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

As the nightlife setting provides a privileged environment for recreational drugs use, the CePT launched the project Party MAG-Net under the INTERREG IV A Programme: Great Region 2007-2013, Project 52 GR 3 3 100 (www.mag-net.eu) a harm reduction project targeted at recreational drug users in the party scene of Luxembourg and the surrounding Greater Region. The referred project includes the creation of a network of experts from Germany, France, Belgium and Luxembourg aiming to develop preventive measures for school, recreational and social settings. In the framework of the MAG-Net project, a directory of all the counselling and help services related to drugs and addictions was published for the Greater Region.

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

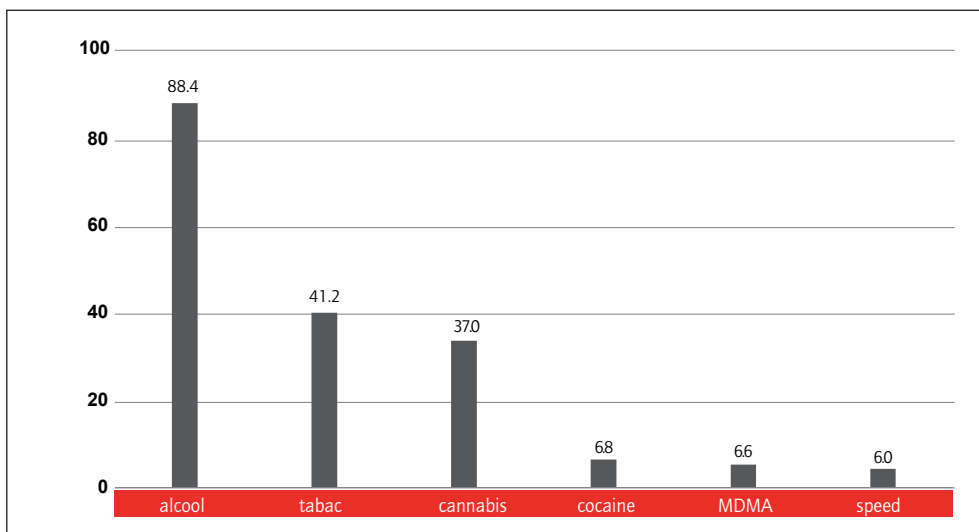
In addition to the survey launched on a continuous annual basis by PIPAPO (since 2016), the CePT in close collaboration with the Ministry of Health, the Public Prosecutors' Office and the National Laboratory of Health (LNS) has launched in 2014 a pilot project named '*DUCK*' (DrUg CheCKing) (CePT, 2014). The '*DUCK*' service onsite drug testing in festive settings. '*DUCK*' services are provided at the Party MAG-Net stand, at festive areas. In 2014, the '*DUCK*' team was present at 12 events. In total, 53 samples of drugs were collected for toxicological analyses. In 2016, the DUCK team collected 21 samples in various festive settings. Since 2017 the DUCK project is managed under the generic name PIPAPO by an NGO, called *4Motion*, primarily active in the field of youth and training activities. The project is supported and cofinanced by the Ministry of Health. In 2017, 43 samples were collected and could be analysed allowing the identification of the substance. An estimate of the concentration of the substances is made with liquid chromatography and with mass spectrometry (LC-MS). Of the 43 samples collected, 23 (53%) were identified as suspected MDMA substances. Among these samples were 19 pills (80%), 2 powder samples (10%) and 2 crystal samples (10%). In all cases, laboratory results showed a high presence of MDMA. Quantification of different pills was performed ranging from 180mg to 400mg of MDMA per pill. Samples in the form of powder and crystals were estimated to pure MDMA. Of the 43 samples, 6 samples did not meet the expectations of the consumer regarding the psychoactive substance or the composition of the product. In one sample, presence of 3 different synthetic cannabinoids was found. These results were transmitted for information to the Ministry of Health, the Luxembourg focal point and the working group European T.E.D.I. (Trans-European Drug Information) of the cooperation network of the association NEW-Net (safernightlife.org).

In the framework of the PIPAPO project, 4motion carries out a low scale survey among participants of various festive events in Luxembourg (since 2016). The main objective is to characterize the audience of these events, but also to track cross-border flows of visitors and their recreational consumption of drugs at national festive settings.

The survey was conducted between February and November 2017 at 24 festive venues in the Grand Duchy of Luxembourg, gathering around 40,000 visitors. This survey aimed to characterize attendees of festive events as well as their recent consumption of psychotropic drugs during the last two weeks. The questionnaire completed anonymously by the participants themselves and deposited in a box provided for this purpose. In 2017, 2,547 visitors of festive events participated in the Pipapo survey. After validation, 2,450 questionnaires were analysed, including 1,195 male (48.8%) and 1,255 female (51.2%). The median age of respondents was 23 years, with a minimum age of 11 years and a maximum age of 66 years. Regarding the country of residence, 66.9% of respondents indicated to live in Luxembourg, whereas 21.2% lived in Germany, 4.4% in Belgium, and 3.7% in France (Paulos, 2017). Figure 3.5 indicated the types of substances that were used, with the majority using alcohol followed by tobacco and cannabis. Males reported a higher consumption for each of the substances (5-10% higher) than females.



Fig. 3.5: Substances consumed during the last 2 weeks in festive settings, February-November 2017 (n=2,450) (PIPAPO 4motion a.s.b.l.)



Source: Paulos et al., 2018

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

Occupational settings

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

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

INDICATED PREVENTION

Children at risk with individually attributable risk factors

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

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

NATIONAL AND LOCAL INTERVENTION SERVICES

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

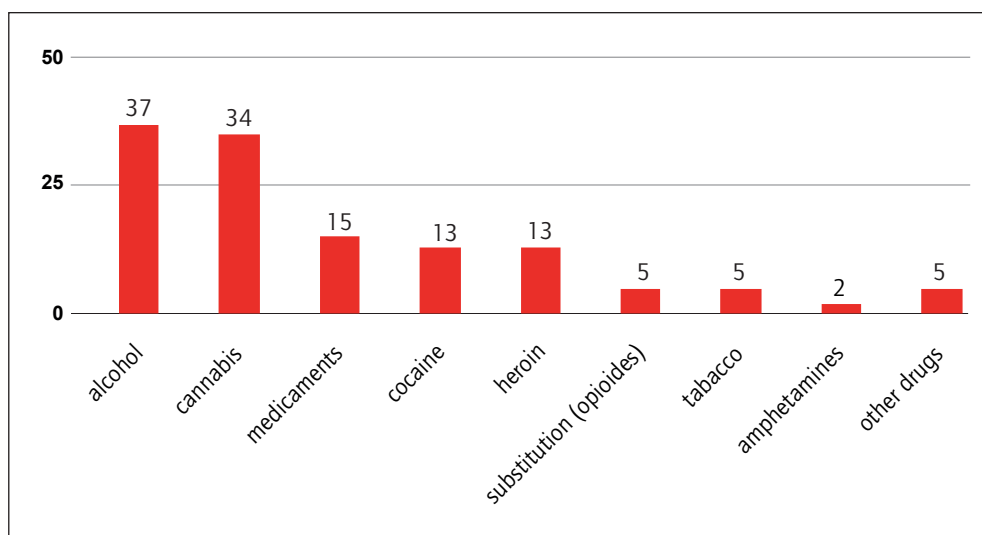
In total, the 'Fro No' service was solicited 252 times during the year 2017 (194 in 2016). There were 133 requests for information and orientation (99 by telephone, 31 by mail and 3 visits) and 119 requests for material, including pamphlets on the different substances, brochures on the support services and other information materials developed by the CePT. As in previous years, the most frequent questions were related to cannabis and alcohol abuse.

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

In 2017, 7,316 leaflets on substances were distributed (11,288 in 2016). The number distributed is one-third lower than last year which is due to a significant decrease in the reserve stock in leaflets. The brochures on Specialized Services in the field of Drugs and Drug Addiction and Consultation Services for Children, Youth and their Parents were reprinted in 2017 with the financial support of the « Œuvre national De Secours G.-D: Charlotte ». The brochures were distributed to 2,790 recipients in specialized services in the field of drugs and drug addiction.



Fig. 3.6: Dispatched leaflets on drugs and psychotropic medications in 2017 (in %)



Source: CePT, 2018

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

In 2017, the majority of information and guidance seekers were family members or close friends (53%) followed by professionals / specialists (43%), of which 49% from the school sector and 39% from the social sector. Applicants for information and guidance from the work environment represent 4%. Telephone contacts were 68% in Luxembourgish, 28% in French and 4% in German. The number of requests for help from women (n=85) exceeds that from of men (n=48). There is a very strong trend of increased female calls compared to 2016, which is almost double that of male calls. Also for 2017, the typical profile of the person who contacts the CePT is that of a woman speaking in Luxembourgish who aims to get information for a man (partner / spouse / son).

4. HIGH RISK DRUG USE

INTRODUCTION

At the national level 'high risk drug use' (HRDU) or 'harmful use' is defined according to the WHO Lexicon of Alcohol and Drug terms (WHO, 1994): *'A pattern of psychoactive substance use that is causing damage to health, physical or mental. Harmful use commonly, but not invariably, has adverse social consequences [...]'*. According to the EMCDDA, the term 'high-risk drug use' refers to 'recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms' (EMCDDA, 2013). Regular and/or long duration use of heroin via inhalation is thus included. According to the national definition, high-risk drug use is associated to a high probability of intervention or the need of involvement of a third party from the law enforcement or care sectors. This approach is consistent with the fact that HRDU surveillance systems in Luxembourg are based on the institutional contact indicator and not exclusively on the treatment demand indicator.

Data on HRDU in this chapter originate from the national drug monitoring system RELIS developed and maintained by the national EMCDDA focal point. The RELIS network includes specialised drug agencies (100% coverage), law enforcement agencies, national prisons and since 2009, psychiatric departments of general hospitals nationwide.

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

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

PREVALENCE AND INCIDENCE ESTIMATES OF HRDU

National prevalence data

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

51 Downloadable at <http://sante.public.lu>



The research strategy relied on the methodological framework of the Luxembourgish Information System on Drugs and Drug Addiction (RELIS), set up in 1995 by the national focal point of the EMCDDA. RELIS stands for a nationwide multi-sectorial information network and was built upon the methodological assumption that data exclusively from drug treatment settings may not provide an accurate picture of high-risk drug use as these notably exclude out-of-treatment users whose drug use has generated conflicts with law enforcement only. Hence, to approach the genuine heterogeneity of the drug misuse phenomenon, RELIS routinely compiles data from all existing specialised in- and out-of treatment sources, in- and outpatient service sources, low threshold agencies, psychiatric departments of general hospitals, substitution treatment programme, prison, and law enforcement agencies. Moreover, RELIS relies on the 'institutional contact indicator', as an alternative to the more commonly used 'treatment demand indicator'. As such, it provides for the most comprehensive and reliable data on high risk drug users indexed by national institutions.

In compliance with RELIS case definitions, the present study specifically aims at the prevalence estimation of high-risk use of illicitly acquired high risk drugs (HRC) in the national population aged 15 to 65 years.

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

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

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

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

OU prevalence estimation

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

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

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

which equals to a **national OU prevalence rate (R^{OU})** in 1,000 inhabitants aged 15-64 years of **4.46⁵²**

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

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

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

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

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

HRDU prevalence estimation

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

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

R^{OU} applied to year 2015: 0.77

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

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

IDU prevalence estimation

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

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

R^{IDU} applied to year 2015: 0.65

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

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



List of variables:

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

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

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

N^{OU}: Number of opiate users

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

N^{HRDU}: Number of high-risk drug users

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

N^{IDU}: Number of injecting drug users

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

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



Source: Origer, 2017

Note:

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

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

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

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

M4: extrapolation from treatment data.

IOMM: Incremental OST Multiplier Method

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

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

OU: Opioid Use prevalence estimate

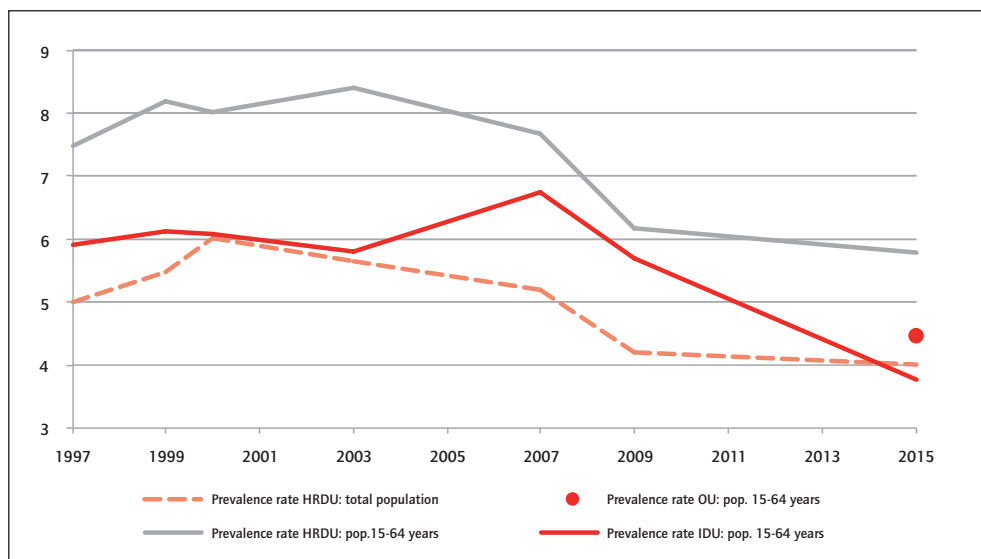
Table 4.1: Absolute national prevalence and prevalence rates according to selected sub-groups (1997 – 2015))

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

Source: Origer, 2017



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



Source: Origer, 2017

The mid-point estimation performed on 2009 data provides an absolute prevalence of problem HRC drug users (HRDU-HRC) of 2,070 persons (C.I. (95%): 1,553 to 2,623). In terms of prevalence rates estimates for the same age categories, 6.16 out of 1,000 habitants aged between 15 and 64 years show high risk drug use.

According to serial data available for the period 1997 to 2015, HRDU prevalence rates witness a continuous downward trend 2000 onwards.

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

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

The number of fatal drug-related overdoses has peaked in 2007 and has been witnessing an obvious decrease since then. Comparable to other EU Member States, the evolution of the referred indicator is known to show fairly important variations due to factors such as quality of available drugs, consume patterns, availability of harm reduction services, etc. Moreover, the absolute number of fatal overdoses has decreased compared to previous years. Changes in small figures may produce great variations in percentages. Comparison of overdose rates over the years would probably make the downward trend more obvious, which

is in concordance with national prevalence figures. The number of clean syringes distributed by the national needle exchange programme has been showing an increasing trend, which is partly due to increased NEP offers and syringes' availability at the national level.

Admission statistics in low threshold drug agencies depend of course on the capacities of low threshold offers and level of access to harm reduction measures at the national level. Harm reduction offers have been further developed in Luxembourg, the number of contacts with the latter decreased in 2011 but have been following an increasing trend since.

LOCAL OR REGIONAL PREVALENCE STUDIES

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

CHARACTERISTICS OF INDEXED HRDU

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 *high risk drug users* population. The 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 high risk drug users.

The **number of HRDU person-contacts** indexed by national institutions in 2017 figured 5,285 (2002: 4,701) (in this figure double counting is included meaning that a given person could have been indexed twice and more by different institutions. It is thus not representing the actual prevalence, which has to be assessed by other methods).

More precisely, 2,383 users have been indexed by national specialised drug demand reduction agencies and 2,318 drug law offenders by supply reduction agencies in 2002. In 2017, the same agencies have indexed 2,992 and 2,293 persons respectively.



Table 4.2: Main characteristics of HRDU indexed by the national drug monitoring system, RELIS (valid percentage) (2000-2017)

	2000	2004	2008	2010	2012	2014	2015	2016	2017	TREND
Gender										
Male	77%	78%	77%	80%	84%	83%	84%	85%	77%	=
Female	23%	22%	23%	20%	16%	17%	16%	15%	23%	=
Nationality										
Natives	54%	54%	48%	49%	42%	52%	42%	37%	62%	↗
Non-natives	46%	46%	52%	51%	58%	48%	58%	63%	38%	↘
- of which										
Portuguese	51%	58%	38%	39%	38%	32%	27%	28%	39%	=
French	17%	11%	28%	23%	17%	11%	12%	21%	18%	=
Others	32%	31%	34%	38%	45%	57%	61%	51%	43%	=
Mean age										
Male	29Y4M	31Y2M	31Y8M	32Y4M	33Y8M	32Y6M	35Y1M	35Y0M	38Y3M	↗
Female	26Y10M	28Y4M	28Y5M	28Y9M	30Y6M	31Y5M	34Y4M	34Y7M	39Y0M	↗
Total	28Y9M	30Y6M	30Y11M	31Y7M	33Y2M	32Y3M	34Y11M	34Y2M	38Y6M	↗
Primary drug										
Opiates	84%	76%	72%	80.6%	55.8%	53.8%	55.9%	46.1%	61%	=
Cocaine	7%	16%	17%	9.5%	12.2%	19.9%	19%	17%	22%	↗
Others	9%	8%	11%	9.9%	32%	26.3%	25.1%	36.9%	17%	↘
Polydrug use	87%	93%	89%	76%	54%	54%	61%	54%	76%	=
Primary opiates administration mode										
Injecting	56%	55%	45%	59%	42%	50.3%	43%	47%	41%	=
Not injecting	44%	45%	55%	41%	58%	49.7%	57%	53%	59%	=
Infectious diseases										
HIV	4.3%	4%	4%	6%	4%	5%	8%	10%	6.7%	=
HCV	40%	58%	65%	52%	54%	61%	56%	52%	54.7%	=

In 2017, the male ratio of the HRDU population is around 77/100. During the last ten years the proportion of indexed non-native HRDU has shown strong variations. The population of non-native drug users largely consists of Portuguese nationals, followed by French nationals.

The mean age of indexed HRDU evolved from 28 years and 4 months in 1995 to 38 years and 6 months in 2017. Mean age of male HRDU has been increasing faster than for females, with the exception of year 2017 for which data indicate on average older female HRDU. In reference to years 2004 to 2012, a discontinuous increase of minors in the overall HRDU population has been observed in police data.

During the last seven years, an increase in the average age of the HRDU has been observed. Even though data from 2017 suggest that, natives and women are on average younger respectively than non-natives and men, these differences are not statistically significant.

Worth mentioning is also the overall, yet discontinuous increase of the average age of overdose victims during over the last 20 years (1992: 28.4 years-old; 2016: 41.5 years-old; 2017: 41.5 years-old). Furthermore, among 2017 indexed HRDU first contact with drug treatment facilities occurred on average before 37 years-old.

Intravenous heroin use associated to polydrug use has been reported as the most common consume pattern in HRDU. The proportion of **polydrug use** has been declining between 1994 (93%) and 2016 (54%). However, 2017 data suggest a new increase in polydrug use (76%).

The injecting consumption mode is progressively decreasing among HRDU. In the last years the highest proportion of injecting use was observed in 2009 (62% of HRDU injected preferably) while in 2017 a decrease to 40.8% of the injection mode has been observed.

Provision of 'blowing paraphernalia' (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns. The prevalence of the use of cocaine as primary drug has been discontinuously increasing since 2000 (7%). Currently, 21% of the HRDU use cocaine as primary drug.

The consumption of ecstasy (MDMA) and amphetamines (ATS) substances as primary drugs is very low among HRDU (1.2% and 0.6% respectively).

The number of persons in contact with the national specialised network for (preferential) cannabis use has been showing a globally increasing trend since 2007 (2016: 32.8%). This increase was not confirmed in 2017, on the contrary, data suggest a decrease in the number of cannabis treatment demanders. However, it is important to note that, in 2017 the number of data collected by the cannabis specialised treatment agencies decreased significantly. Hence, this result should be taken with caution and confirmed in the following years.

HRDU showed fairly stable infection rates of HIV between 2000 and 2013. After an important increase in the number of IDUs with HIV between 2014 and 2016 (2014: 19; 2015: 20; 2016: 21), the number decreased again in 2017 (10). The HCV prevalence rate among HRDU in general is fairly stable since 2004 (2017: 54.7%). When looking specifically at IDUs, self-reported based prevalence increases to 67.2% and serology-based data provide a 75.8% rate.

The **residential status** of indexed respondents has improved over the last years. In 1995, 31% of the users reported stable accommodation; currently the proportion situates at 65%. This improvement is partly due to various accommodation and housing offers for addicted people set up in the framework of the drug action plan.

The **unemployment rate** (60% declared inactive and 16% declared "other" which mainly includes RMG beneficiary) tends to plateau. The proportion of professionally active respondents reporting a stable job situation (e.g. long-term contract) reached 15% in 2017.

DATA ON HRDU FROM NON-TREATMENT SOURCES

Data on HRDU from non-treatment sources are mainly provided by the national specialized drug unit of the Judicial Police. The profile of these users is similar to HRDU from treatment settings knowing that the national drug monitoring system indexes both sources.

The ratio of male and female HRDU was almost identical to HRDU from treatment sources in the last years. In 2017, the percentage of male offenders was 86%, 11% female offenders (and 3.6% missing) vs. 77% males and 23% females from treatment sources. The mean age of offenders was 27.2 years (34.8 in 2015 and 27.4 in 2016). Women were slightly younger than men with 26.2 years (34.9 in 2015) for female and 27.3 years (34 in 2015) for male offenders.

In 2017, 39.6% of the offenders were natives.

Data from the RELIS database point out that most offenders (53.7%) are recidivists (had more than one police record during their lifetime). As regards illegal drug dealing, 26.2% were arrested whereas 31.9% were charged with possession or consumption of illegal drugs. Drug-law offenders (being simultaneously problem drug users) have mostly been arrested for heroin and cocaine related offences. A majority are reported polydrug users.



5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

INTRODUCTION

Drug treatment is the 'use of specific medical and/or psychosocial techniques with the goal of reducing or abstaining from illegal drug use and thereby improving the general health of the client'.⁵³

According to the EMCDDA, specialised drug treatment centres comprise public or private, governmental or non-governmental facilities which specialise in and whose primary focus is the treatment of drug dependence on an outpatient basis. Specialised drug treatment facilities are relying on state financing and on ministerial control and quality assurance mechanisms. Treatment offers are decentralised and most commonly provided by state accredited NGOs.

For the purpose of the present chapter, drug treatment is divided in the following categories:

- **Outpatient treatment:** the patient receives drug treatment without staying overnight, pharmaceutically assisted or not⁵⁴;
- **Inpatient treatment:** the patient is staying overnight, pharmaceutically assisted or not (including detoxification);
- **Opioid Substitution Treatment (OST):** a type of medical treatment provided to opiate addicts primarily based on the delivery of a similar or identical substance to the drug normally used. Substitution treatment may be accompanied by psychosocial care. OST may be provided in in- and outpatient settings.

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

DRUG TREATMENT STRATEGIES AND POLICY

In the mid-seventies the cooperation between the State and NGOs working in the social field has progressively gained structure. The first (financing) convention between the Ministry of Family and a series of NGOs, signed in 1975, was the starting point of what is known today as the 'Conventionned sector'. Over the years, the collaboration schemes between State and NGOs evolved and were extended to the Public Health sector. In 1998, the so-called ASFT law⁵⁵ entered in force, regulating the relationship between State and private organisations working in the social, family and therapeutic fields.

Treatment needs' assessment as well as quality control largely rely on the ASFT legal framework and the existing network of conventionned service providers who have to meet a series of quality standards and be granted a special accreditation from the Ministry of Health. The elaboration of the demand reduction section of the national drugs strategies and action plans builds upon the expertise and involvement of the referred network. A detailed description of collaboration and control mechanisms in place is provided below.

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

54 'Drug free treatment focus on psychosocial and therapeutic techniques and is not primarily based on the routine prescription of a substance or medicament with the goal of reducing or abstaining from illegal drug use thereby improving the general health of the client'

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

The first specialised drug counselling agency, the Youth- and Drugs Aid Foundation (Jugend- an Drogenhëllef (JDH)), was created in 1986 and addressed both drug addiction and youth. The JDH maintains various assistance services in the field of psychosocial, therapeutic and medical care for consumers of illicit drugs, for problem drug users and their relatives. As far as possible, the various offers take into account the principles of regionalization and differentiation.

Preliminary work done in the framework of the first drug action plan 1999-2004 allowed to better assess national needs and to initiate and develop interagency coordination mechanisms. To date, treatment agencies are specialised whether in polydrug use including illegal drugs, in alcohol abuse, or gambling, etc. As far as illegal drugs are concerned, drug care providers address the whole range of substances meaning that no specialised offers exist according to a given type of substance or problems related to it. In recent years, the national drug treatment strategies have been evolving towards a more holistic concept of addiction treatment (including illegal substances related addictions and others).

As far as national expenditures for drug treatment provision are concerned please refer to chapter 1.

TREATMENT SYSTEMS

Organisation and quality assurance

All specialised drug treatment services are relying on governmental support and control. Specialised agencies need an accreditation to sign a convention with the Ministry of Health that guarantees their annual funding. Outpatient drug treatment is provided free of charge by specialised agencies. Inpatient treatment and detoxification is covered by health insurance schemes. As far as substitution treatment is concerned, health insurance takes in charge medical interventions and counselling and State covers pharmaceutical costs and pharmacy fees.

NGOs involved in drug treatment fall under the terms of the above referred to 'ASFT' law (8/09/98) and the subsequent grand ducal decree of 10 December 1998⁵⁶, both regulating the relation (duties and rights) between State and NGOs or organisations providing psycho-medico-social and therapeutic care. The overall management of the referred agencies is ensured by a 'coordination platform' that includes a maximum of three members of the referred institution and at least one representative from the competent ministry. All referred institutions work in close collaboration and have to be viewed as an interdependent therapeutic chain. A series of formal collaboration agreements have been signed in 2008 and 2009 between various agencies in order to insure rational use of resources and through-care. The 2015-2019 national drugs action plan further develops these synergies.

The governmental quality standard certification, as foreseen by the law 'ASFT' of 8 October 1998, represents the main instrument of a standardised quality control of drug treatment offers. General guidelines on setting requirements and human resources/clients keys are set by a grand-ducal decree of 10 December 1998 regarding the accreditation of services from the medical, social and therapeutic field. The quality standard certification commits respective NGOs to undertake necessary evaluation measures of their activities. Drug treatment agencies have developed proper evaluation strategies mostly in collaboration with external evaluators. Examples are the evaluation of current offers in the field of socio-professional integration, which future development has been promoted by the national drugs action plan, the implementation of a computer based evaluation procedure by the national substitution programme and prevention interventions in schools by the national drug addiction prevention centre, the CePT (Centre de Prévention des Toxicomanies). The external evaluation of the drugs action plan also significantly contributes to assess the functioning and the gaps of the national treatment network.

⁵⁶ Règlement grand-ducal du 10 décembre 1998 concernant l'agrément à accorder aux gestionnaires de services dans les domaines médico-social et thérapeutique (entry in force 18/12/1998)



An external assessment of quality management mechanisms run by specialised NGOs has been foreseen by the national drug action plan. Outcomes have shown that current quality assurance routines implemented within involved drug agencies are highly diversified and differ in terms of coverage and complexity ranging from internal activity assessment procedures to EFQM certifications for instance. These outcomes are highly valuable for future improvement of quality assurance and documentation routines of drug related care services.

Understanding the nature and scale of the drugs problem is critical for effective policymaking and action. As such, the EMCDDA uses a variety of monitoring methods and tools that offer countries a 'common language' that help to assess and interpret the drugs phenomenon. Among these instruments is the Treatment Demand Indicator (TDI) as one main key epidemiological indicator. The purpose of the TDI is to gather comparable and reliable information on the number and characteristics of drug users presenting for treatment in EU Member States, including Luxembourg. It provides a measure of treatment demand, indicates prevalence trends of problem drug use, and provides profiles of problem drug users, while also identifying patterns in the use and uptake of treatment facilities.

The national TDI database, the so-called RELIS database, on high risk drug users provides relevant data for evaluation and policymaking purposes, since it includes detailed data on demographic factors, drug consume patterns, socio-economic situations, risk behaviours, and treatment or law enforcement contacts, etc. In the long run, drug use '*careers*' can be analysed by means of the RELIS indexing system, which allows following up treatment demands and law enforcement contacts of indexed and de-identified drug users. These data can be used to assess the impact and the performance of specific treatment approaches, and analyse the national epidemiological situation of drug users that are in need of help. A practical example of the application of evaluation results is to be seen in the conceptualisation and external evaluations of the national drug action plans, which did greatly rely on RELIS data and ad hoc evaluation initiatives from field institutions.

Table 5.1 reports admission and contact statistics of national drug treatment agencies according to the applied typology from 1994 to 2017. Intra-institutional multiple counts are excluded meaning that all treatment demanders indexed by a given agency are only indexed once by the referred agency during a reporting year. Inter-institutional multiple counts are not excluded since a given treatment demander may have contacted several national agencies during a given year. More detailed admission data, including low-threshold agencies, are provided in respective sub-chapters.

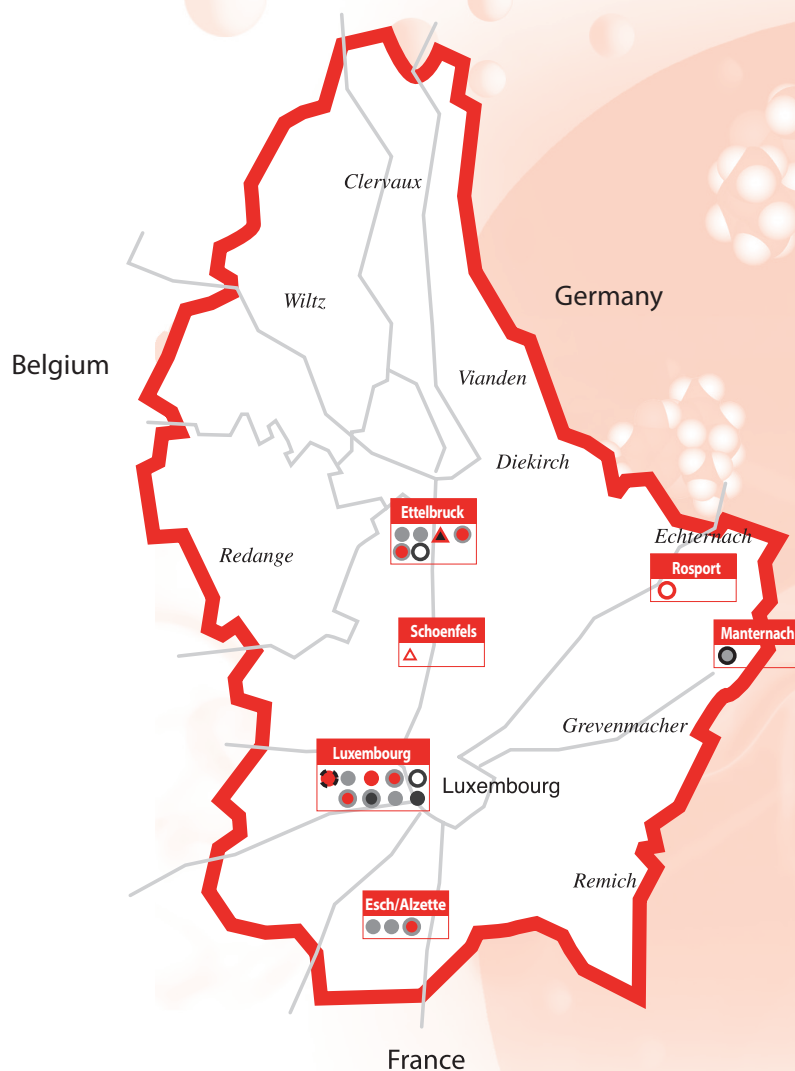
Availability and diversification of treatment

As can be seen in map 5.1, drug treatment and re-integration facilities are spread over different regions. All listed services are specialised with the exception of regional general hospitals providing detoxification treatment via their respective psychiatric departments. In July 2005, the first 'supervised drug consumption room' has been opened in Luxembourg City. It has been integrated in the Abrigado centre providing day care, night shelter and low threshold services to drug addicts. The opening of a second supervised drug consumption room in the south of the country, in the city of Esch-sur-Alzette is foreseen for the first semester of 2019.

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

The following treatment typology is applied:

Map 5.1 Geographical coverage of specialised drug agencies in the Grand-Duchy of Luxembourg (status 2018)



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



Outpatient: services and offers for adults

As mentioned above, the most relevant national outpatient treatment facility is the JDH. 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.

The service Quai57 (Arcus asbl) implemented in Luxembourg-City is primarily a counselling and referral agency providing help for people who suffer from an addictive disorder or addictive behaviour (with or without substance abuse) or for their environment. The Quai 57 offers the following:

- Psychosocial outpatient consultation centred on the development of individual projects;
- Psychotherapeutic consultations related to addiction and related disorders;
- Guidance, support and administrative, social and therapeutic follow-up of patients undertaking a stationary therapy (Luxembourg, Germany, Belgium, France, Italy);
- Sociotherapeutic support in professional, administrative, judicial and / or housing-related social integration initiatives;
- Information, training and / or awareness about addictions for the general public and / or professionals;
- Development of the services mentioned above in the framework of regional consultations.

A third specialised outpatient service is also implemented in Luxembourg-City, the 'Alternativ Berodungsstell' (Alternative Counselling Centre). The main objectives of the referred centre are the following:

- Establish a first contact with the drug-addicted clients;
- Help drug-addicted clients in the development of a therapeutic project with orientation either towards the intermediate-term structures, or towards residential therapy centres;
- Organisation of detoxifications in local psychiatric services or further psychotherapeutic interventions;
- Informative and therapeutic discussions with the drug-addicted clients and their families before and after the detoxification.

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

Outpatient: services and offers for minors

Specialised drug care agencies for minors exist in the centre and since 2007 in the north of the country. Although drug-counselling agencies accept underage treatment demanders, part of the latter are referred to a specialised service established in the centre of the country (Service Impuls, Solidarité Jeunes a.s.b.l.). The Impuls service provides, in the context of youth protection, psychosocial and therapeutic assistance to young people (below the age of 21 years), their families and the institutions concerned when they are confronted with the consumption of legal and illegal psychoactive substances.

Outpatient: substitution treatment and HAT

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

Substitution treatment is provided at the national level since 1989 by the JDH. Until the beginning of 2001, however, there has been no genuine legal framework regulating drug substitution treatment. The law of 27 April 2001 modifying the basic drug law of 19 February 1973 introduced a legal framework for substitution and maintenance treatment. The grand ducal decree of 30 January 2002, amended by the grand-ducal decree of 1st March 2016⁵⁷, regulates the practical modalities of substitution. The referred law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of substitution treatment licenses granted to MDs and specialised agencies, the application of training requirements for prescribing MDs and adequate control mechanisms of multiple prescriptions (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a structured and multidisciplinary substitution treatment programme (JDH - mainly liquid oral methadone provided by specialised agencies) and a substitution treatment offer provided by freelance state licensed MDs (MEPHENON®, METHADICT® and SUBUTEX®).

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

The list of substitution substances may be modified within reasonable delays by amending the referred decree. In addition to drug prescription and medical care, the grand ducal decree on drug substitution treatment (30/01/2002) defines a series of psychosocial counselling services to be provided by licensed specialised centres. OST licensed MDs may refer substitution patients to specialised treatment centres for more in-depth psychosocial counselling.

A central substitution register jointly implemented by the 'Surveillance Commission on Substitution Treatment'⁵⁸, the National Drug Coordinator and involved specialised treatment providers. Multiple prescriptions could be markedly reduced since the launch of the national substitution register. The substitution treatment surveillance commission has been reformed and is chaired by the National Drug Coordinator since August 2010.

Outpatient: low threshold services and offers

Currently two agencies offer harm reduction services in the Centre, the South and the North of the country including offers such as day and night shelter and supervised injection facilities (currently only in the centre). A new integrated low threshold centre for drug addicts is planned to be implemented in the main city of the South of the country. The further development of harm reduction services in the North is part of the national drug action plan. In this context, a new low-threshold offer has been implemented in the North of the country in 2014.

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

58 The decree of 30 January 2002 replaces the former 'Methadone Commission' by the 'Surveillance commission on substitution treatment' mandated to control all aspects of substitution treatment at the national level. Established in 2002, it is composed of delegates from the programme, the Directorate of Health, two pharmacists and two GPs affiliated to the programme, and is in charge of admissions, releases and exclusions of substitution treatment demanders or patients.



Inpatient: detoxification services and offers

Physical drug detoxification is provided by four regional hospitals via their respective psychiatric units. The 'Centre Hospitalier du Kirchberg – CHK' initially joined the list of national institutions providing detoxification treatment in 2005. In 2016, the CHK merged with another hospital in the centre of Luxembourg, the 'Hôpital Ste. Thérèse', and both were renamed 'Hôpitaux Robert Schuman' but remain on their respective sites. CHK has been renamed 'Hôpitaux Robert Schuman – Kirchberg' and 'Hôpital Ste. Thérèse' changed its name into 'Hôpitaux Robert Schuman – Zithaklinik'. Clients arriving at Kirchberg are referred to its addictology department situated at 'Zithaklinik'. Medical interventions and psychosocial support are provided to control and reduce withdrawal symptoms in the framework of a 1-2 week detoxification programme. Ideally, detoxified patients are referred to more psychotherapeutic oriented institutions.

Detoxification treatment is provided by psychiatric units within the following general hospitals:

Centre Hospitalier du Nord – Ettelbrück (North)

Centre Hospitalier Emile Mayrisch – HVEA (South)

Centre Hospitalier de Luxembourg – CHL (Centre)

Zithaklinik/ Hôpital Kirchberg – *Fondation Hôpitaux Robert Schuman* (Centre)

Inpatient: services and offers for adults

The national residential therapeutic centre called 'Syrdall Schloss' (CTM-CHNP) is situated in the East of the G. D. of Luxembourg. The 'Syrdall Schloss' is a therapeutic centre for people dependent on illegal substances. The centre is organised as a therapeutic community and can accommodate up to 25 people, whereas patients are able to follow a methadone substitution treatment. In some cases, it is possible to welcome mothers and/or fathers accompanied by their children. The goal of the therapeutic community is to help each individual to allow them to live a fulfilling life without drugs and to successfully reintegrate into society and work.

Before admission to 'Syrdall Schloss', it is mandatory to first consult the 'Alternativ Berodungsstell' orientation office in Luxembourg city.

The therapeutic programme of the 'Syrdall Schloss' is divided into three progressive phases. The duration of a therapeutic stay usually varies from 3 months to 1 year.

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

In the framework of the national drug action plan an extension of 'Syrdall Schloss' offers occurred by creating a network of modular therapeutic annexes for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone, etc. These annexes are operational since September 2002 and are situated in the vicinity of the main centre (see map 5.1) in order to take advantage of training and social reintegration facilities offered by the 'Syrdall Schloss'. Based on past experience, the 2005-2009 drugs action plan has foreseen the further development of these annexes. In 2008, a new annex providing therapeutic offers to specific target groups such as mothers with child/children or patients in the last therapy phase has become operational on the very site of the main centre.

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

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

Inpatient: services and offers for minors

A specialised residential centre for problematic youngsters has been opened in the beginning of 2007 in the North of the country under the management of CHNP.

CHARACTERISTICS OF TREATED CLIENTS AND TRENDS OF CLIENTS IN TREATMENT

Table 5.1 summarises drug-related institutional contacts of HRDU. Inter-institutional multiple counts are not excluded meaning that a given HRDU could be indexed twice and more. Hence, these data do not represent the national prevalence of HRDU but they allow a trend follow-up.

The present section is divided in a general description of the drug treatment population and a more in-depth analysis of clients' characteristics and observed trends. Both parts are based on RELIS data and on in-house statistics of specialised drug treatment agencies at the national level.

Below is presented a more detailed analysis of treatment demands and trends according to type of treatment:



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

	DEMAND REDUCTION: SPECIALISED DRUG TREATMENT														NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)											
SETTING	NUMBER OF ADMISSIONS NUMBER OF CONTACTS (Low threshold)																									
	2002	2004	2006	2008	2010	2012	2013	2014	2015	2016	2017	2002	2004	2006	2008	2010	2012	2013	2014	2015	2016	2017				
DEMAND REDUCTION: SPECIALISED DRUG TREATMENT																										
OUTPATIENT - Drug Free - Substitution												828	916	928	1,162	980	1,294	1,307	1,296	1,586	1,477	1,398				
												1,040	1,065	1,044	1,050	1,163	1,180	1,126	1,121	1,078	1,085	1,142				
INPATIENT - Specialised - Hospital care												153	182	183	124	128	127	89	64	86	83	102				
												429	476	484	397	297	262	267	310	313	329	350				
LOW THRESHOLD AGENCIES (contacts)	29,536	39,526	55,808	78,415	140,093	127,080	124,048	131,375	142,054	150,937	164,254															
SUB TOTAL A: Number of drug treatment demanders (Multiple counts not excluded)												2,450	2,639	2,639	2,733	2,568	2,863	2,789	2,791	3,063	2,974	2,992				
SUPPLY REDUCTION: LAW ENFORCEMENT INSTITUTIONS																										
National prisons												101	92	243	332	232	306	226	223	240	306	324				
Police - Judicial Police - Customs												2,217	1,808	1,573	1,487	2,530	1,782	2,066	2,792	3,345	2,566	1,969				
SUB TOTAL B: Number of drug law offenders (Multiple counts not excluded)												2,318	1,900	1,816	1,819	2,762	2,088	2,295	3,015	3,585	2,872	2,293				
TOTAL NUMBER OF PERSONS SHOWING DRUG-RELATED INSTITUTIONAL CONTACTS (Multiple counts not excluded)																										
												4,768	4,539	4,455	4,542	5,330	4,951	5,084	5,806	6,648	5,846	5,285				

Source: RELIS, 2018 / CNS (2017 data)

Note: CNS – Caisse national de santé (National health insurance fund)

Overall, the number of persons showing drug-related contacts with national DR or SR agencies peaked in 2010. Both, the number of drug treatment demands and the contacts with law enforcement agencies have been discontinuously increasing since 2000/2001. The number of substitution treatment (OST) demanders has been slightly decreasing since 2013. Since 2009, the most marked increase has been observed in outpatient drug free treatment demanders. The number of contacts in low threshold facilities has been increasing 2013 (124,048) onwards (2016: 150,937; 2017: 164,254). According to 2017 RELIS data, around 27% of respondents are first treatment demanders (15.5% in 2016), all treatment centres included. As far as **first treatment** demanders are concerned, 31% are females for 69% of males.

Of clients in drug treatment (all treatments and all types of units included) in 2017, RELIS data shows that 77% (81% in 2016) are male for 23% (19% in 2016) females. The mean age of treatment demanders has been increasing during the last ten years (1997: 28 years/ 2015: 35.1 years/ 2016: 33 years/ 2017: 38.5 years), primarily due to an observed increase in average male age (1997: 28.2 years/ 2015: 35.3 years/ 2016: 33.45 years/ 2017: 38.3 years). The mean age of female clients has been slightly lower in previous years (2015: 34.9/ 2016: 31.06) and compared to their male peers, however, in 2017, the age of females was slightly higher than the average age of male treatment demanders (39 years). Of the clients in drug treatment, 62% of clients in treatment are natives and 38% are non-natives. The population of non-natives consists for the vast majority of Portuguese nationals, followed by French, Italian, German, Russian and Spanish citizens.

Regarding the educational level of the clients in treatment in 2017, 14.5% have completed primary or complementary school, 71.5% have completed secondary school and 9.5% obtained a higher degree. In total, 14.5% of respondents reported stable employment (important decrease – 1997: 65%; 2016: 16%) against 59.8% who are inactive or unemployed. Furthermore, 2.2% are students or engaged in a training contract, whereas 5.6% have a temporary employment or engage in illicit work. As regards risk behaviour, 12.8% of indexed treatment demanders had experienced one overdose, whereas 34.6% have experienced at least two overdoses or more in the past. As far as the exchange of syringes is concerned, 35.8% (68.3% in 2016; 45.5% in 2015; 25% in 2012; 32.9% in 2011) reported that they never shared syringes during their lifetime, whereas 58.1% (96% in 2016; 83.9% in 2015; 44.6% in 2012; 51.7% in 2011) indicate to not have shared a syringe during the past month. IDU combined to polydrug use is the most observed consume pattern in drug treatment demanders.

As regards clients in treatment in 2017, their age of first use of drugs averages 16 years. Regarding the route of administration by primary drug, 32% report an injecting behaviour, 44% report smoking/inhaling, whereas 10% report sniffing, 3% eating or drinking, and 9% report another form of route of administration or unknown behaviour. Half of all treatment clients report using drugs on a daily basis, whereas 24% report using drugs on 4-6 days a week, 9% reporting using drugs once a week or less and 13% report not having used any drug in the last 30 days. Almost three-quarter (71%) of all clients report polydrug use. Opioids, and especially heroin, remain to be used most among clients (61%), followed by cocaine (22%), and cannabis (16%). Self-referral, or referral from family, friends, where no other agency or institution is involved, remains the most important source of referral with 74% in 2017.



Outpatient: services and offers for adults

RELEVANT TREND: Increase of male treatment demanders (77% male, 23% female). Increase of clients aged 30 and more (2017: 38.5 / 2016: 53% / 2015: 71% / 2014: 88% / 2013: 86%). A current trend is also to be seen in the increasing number of drug users that have shared used syringes in 2017.

National outpatient drug counselling centres have been showing increasing admission rates 2000 onwards. Gender distribution showed an overall increase of male clients over the last 10 years. Age distributions are varying according to the geographical situation of treatment centres. All in all, however, the proportion of treatment demanders aged 30 years and more showed an important increase in 2017 after having stabilised at high level during recent years (2017: 86.6%; 2016: 53% / 2015: 71.4% / 2014: 88% / 2013: 86%). Treatment demands from underage clients tend to decrease until 2007 and increase since then, mainly because specialised agencies for minors have been implemented meanwhile. Cannabis-related demands have shown a clear upward trend since 2009 (2016: 45% / 2015: 29.4% / 2014: 25%), though in 2017 cannabis-related treatments have decreased again to 16.2%. In 2017, most drug users are in treatment due to a high-risk heroin consumption (58.1%) and a high-risk cocaine consumption (21.8% in 2017; 12% in 2016). The prevalence of cocaine use-related treatment demands also tends to increase. Treatment demands for problem injecting use of opiates remains a very frequent demand pattern (51.4% report a current injecting use). In total, 72.6% of all treatment demanders report polydrug use.

Outpatient: services and offers for minors

RELEVANT TREND: Increase of the number of counselling episodes. Cannabis-related problems are the main cause of consultation. Moreover, the consumption of XTC/MDMA and cocaine has increased significantly during the last two years among minors.

The annual report of the service Impuls (Service Impuls de Solidarité Jeunes a.s.b.l.) reveals a total number of 530 clients in 2017 (N=571 in 2016 / N=348 in 2010), of which 32.3% were previously in their treatment. Factors that may explain the more extensive treatment coverage nowadays are mostly related to dependence and co-morbidities related to increasing THC levels in cannabis, but also interfamilial difficulties. The vast majority of the clients that are in treatment at the service Impuls is aged between 14 and 17 years (64.3%). There is also a considerable increase in young applicants from the age of 18 (33.9%). The vast majority (2017: 74% / 2016: 78% / 2015: 77.5% / 2014: 73%) of minor clients are male. Cannabis use is the main reason of treatment demands witnessing a currently increasing trend (2017: 88% / 2016: 89%). However, the use/abuse of licit drugs (alcohol 2017: 85% / 2016: 84.5%) and tobacco 2017: 81% / 2016: 85%) and the combination of alcohol consumption with illicit drugs is increasingly reported as reason of treatment. Moreover, the consumption of XTC/MDMA, hallucinogens, cocaine and medicinal drugs has increased significantly in the last two years among the population of the service Impuls. According to the service Impuls, this phenomenon is due to the fact that the age of their population has also increased. As for synthetic drugs, they are mainly consumed in a recreational context such as electronic music events. An increasing proportion of youngsters presenting psychiatric symptoms and/or socially deviant behaviour in addition to drug abuse are reported by specialised field agencies.

Outpatient: substitution treatment and HAT

RELEVANT TRENDS: Overall stabilisation of the number of OST patients for the last ten years. Between 2005 and 2012 decrease of number of patients in structured JDH substitution programme followed by a slow increase since 2014. Stabilisation of gender ratio (3 males/ 1 female) – Increase of average age of substitution treatment demanders.

The number of patients admitted to the national multidisciplinary substitution programme (JDH) has been decreasing from 2005 to 2012 and shows a slow increase since 2014 (113 patients in 2014, 119 patients in 2015, 131 patients in 2016 and 150 patients in 2017). The proportion of female substitution treatment demanders (26.7%) is higher than the proportion of female HRDU in the overall drug treatment population. In total, 22.6% of the clients in substitution treatment are aged under 34; 54.7% are over 40 years old and the oldest client was 62 years in 2017. Regarding the nationality, 51.3% of the clients are natives.

The total number of OST patients nationally has known a steep increase between 2008 and 2010 [(1,158 patients in 2010, multiple counts excluded (2008: 961)]. Since 2011, a stabilisation in the number of total number of OST demanders has been recorded (2016: 1,085; 2017: 1,142). In 2017, 75.5% of OST demanders were male and the average age of all OST demanders was 42 years and 6 months.

The National Health Insurance Fund (CNS) annually provides the number of OST patients as well as the number of OST prescribing MDs. A sound increase of substitution demands addressed to accredited liberal MDs was observed until 2013 and an overall decrease of the number of patients treated within the multidisciplinary JDH programme, more demanding in terms of treatment constraints. Over 95% of prescriptions delivered in the framework of substitution treatment refer to methadone followed by buprenorphine.

Table 5.2: Outpatient prescription of substitution drugs by the national network of licensed MDs (2000-2017)

YEAR	2000	2002	2004	2006	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Number of indexed patients (double counting controlled)	844	820	945	939	1,050	1,128	1,163	1,160	1,180	1,126	1,121	1,078	1,085	1,142
Number of licensed GPs (double counting controlled)									124	129	138	145	151	155

Source: Caisse nationale de santé, 2018

Table 5.3: Age distribution (%) of OST patients (2008-2017)

AGE CATEGORIES	2008	2009	2010	2011	2013	2014	2015	2016	2017
< 15 years									
15-19 years	2	1	0.5	0.1	0.1	0.0	0.0	0.0	0.0
20-24 years	9	9	7	7	0.4	0.5	0.1	0.1	1.9
25-29 years	17	16	15	13	3.7	3.5	2.4	1.9	6.8
30-34 years	19	20	20	19.3	11.0	10.3	8.3	6.9	14.3
35-39 years	19	18	20	20.4	18.3	17.2	16.9	14.9	18.2
40-44 years	18	18	17	17	20.5	20.1	21.0	20.6	21.4
45-49 years	9	11	12	14.7	18.9	18.9	18.9	19.7	16.9
50-54 years	5	5	6	6.4	15.5	17.3	17.0	17.9	13.4
55-59 years	1	1	1.5	2	7.7	8.4	10.6	12.2	5.5
60-64 years	1	1	1	0.1	3.1	3.2	4.2	4.7	1.2
> 64 years									0.4
Total number					1,111	1,121	1,085	1,078	1,142

Source: Caisse nationale de santé, 2018 – data reformatted by NFP



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

Outpatient: low threshold services and offers

RELEVANT TRENDS: The **number of contacts indexed by low threshold agencies**⁵⁹ (2017: 164,254; 2016: 150,937) **witnesses an increasing trend since 2013** (124,048). An increasing number of 437,946 sterile syringes have been distributed in 2017 (2016: 423,060) by the same agencies with a re-collection rate of 92% (94% in 2016). In total, 6,946 syringes were sold through vending machines in 2017, whereas 1,372 were distributed in the prison setting. The majority of the clients of the low threshold services are more than 35 years of age.

Inpatient: hospital based care

RELEVANT TRENDS: Hospital based detoxification and treatment units throughout the country have been showing a continuous increase regarding the number of patients until 2006 (484) and onwards a steady decrease to 274 (277) patients in 2015. In 2017, though, 350 patients have been registered, marking a new increase in hospital care (2016: N=329). Gender distribution has remained fairly unchanged between 2002 and 2017. Multiple drug use, including heroin, is the main reason for drug-related hospital care demands.

Inpatient: services and offers for adults

RELEVANT TRENDS: The **number of inpatient treatment demanders (hospital treatments excluded) has been showing a fairly stable trend over the last 10 years. However, the proportion of first treatment demanders has slightly decreased in 2017 and currently sets around 35% (38% in 2016).**

According to the RELIS monitoring system, heroin as preferential substance is reported by 60% of inpatient treatment demanders.

The vast majority of inpatient treatment demands are addressed for heroin problems (60%) followed by cocaine (30%), cannabis (7.5%) and MDMA derivatives (2.5%).

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

6. HEALTH CORRELATES AND CONSEQUENCES

INTRODUCTION

Two drug-related deaths indexing routines currently exist at the national level:

The Special Drug Unit of the Judicial Police (SPJ) maintains a register on acute drug deaths (RSPJ). The RSPJ indexes all direct overdose cases due to illicit drug use documented by forensic evidence. As police forces are routinely informed by medical emergency services in case of a suspected overdose case, they are able to collect evidence at the site of the incident and confirm or not, in combination with post mortem toxicological evidence, the suspected overdose. RSPJ applies the following definition of acute/direct drug-related death:

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

The statistical department of the Directorate of Health maintains the General Mortality Register (GMR) indexing all deaths that occurred on the national territory by means of death certificates provided by MDs. Since 1998, the GMR applies the 10th revision of the International Classification of Diseases (ICD-10). Special software jointly developed by the statistical department and the National Focal Point allows extracting drug-related death cases from the GMR by the application of a predefined standard (e.g. Drug-related death (DRD)).

Both sources are independent, meaning that for the SPJ register data collection occurs via police records and forensic evidence, while the GMR is updated according to information contained in death certificates. Discrepancies between the referred registers mainly originate from different encoding routines (e.g. death certificates often only mention primary cause of death) explaining the fact that the DRD v 0.3 systematically underestimates the SPJ based number of drug-related deaths as can be seen in Figure 6.6.

Even though DRD based data is provided to the EMCDDA, national figures on drug induced deaths published in the national annual drugs report are, for reasons explained above, based on the register from the SPJ (RSPJ) whose case definition is compatible with the EMCDDA definition: [...] *deaths that are caused directly by the consumption of drugs of abuse. These deaths occur generally shortly after the consumption of the substance(s)* (EMCDDA).

Infectious diseases, including HIV and viral hepatitis have to be reported (notification procedure) when diagnosed to the Directorate of Health (Ministry of Health) that compiles data and is in charge of nation-wide epidemiological follow up. These data do however not allow to breakdown infection prevalence according to HRDU status. The national drug monitoring system RELIS therefore allows to gather self-reported data on infectious diseases in HRDU. Furthermore, specific diagnosed based studies provide complementary information. The report includes data from two recent studies on infectious diseases in HRDU (Origer & Removille, 2007; Devaux et al., 2017) based on serological test results to assess current prevalence rates and apply vaccination schemes when medically indicated.



DRUG-RELATED INFECTIOUS DISEASES

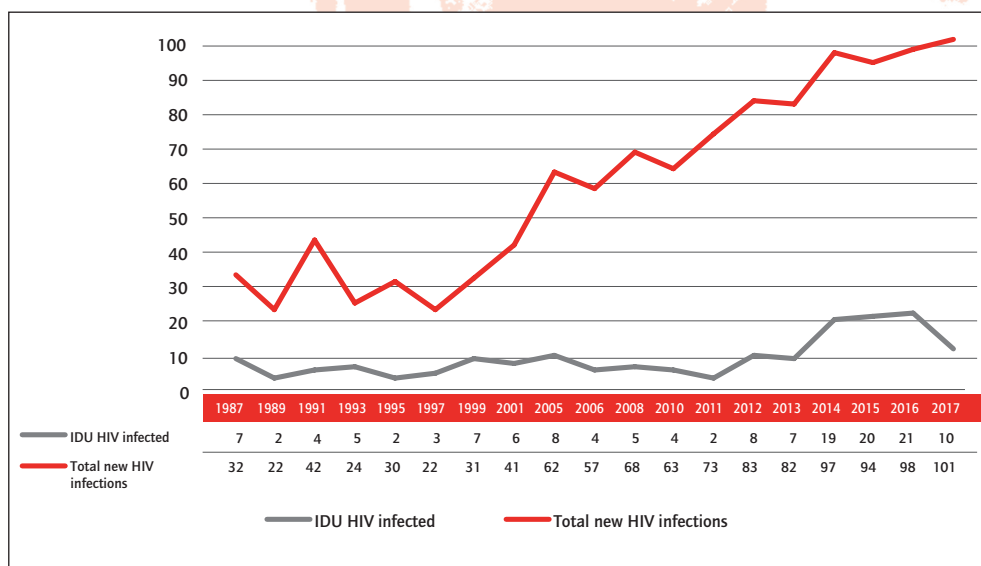
HIV/Aids, viral hepatitis, STD, tuberculosis, other infectious morbidity

Injecting drug use continues to drive the expansion of the HIV epidemic in many countries around the world. In 2017, UNODC estimates that there are 12 million people who inject drugs worldwide, and of these, 1.6 million are living with HIV, representing a global HIV prevalence of 14% among people who inject drugs.

Data on drug-related infectious diseases are centralised at national level. Official data from the national Retrovirology Laboratory of the Luxembourg Institute of Health (LIH) provide the number and proportion of IDUs in HIV infected patients. Between 1984 and 2017, 1,640 HIV infected persons have been recorded at the national level; 207 of the former were reported IDUs, which leads to an average proportion of IDUs in the national PLWHIV population of 12.6% since the reporting of the first HIV case in Luxembourg in 1984.

Currently intravenous drug use appears to be the third most reported transmission mode of new HIV infections since 1989 (heterosexual and homo/bisexual transmission are currently in first and second position respectively). The proportion of injecting drug use transmission has noticeably decreased between 1998 (23%) and 2011 (2.77%). The lowest proportion of IDU transmission mode ever recorded was observed in 2011 followed, however, by a subsequent increase until 2016.

Fig. 6.1 IDUs in newly infected HIV patients and total number of new HIV infections (1987-2017)



Source: Laboratoire de Retrovirologie – LIH, 2018; Rapport d'activité du Comité Sida, 2018 (data formatted by NFP)

The proportion of IDUs in newly detected HIV cases increased importantly between 2014 and 2016, whereas it decreased in 2017. An expert group worked on this issue in order to understand reasons for this increase and possible responses. The recent increase in cocaine injections seems to be part of the bigger picture. Higher availability of cocaine, more frequent injections due to shorter effect-windows compared to heroin, marginalised user groups with no or poor service contact as well as an increased proportion of drug use related prostitution in new HIV cases are some additional factors at play. Genotyping of new cases has been performed and results have been presented at the last EMCDDA DRID expert meeting. Research results are currently considered for publication. The HIV infection rates for all categories (HRDU and IDU) appear to be in an increasing trend since 2014 as well as the AIDS prevalence rate since 2015. First related research has been published (Fischer et al., 2017) and first response measures have been implemented in the framework of the current national drugs action plan and complementary offers have been included in the new HIV/AIDS action plan. Recent data from 2017 suggest a positive turn and reveal a decrease in the number of new IDUs diagnosed with HIV (10 in 2017, whereas 21 in 2016) and consequently in the respective proportion of IDUs among new HIV infected people (9.9% in 2017 and 21.4% in 2016).

The Origer and Removille study (2007) assessed the national HIV, HCV, HAV and HBV in the population of problematic users of illicitly acquired drugs prevalence via serological test results. Furthermore, the authors performed a cross sectional analysis of the relation between the studied infections and selected observable factors, to increase the national vaccination coverage and to refer infected persons towards appropriate medical treatment centres.

Main results are the following:

Table 6.1: Prevalence of hepatitis B surface antigens (HbsAg), antibodies to hepatitis B core antigen (anti-HBc), hepatitis C virus (anti-HCV), and HIV (anti-HIV 1 and 2) in HRDU and ever-injectors according to national recruitment settings

	Total number of respondents †	Anti-HBc and/or HBsAg* N‡, n (%; 95% CI)	Anti-HCV (%; 95% CI)	Anti-HIV 1 and 2 (%; 95% CI)
Total sample	362	310 67 (21.6; 17.1 to 26.2)	343 245 (71.4; 66.6 to 76.2)	272 8 (2.9; 0.9 to 4.9)
Ever injectors §	310	239 59 (24.7; 19.6 to 29.8)	268 218 (81.3; 71.4 to 91.2)	202 5 (2.5; 0.2 to 4.8)
Outpatient drug treatment centres	159	147 24 (16.3; 10.3 to 22.3)	158 92 (58.2; 50.5 to 65.9)	158 3 (1.9; 0.0 to 4.0)
Inpatient drug treatment centres	61	53 8 (15.1; 5.5 to 24.7)	61 46 (75.4; 64.6 to 86.2)	49 0 (0.0; 0.0 to 0.0)
Prisons	135	110 35 (31.8; 23.1 to 40.5)	124 107 (86.3; 80.2 to 92.3)	65 5 (7.7; 1.2 to 14.2)

Source: Origer & Schmit, 2012

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

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

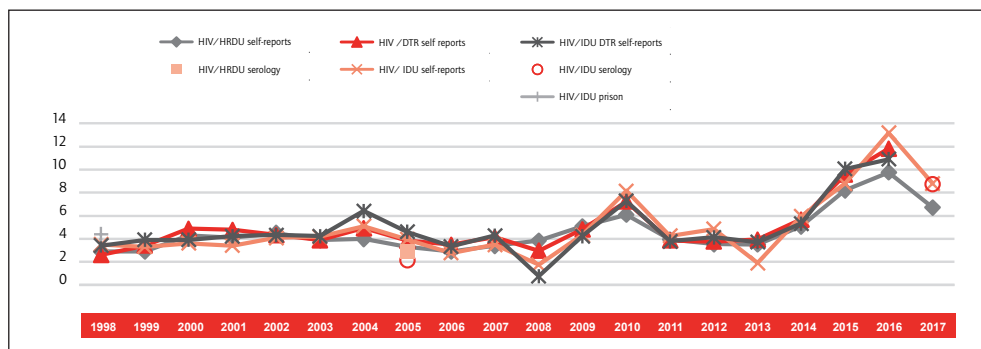
‡ Number of respondents for whom valid blood test serology for HBV was available

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

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2017, (N=123), 68.7% of RELIS indexed HRDU reported a HIV test during the last 12 months (14% reported not having done a test in the last 12 months; 14.5% do not know; 2.8% missing-values). The testing rates of female HRDU were slightly lower than those of male HRDU.



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



Source: RELIS, 2018 (2017 data); Origer & Schmit, 2012; HIV-UD, 2017

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

YEAR	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HIV rate in high risk drug users (RELIS self-report)	2.9	4.3	4.49	3.98	3.31	2.9	3.39	3.82	5.08	6.09	3.94	3.54	3.5	5.07	8.19	9.77	6.7
HIV rate in high risk drug users (serology-based) (Origer & Removille, 2007)	/	/	/	/	2.90	/	/	/	/	/	/	/	/	/	/	/	/
HIV rate in drug treatment demanders (DTR) (RELIS self-report)	2.6	4.87	4.32	4.93	3.84	3.49	4.13	2.96	4.83	7.22	3.85	3.76	3.92	5.66	9.56	11.81	/
HIV rate in current IDU (RELIS self-report)	3.5	3.6	4.08	5.10	3.96	2.76	3.48	1.75	4.32	8.14	4.26	4.84	1.9	5.94	8.8	13.18	8.8
HIV rate in current IDU treatment demanders (RELIS self-report)	3.4	3.9	4.32	6.41	4.59	3.33	4.27	0.76	4.24	7.29	3.77	4.14	3.7	5.31	10.07	10.09	/
HIV rate in life-time IDU (serology-based)	/	/	/	/	2.50	/	/	/	/	/	/	/	/	/	/	/	9.1
HIV rate in current IDU prisoners (Schlink, 1998)	4.4	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/

Source: RELIS, 2018 (2017 data)

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

YEAR	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
AIDS rate in problem drug users (RELIS)	2.5	1.35	1.72	2.13	1.81	1.19	1.86	0.87	1.33	3.05	1.95	0.79	1.67	1.41	6.33	3.33	3.1
AIDS rate in drug treatment demanders	/	1.76	1.60	2.69	2.37	1.65	2.64	0.92	1.96	3.96	2.05	0.65	2.6	1.28	6.74	3.34	/

Source: RELIS, 2018 (2017 data)

HIV rates in current HRDU have been varying over the last ten years although in quite narrow margins figuring 3 to 5%. In 2010, however, based on self-reported data from RELIS, the HIV rate increased for all categories figuring 6 to 8%. In 2011, 2012 and 2013, however, HIV rates stabilised around 3 to 5% to increase again in 2015 (8 to 10%) and 2016 (9 to 13%) for all categories. An indication of a positive turn

was observed in 2017. The self-reported HIV rate in HRDU and in IDUs (RELIS monitoring system data), as well as the serology data from a study on HIV rate in lifetime IDUs (Devaux et al., 2017) suggest a decrease in HIV among HRDU and IDUs in 2017. As for AIDS rate among HRDU, 2016 data indicated a relevant decrease, confirmed by the recent 2017 data.

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

YEAR	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Self-reported HCV rate in drug users (RELIS)	25	46	49	64.55	64.94	64.95	64.06	63.39	50.55	49.61	61.45	54.19	61.71	61.49	56.13	51.77	54.7
HCV rate in HRDU (Origer & Removille)	/	/	/	/	71.40	/	/	/	/	/	/	/	/	/	/	/	/
Self-reported HCV rate in drug treatment demanders	29	53	54	66.16	66.22	63.23	63.08	61.11	53.79	50.47	62.31	60.27	67.24	66.39	63.52	54.46	/
HCV rate in IDU prisoners (saliva tests)	37	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Self-reported HCV rate in IDUs (RELIS)	45	53	53	74.14	74.38	69.58	72.02	65.48	58.94	62.63	74.81	74.21	77.78	76.61	73.86	69.69	67.2
HCV rate in ever-injectors (HCV-UD project, 2017)	/	/	/	/	81	/	/	/	/	/	/	/	/	/	/	/	75.8

Source: RELIS, 2018 (2017 data); Origer & Removille, 2007; Devaux et al., 2017 (HCV-UD project)

Summarily, HCV prevalence in HRDU show fair variations. After a marked decrease between 2008 and 2010, and later in 2012, it reached 61.7% in 2013, and remained stable in 2014 (61.5%). In 2015 and 2016, a slight decrease was observed for HCV prevalence in HRDU (56.13% in 2015 and 51.77% in 2016), translating a high level stabilisation, which was confirmed by 2017 data (54.7%).

OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

Psychiatric co-morbidity (Dual diagnosis)

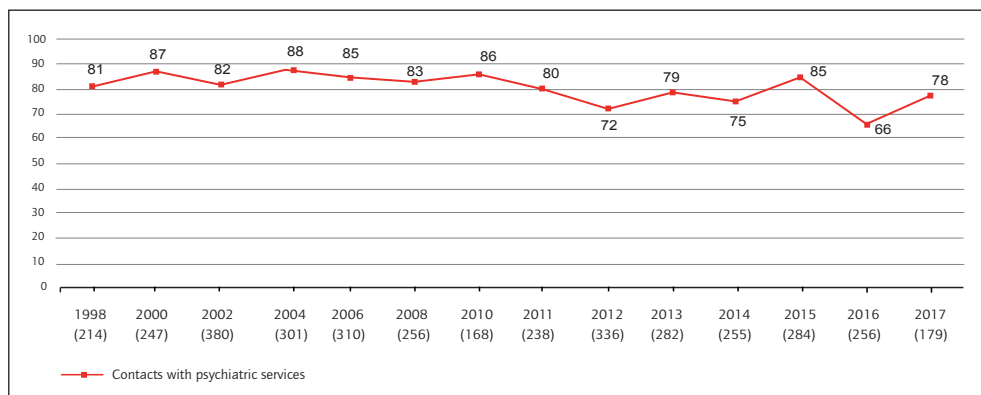
To date any genuine study on co-morbidity patterns in HRDU has been performed at the national level. Data presented in the present chapter have been provided by specialised drug agencies and the RELIS drug monitoring system and thus reflect experiences and trends as observed during recent years.

Most common mental disorders observed in clients seeking help in specialised drug agencies or in contact with other institutions are anxiety, depression, neurosis, psychosis and borderline behaviour. Residential drug care settings estimate that 10% of their clients show psychotic symptoms. Furthermore, Post-Traumatic Stress Disorders (PTSD) are most common and show great similarities with borderline behavioural aspects as for instance rapidly changing mood and auto-destructive tendencies.

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

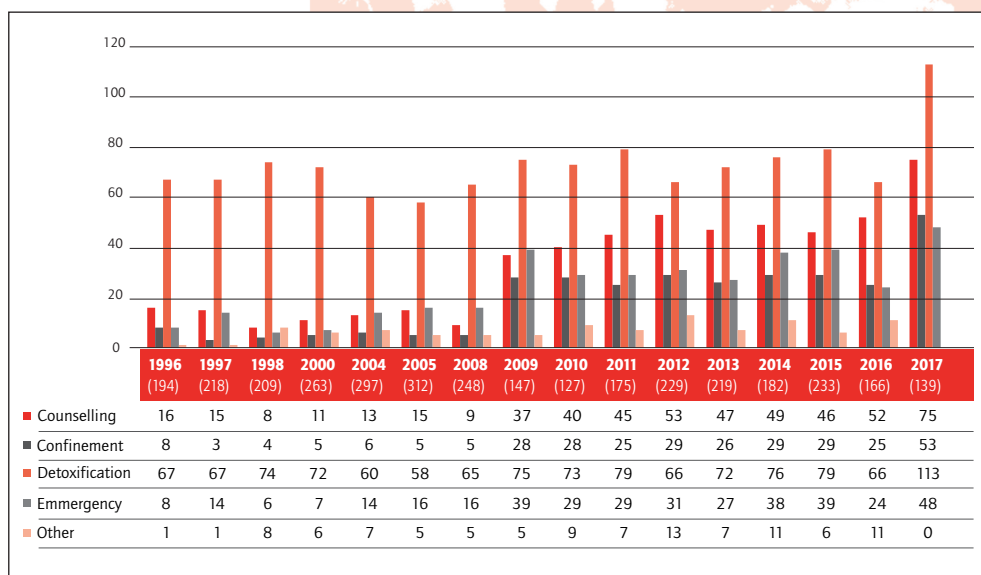


Fig. 6.3 Previous contacts with psychiatric services of RELIS indexed drug users (1998- 2017)



Source: RELIS, 2018 (2017 data)

Fig. 6.4 Reasons for psychiatric care demands 1996-2017



Source: RELIS, 2018 (2017 data)

Data from 1996 to 2011 reveal a fluctuating but fairly stable long term proportion of HRDU showing a psychiatric history, reaching, however, an historical minimum in 2012 to increase again in 2013 and 2015. After another significant decrease in reported the number of previous contacts with psychiatric services in 2016, data from 2017 shows a new marked increase.

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

DD patients are considered as drug treatment demanders with specific and highly diversified needs that are difficult to encounter in traditional drug care agencies. The concept of 'multiple vulnerabilities', i.e., concomitant vulnerabilities to drug abuse and mental disorders, tends to be recognised by professionals. DD patients very often present a lack of behavioural structure or stability. Usually those patients are unable to function in a regulated environment. Moreover, the requirement of most therapeutic settings include that the patients submit to detoxification treatment prior to admission. This latter requirement is often impossible to meet with DD clients as drug intake often represent a kind of self-managed auto-medication, dangerous to change radically at the beginning of a therapeutic process. It is therefore most difficult to integrate DD patients in traditional drug care settings also in terms of consistency of rules to be respected by all drug treatment demanders. To date, no care facilities specialised in drug addiction co-morbidity exist at the national level. The Department of Medical Control of Social Security Administration, in collaboration with drug agencies, assesses whether a given patient should be referred to specialised institutions in foreign countries. Agreements between the latter administration and a series of specialised care agencies abroad have been made. If the referral demand is approved, related costs are reimbursed by Social Security.

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

Compulsory treatment or confinement does only occur if there is a proved offence against the law by which the offender is declared irresponsible of his/her own behaviour. This only occurs following a legal psychiatric expertise.

Somatic co-morbidity

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed HRDU except for HCV prevalence. In 2017, 81% of high risk drug users reported a self-perceived satisfying general health condition against 53% in 1997. A total proportion of 50.6% report to have never experienced an overdose(s) during lifetime which represents a decrease compared with the previous year (74%).

DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

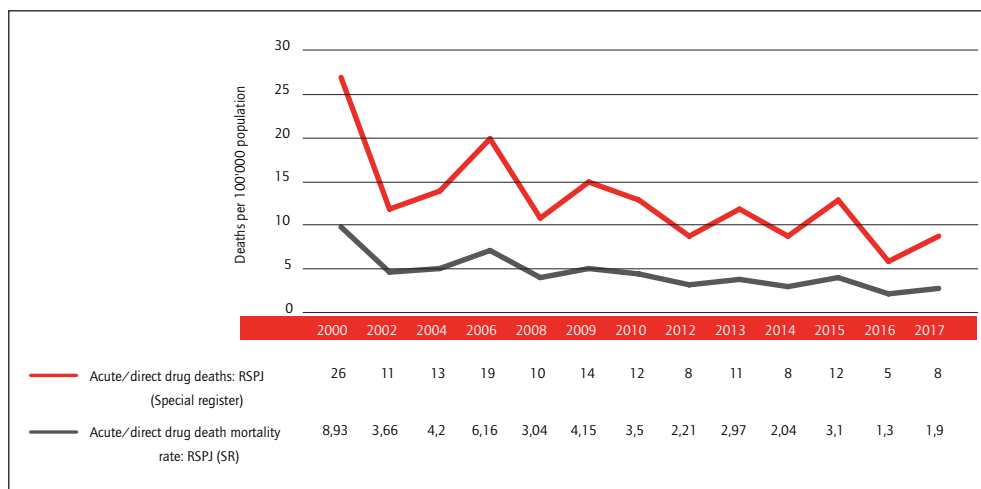
Direct drug-related overdose deaths

Methodological information and Drug-Related Deaths (DRD) data collection and processing routines can be found in the introduction of the present chapter and in annex I under 'Databases and information systems'.

The number of **fatal acute overdoses** indexed at the national level has shown an overall discontinuous decrease since the beginning of the 21st century. In 2000, 26 acute drug deaths were registered, whereas 5 cases were reported in 2016 and 8 cases in 2017.



Fig. 6.5: Evolution of drug-related death cases and mortality rates per 100,000 inhabitants aged 15 to 64 from 2000 to 2017



Source: National Judicial Police, Department of Drugs and the National Health Laboratory (2018) (2017 data)

According to most recent national prevalence figures on high risk drug users referring to data of 2015 (N = 2,257), (Origer, 2017), **overdose rate in HRDU** situates at 0.35 % cases / HRDU (1.1 % in 2000). The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants⁶⁰ in 2000. In 2016, overdose rates of 0.9 and 1.3 per 100,000 inhabitants aged 15 to 64 years respectively have been observed. In 2017, 1.9 overdose deaths per 100,000 inhabitants aged 15 to 64 years were observed (and 1.4 considering the entire population).

The overall discontinuous decrease of acute overdose cases from 1994 onwards has been associated to the regionalisation and extension of the methadone substitution programme as well as to the further development of low threshold facilities. The decreasing trend from 2000 to 2002 is thought to be a medium term consequence of the higher proportion of non-injecting opiate users observed during that same period followed by a stabilisation around 4.5 percent. The positive evolution of the number of direct drug-related deaths is to be associated to the implementation of the first national drug consumption room in 2005. Considering that since the opening in 2005 of the drugs injection room more than 2,200 overdose victims could be assisted and reanimated in this same facility, the life-saving effectiveness of such an offer is given.

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

Forensic data by the department of National Toxicology Laboratory on Health⁶¹ show that the most frequently involved substance in overdose cases is heroin, followed by methadone and cocaine. To stress that since 2000, the presence of methadone in blood samples of overdose victims has been increasing.

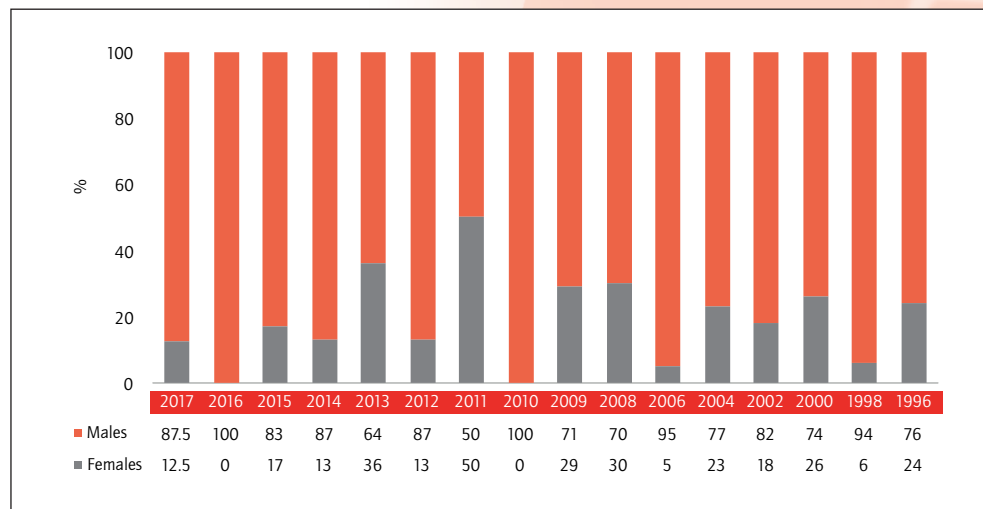
60 All age groups

61 Département de Toxicologie du Laboratoire National de Santé

Among the overdose victims in 2017, 7 were male. The mean age at the moment of death has been increasing over the past 20 years (in 1992: 28.4 years and in 2017: 41.5 years). Although the mean age of drug overdose victims has been increasing, the number of victims aged less than 20 years has been remaining relatively unchanged during the referred observation period (0 case in 2017).

Also worth mentioning is that a majority of acute drug death victims are known by law enforcement agencies (75%) for their drug user "career". As far as the place of death is concerned, since 2004 approximately 50-65% occurred at the victims' home (62.5% in 2017), followed by public places such as cars, trains or public bathrooms (25%).

Fig. 6.6: Gender distribution of direct drug-related death cases (1996 - 2017) (%)



Source: RELIS, 2018 (2017 data)

Table 6.5: Age distribution of direct drug death cases indexed from 1996 to 2017

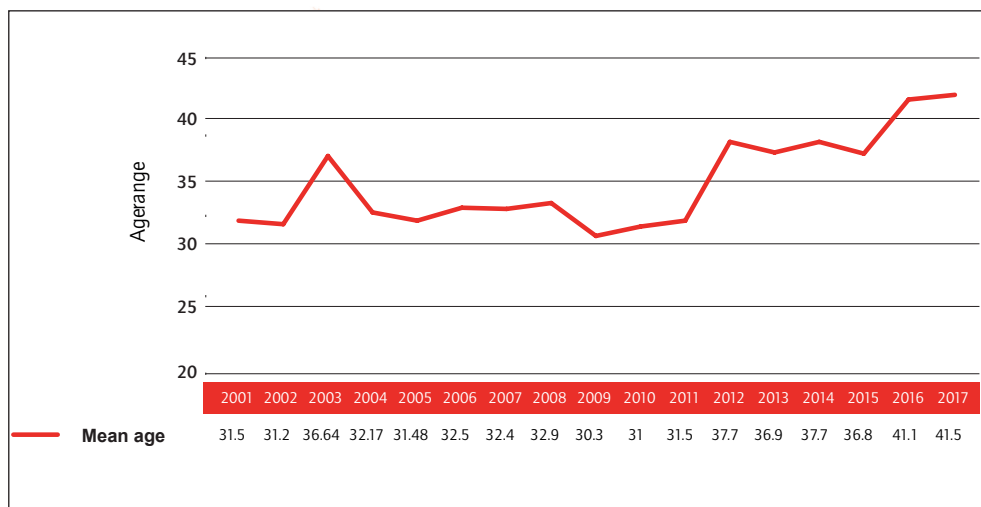
	2017	2016	2015	2014	2013	2012	2010	2008	2006	2004	2002	2000	1998	1996	Total
< 20	0	0	0	1	0	0	1	0	1	0	0	1	0	1	5
20-24	0	0	0	0	0	0	4	2	4	1	4	8	2	5	30
25-29	2	1	4	0	0	2	2	2	4	4	1	6	5	5	37
30-34	0	1	1	3	5	2	2	1	2	3	3	6	2	4	35
35-39	1	0	3	2	1	0	0	3	5	2	1	4	4	1	27
40-44	1	0	3	0	4	2	2	2	2	2	0	1	3	0	22
45-49	2	1	0	1	0	2	1	0	0	1	2	1	0	0	11
≥ 50	2	2	1	1	1	0	0	0	1	0	0	0	0	1	9
Mean Age	41.5	41.1	36.8	37.7	36.9	37.7	31	33.16	32.5	32.17	31.18	29	32.3	28.5	
Male	43.9	41.1	36.3	40.35	39	38.3	31	32Y8M							
Female	25	/	39.5	19.74	33.2	34	/	33Y8M							

Source: RELIS, 2018 (2017 data)



In 2012, the mean age of male overdose victims showed an important increase compared to previous years. Following a 3-years stabilisation period, in 2016 the mean age of male overdose victims showed again an important increase (41 years) confirmed in 2017 (41.5 years). The youngest victim in 2017 was aged 25 years (as in 2016) and the oldest was 53 years (51 years in 2016). No underage victim was reported in 2017. Considering the nationality of overdose victims, the majority (87.5%) were natives.

Fig. 6.7 Mean age of acute drug overdose victims 2001 -2017



Source: RELIS, 2018 (2017 data)

Mortality and causes of deaths among drug users

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

Since the implementation of ICD-10 coding by the GMR (1998), a vast majority of acute drug death cases have been recorded as 'accidental poisoning' (**X40 – X49**), which is consistent with the national definition of an acute overdose death. To date over 60% overdose cases have been indexed as follows: **X42.-, T40.-, T42.-, T43.-**. At a more restricted level the code sequence: **X42.-, T40.-** includes around 70% of all reported overdoses.

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

Abstract

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

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

Abstract

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

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

Abstract

Background/Aim: We analysed gender differences in national fatal overdose (FOD) cases related to opiates and cocaine use between 1985 and 2011 (n = 340). **Methods:** Cross-examination of national data from law enforcement and drug use surveillance sources and of forensic evidence. Bivariate and logistic regression analysis of male/female differences



according to sociodemographics, forensic evidence and drug use trajectories. **Results:** The burden of deaths caused by FOD on the general national mortality was higher for men (PMR/100 = 0.55) compared with women (PMR/100 = 0.34). Compared with their male peers, women were younger at the time of death ($t = 3.274$; $p = 0.001$) and showed shorter drug use careers ($t = 2.228$; $p = 0.028$). Heroin use was recorded more frequently in first drug offences of female victims (AOR = 6.59; 95% CI 2.97-14.63) and according to forensic evidence, psychotropic prescription drugs were detected to a higher degree in females (AOR = 2.019; 95% CI 1.065-3.827). **Conclusion:** The time window between the onset of illicit drug use and its fatal outcome revealed to be shorter for women versus men included in our study. Early intervention in female drug users, routine involvement of first-line healthcare providers and increased attention to use of poly- and psychotropic prescription drugs might contribute to prevent premature drug-related death and reduce gender differences.

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Origer, A., Bucki, B., & Baumann, M. (2014). *Socioeconomic inequalities in fatal opiate and cocaine related overdoses: transgenerational baggage versus individual attainments*. Paper presented at the 28th Conference of the EHPS « Beyond prevention and intervention: increasing well-being », 26th-30th August, 2014, Innsbruck, Austria.

Abstract

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

Origer, A., & Baumann, M. (2013). *Suicide attempts prior to fatal overdose in Luxembourg from 1994 to 2011*. Paper presented at the 21st World Congress Social Psychiatry, 29th June – 3d July 2013, Lisbon, Portugal.

Abstract

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

Origer, A., & Baumann, M. (2013). *Opiate and cocaine related fatal overdoses in Luxembourg from 1985-2011: a time-stratified study*. Paper presented at the 21st IUHPE World Conference on Health Promotion. 25-29th August 2013, Pattaya, Thailand.

Abstract

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



7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

INTRODUCTION

Responses to health correlates and consequences of drug use aim at minimising risk and damage for the drug users and their environment, and at increasing individual and collective resources. The concept of risk and harm reduction is directly linked to health consequences of drug use, whereas nuisance reduction is seen as a correlate of the latter.

Health care offers to drug users are provided by specialised drug care agencies as well as by the general health care system. Major efforts have been undertaken in recent years to improve data on drug treatment demands from general healthcare providers by including psychiatric departments of general hospitals in the RELIS data collection network and the implementation of a national substitution treatment register. In addition to the national drug surveillance system RELIS, these new data sources and tools will allow to draw a more accurate picture of intervention outcomes.

At present, national drugs action plans, the national HIV/AIDS action plans, and a national action plan on hepatitis exist.

- national drugs action plans: <http://sante.public.lu/fr/prevention/drogues/politique-drogues-addictions/index.html>
- national HIV/AIDS action plans: <http://sante.public.lu/fr/politique-sante/plans-action/plan-action-nationale-sida-2018-2022/index.html>
- national action plan on hepatitis: <http://sante.public.lu/fr/politique-sante/plans-action/plan-action-nationale-hepatites-2018-2022/index.html>

As far as availability of service is concerned, currently two national agencies offer harm reduction services in the Centre, the South and the North of the country including offers such as day and night shelter and a supervised injection facility (currently in Luxembourg City). The decentralisation of respective offers by implementing new integrated low threshold centres for drug addicts in the South of the country and by further developing harm reduction measures in the North are ongoing. A new harm reduction service has opened in the North of the country in February 2014.

Moreover, a new centre is currently under construction in the city of Esch/Alzette (i.e. in the South of Luxembourg) and expected to open in the second semester of 2019. The centre will include the second national supervised drug consumption room offering the possibility of supervised drug injections and inhalation. The concept also includes medical and psychosocial care and referral to specialised services.

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

Research and recommendations

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

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

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

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

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

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

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

Drug injection rooms and low-threshold shelters

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

The implementation of a first drug injection room in 2005 has to be seen as a part of a broader harm and nuisance reduction oriented strategy. The national drug action plan refers to the creation of low threshold emergency shelter facilities for drug addicts to be implemented regionally.

A low-threshold emergency centre for drug addicts (Abrigado) was inaugurated in December 2003 and initially provided day care and night shelter. In July 2005, the first supervised injection room at national level has become operational and has been integrated in the Abrigado centre, which from then on has been providing the entire range of harm reduction services, counselling facilities, accommodation, washing and laundering facilities. It should be added that the night accommodation offer is not to be seen as a permanent housing facility; there is a daily admission procedure. The target population for the consumption room are primarily IDUs, although the number of non-IDUs has been progressively increasing, suggesting a change towards safer administration modes. The main objective of the project is the reduction of drug-related harm, nuisances' reduction being a secondary objective. More precisely it aims at reducing the risks of overdoses, infectious diseases, public nuisance in the neighbourhood, facilitating contact making with difficult to reach addicts, provision of special designed night shelter facilities and avoiding unnecessary



prison journeys overnight. The project was designed with the support of the Public Prosecutor's Office and law enforcement agencies.

The National Drugs Coordinator's office elaborated the operational concept of the injection room based on available international experience, literature and evaluations. In terms of management, all involved parties meet regularly (called 'the Monday round') to assess the current situation and emerging problems related to the functioning of the consumption room. Incidents, nuisance reports, trends, quality assurance, workload, technical improvements and safety issues are addressed by the 'Monday round' in order to promote rapid solution finding and continuous adaptation to fast changing clients' profile and consume patterns.

Table 7.1 provides an insight in clients' statistics of the Abrigado services since their opening and for 2009 to 2017, respectively:

Table 7.1: Clients statistics of Abrigado centre services (2005-2017)

Injection Room	June 2005 - December 2017	2009	2010	2011	2012	2013	2014	2015	2016	2017
Number of user contracts signed	1,850	94	108	98	222	139	142	108	112	133
Number of users' episodes	424,613	36,558	33,017	26,929	37,004	38,633	40,012	49,120	57,333	61,104
Number of injections	488,274	43,871	39,960	31,588	40,234	40,610	42,644	56,178	67,083	73,154
Number of non-fatal overdoses	2,079	198	327	283	313	378	226	79	69	20
With loss of consciousness	344	54	42	33	37	54	32	20	29	10
Without loss of consciousness	1,735	144	285	250	276	324	194	59	40	10
Number of fatal overdoses	0	0	0	0	0	0	0	0	0	0
Medical emergency interventions	358	46	33	31	43	42	37	31	38	15
Day care	December 2003 – December 2017	2009	2010	2011	2012	2013	2014	2015	2016	2017
Number of clients	722,060	77,333	65,307	62,925	55,622	55,575	59,700	60,144	65,753	74,621
Night shelter	December 2003 – December 2017									
Number of different clients with overnight stay	3,059									

Source: Abrigado, 2018

In January 2012, Abrigado moved into new premises and since February 2012, a separate blowroom has completed the existing offer. Currently the night shelter is open 7 days a week from 22:00 to 07:30 with a capacity of 42 beds. The Abrigado day centre, the injection room (8 injection tables) and the blowing room (6 tables) are open 7 days a week. Abrigado facilities are mostly used by men (84% in 2017); the most commonly used drugs were heroin (67%), cocaine (23%) or both of them (7%). Cocaine use has decreased in 2011 and 2012, to stabilise in 2013 and 2014. In 2015 and 2016, however, an increase of cocaine use was observed (2014: 6%, 2015: 13%, 2016: 15%) that has been continuing to increase towards 23% in 2017. Concerning the administration mode (and regardless of the substance), in 2017, 49% of the Abrigado users were injecting while 48% were smoking/inhaling and 3% sniffing. This represents a decrease of the injection route (57% in 2016) and an increase regarding safer administration routes (in 2016, 41% smoked/inhaled and 2% sniffed their preferential drug). Age category 35 to 44 years is the most representative (54% in 2017 and 52% in 2016).

No fatal overdose has occurred within Abrigado facilities until the end of 2017 whereas over 2,200 overdoses episodes have occurred since the opening of the injection room and due to the immediate intervention of ad hoc staff all victims could be assisted, reanimated and their lives saved. A new centre was opened in the beginning of 2012. Its implementation site is the immediate vicinity of the previous centre. Architectural planning of the replacement structure has built upon past experience and a supervised drug inhalation facility (blowroom) was included in the existing offer in 2012. The concept of the drug injection room has been revised accordingly.

As most relevant drug scenes concentrate in the City of Luxembourg and in the main city in the South of the country, the governmental programme has foreseen the creation of an integrated low threshold offer (including a supervised consumption room) also in the city of Esch-sur-Alzette. Its opening is scheduled for the second semester of 2019. The centre will include the second supervised drug consumption room nationally offering the possibility of supervised drug injections and inhalation by the beginning of 2019. The concept also includes medical and psycho-social care and referral to specialised services.

As far as the northern region of the country is concerned, a needs' assessment, commissioned by the Ministry of Health, (JDH, 2011) clearly emphasised the need of a tailor made low-threshold offer in the region. However, the type of offer needed appears to differ from those currently existing in bigger cities such as Luxembourg and Esch/Alzette. The drug user population living in the northern region is not locally concentrated and non-intravenous use has been reported to be more prevalent than IDU. This said, the phenomena of stigmatisation, isolation and marginalisation of drug users is far more concerning. Moreover, the development of region wide outreach work in addition to community offers appears to be a promising strategy for the northern region. A new low threshold day centre, called Contact-Nord, opened its doors in Ettelbrück in February 2014. The Contact-Nord covers three main activity fields: health and hygiene services, social and psychological assistance and needle exchange programme.

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

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

Heroin assisted treatment (HAT)

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



A drug scene survey was performed in 2008 (JDH, 2009) in order to investigate perceptions and opinions regarding the implementation of HAT. 174 drug users in contact with drug care institutions were interviewed. 85% of respondents consider HAT to be a useful complementary offer for the following reasons (in order of importance): reduction of criminality and petty crime, clean quality controlled heroin, reduction of drug-related mortality, social stabilisation and reduction of harm and health damage. 62% of interviewees declared themselves to be personally interested to enter HAT if available.

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

Moreover, in the framework of the decentralisation of specialised care and harm reduction offers, the creation of a second low-threshold centre in the South of the country is in process. This second harm reduction facility should become operational in 2019 and will include supervised consumption rooms (injection and blow rooms) similar to those of Abridado in Luxembourg-City.

PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

Prevention

Interventions aiming at the prevention of drug-related infectious diseases as for instance needle exchange and substitution programmes have been initiated and developed prior to the set-up of a specific legal framework. The drug law amendment of 2001 did not only allow maintaining and to further developing existing harm reduction offers but also set the foundation for the implementation of new services such as supervised drug injection rooms and medically assisted heroin distribution as foreseen by the national drugs action plan.

The objective of these interventions is straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Both IDUs and non-IDUs are target groups of HR interventions. The inclusion of a drug inhalation facility in the Abridado centre is a sound example of the national approach. Furthermore infectious diseases prevention should not focus exclusively on IDUs as shows a recent action-research project on HIV and hepatitis infection among HRDU (Origer and Schmit, 2010).

The most relevant measure in the field of prevention of infectious diseases in drug users is the national needle exchange programme (NEP) established in 1993 and co-ordinated by JDH. In addition to free of charge needle provision by specialised drug and AIDS agencies, automatic syringes dispensers/collectors have been placed in the most appropriate locations in four different cities of the Grand Duchy.

Regarding the quantity of distributed syringes, Table 7.2 shows that the number of distributed syringes peaked in 2005 and has been significantly decreasing from 2006 onwards, although the return rate remained consistently high. From 2011 onwards quantities of syringes distributed through NEP have been decreasing to increase again since 2014. The number of re-collected used syringes exceeded in 2009 the number of distributed syringes via the national NEP, (vending machines excluded), which suggests that users also bring along syringes bought in pharmacies or originating from vending machines, which is considered to be a highly positive evolution. From 2010 to 2016, the number of collected used syringes has been ranging between 90-97%. In 2017, 92% of all syringes that were distributed were recollected.

According to RELIS data, one third of IDUs procure their syringes primarily in pharmacies. This proportion has remained fairly stable over recent years and does not directly impact on trend figures from specialised needle exchange points.

Table 7.2: National needle exchange programme (NEP) 1996-2017 including specialised agencies, vending machines and the supervised injection room

	Distributed syringes	Collected used syringes
1996	76,259	28,646 (38%)
1998	109,743	58,886 (46%)
2000	189,413	112,625 (59%)
2002	254,596	211,621 (83%)
2004	435,078	376,491 (87%)
2006	332,347	282,909 (93%)
2008	259,607	249,400 (96%)
2009	289,555 of which 45,529 via injection room and 13,353 via vending machines	301,895 (104%)
2010	308,350 of which 44,830 via injection room and 8,109 via vending machines	297,400 (97%)
2011	246,858 of which 35,761 via injection room and 5,169 via vending machines	221,975 (90%)
2012	211,439 of which 29,362 via injection room and 1,336 via vending machines	201,510 (95%)
2013	190,257 of which 23,631 via injection room and 1,127 via vending machines	177,790 (94%)
2014	250,552 of which 24,256 via injection room and 358 via vending machines	235,542 (94%)
2015	359,340 of which 33,633 via injection room and 245 via vending machines	334,881 (93%)
2016	423,060 of which 45,449 via injection room	397,405 (94%)
2017	437,946 of which 39,298 via injection room	406,641 (92%)

Source: Activity report Comité de Surveillance SIDA, 2018

A syringe and needle exchange programme has started in the national prison (CPL) in August 2005. Inmates are seen by medical staff on request and if indicated, an initial injection kit containing sterile injection paraphernalia is handed out. Sterile replacement syringes are delivered on presentation of the used ones and the initial kit. The program is placed under medical secret.



Table 7.3: Needle exchange programme (NEP) in prison (CPL) 2005-2017

	Distributed injection kits	Distributed syringes
08/2005 – 12/2006	64	300
2007	24	77
2008	36	178
2009	33	261
2010	34	328
2011	30	440
2012	48	1,383
2013	31	1,726
2014	46	2,101
2015	40	1,807
2016	31	1,612
2017	23	1,372

Source: CPL, 2018

Quality assurance and follow-up of new injection paraphernalia on the market is ensured by a special expert group chaired by the National Drugs Coordinator, who introduced nationwide distribution of low dead space syringes in 2014 in order to further reduce the spread of blood-borne infectious diseases via injecting drug use.

Moreover, outreach interventions targeted at (drug using) sex workers aiming at establishing contact and to prevent dissemination of infectious diseases have taken place. According to EMCDDA's key indicators and with a view to improve quality of national data on infectious diseases, the NFP has performed an action-research with the objective to estimate HCV and HIV prevalence in HRDUs and IDUs based on medical diagnosis data (blood testing) and to recommend the implementation of required health care measures. The development of new measures to reduce drug-related infectious diseases (e.g. rapid testing, DIMPS, inhalation rooms) largely built and still builds upon the recommendations of the referred report published in September 2007 (Origer & Removille, 2007).

Counselling and testing

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

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

environment has been launched in September 2017. First data indicate that, in 2017, 1,417 syringes were distributed (1,301 were collected) and a total of 552 client contacts were registered.

Finally, it should be stressed that HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison by medical staff.

Infectious diseases treatment

The national service for infectious diseases, implemented within the CHL, provides specialised treatment of infectious diseases. In case the patient has no or no valid health insurance, treatment costs may be covered by state.

Since 2009, a nurse practitioner coordinated clinic for infectious diseases in national prisons was developed (COMATEP) due to the high prevalence of HIV, viral hepatitis and other infectious complications related to illicit drug use.

RESPONSES TO OTHER HEALTH CORRELATES AMONG DRUG USERS

Somatic co-morbidity and general health related treatment

According to longitudinal RELIS data, the general state of health of drug users appears to have improved during the last decade, which could be partly due to the significant development of harm reduction and treatment referral offers.

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

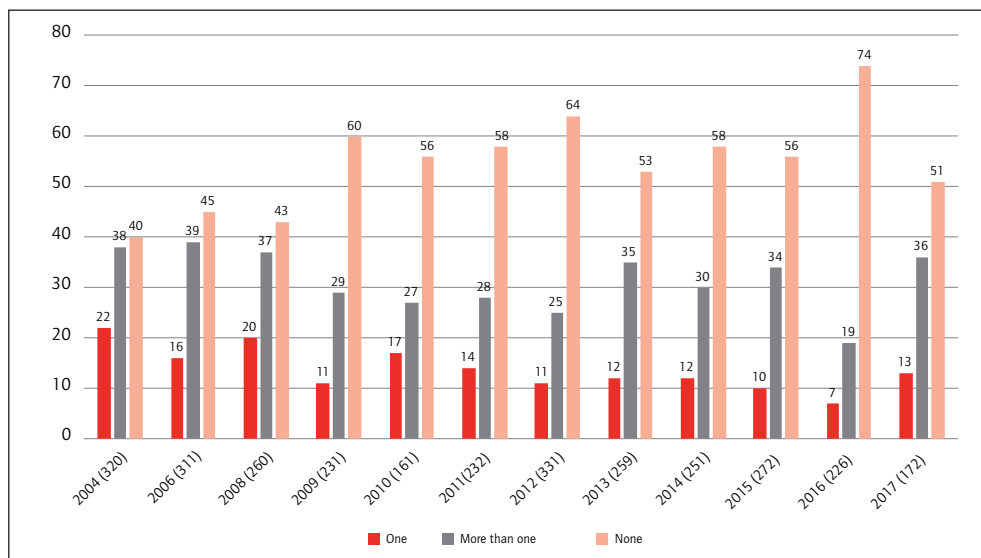
Since the 2010–2014 drugs action plan, a medical service providing free and on site medical care to drug users independently of the institutional setting they are in (except hospitals) has been foreseen.

Non-fatal drug-related emergencies

No specific data on drug-related emergencies are currently available at the national level. Figure 7.1 refers to RELIS data on previous non-fatal and medically assisted drug overdose self-reported by HRDU. The proportion of indexed drug users reporting at least one overdose (as defined) has stabilised in recent years and decreased in 2016. In 2017, a new increase in these figures was observed (13% experienced of at least one and 36% experienced more than one overdose). These figures have to be seen in the light of the significant number of overdose incidents that have occurred in the national supervised drug injection room without fatal consequences, due to immediate assistance (more than 2,200)



Fig. 7.1: Non fatal drug overdoses in RELIS respondents (2004 - 2017) (valid %)



Source: RELIS, 2018 (2017 data)

Note: sample sizes in brackets

Prevention and reduction of road traffic accidents related to drug use

The law of 18 September 2007 modifies the national traffic code and introduces testing of illicit drug use in vehicle drivers. The homologation of respective roadside tests has been regulated by a grand-ducal decree of November 18, 2011. For more details on the new legislation please refer to chapter 1 (laws).

Interventions concerning pregnancies and children born to drug users

In the context of the development of social paediatrics at national level, childcare professionals and paediatricians call for the implementation of specialised care structures for children at risk. The approach of social paediatrics considers a child in his global context including physical, psychological, social and cultural health, family and environmental context and promotes coordination and collaboration between different social and medical services.

Due to the improvement of, and the better access to drug-related treatment and especially the spread of substitution treatment, the birth rate in drug users has increased over recent years. This evolution has been leading to the first parental project launched by JDH in 2003 with the aim to provide psychosocial aid to drug-dependant parents and their children. The primary objective of the project is to ensure security and well-being to children and to strengthen parents' educative abilities. This long-term project is based upon contractual commitments, co-intervention, home visits and functions in close collaboration with involved services. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

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

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

INTRODUCTION

Social correlates of drug use involve Justice, Health and Educational competences. The Ministry of Health and the Ministry of Family and of Integration both intervene by financing measures to reduce social consequences ranging from early detection of drug use to social-professional rehabilitation interventions. The reduction of drug-related crime drug supply involves the Ministry of Justice and the Ministry of Internal Security. The Ministry of Health implements besides treatment and specialised counselling offers, various measures targeting socio-professional re-integration of drug addicts and thus the prevalence of acquisition crimes.

SOCIAL EXCLUSION AND DRUG USE

Social exclusion among drug users

The question whether substance abuse leads to social degradation and exclusion or social factors (e.g. family situation, poverty, low education, or job perspectives) lead individuals to substance use is an unanswered one. Obviously, a vast majority of homeless and socially excluded people also present to various extends licit and/or illicit substance abuse. Moreover, economic parameters tend to have a tangible impact on drug use prevalence and patterns as well as on the level of acceptance and perception of drug addicts by the general population.

A sound example of how social rejection and drug abuse are dynamically linked might be seen in the national results of the 4th wave of the European Values Study⁶². In total, 55% of national respondents (N: 1,610) described drug addicts as most unwanted neighbours. In 1999, drug addicts occupied the second position (43%).

Furthermore, providing medical and psychological care to drug dependent persons is not enough, as the social situation of these people needs to be improved before sustained outputs in drug treatment is expectable. This said, the national strategy of care for socially excluded people is based on the principle of progressive reintegration through capacity building and the improvement of the social abilities and environment. Associations as 'Stëmm vun der Strooss' (Street voice) and Quai 57, financed by the Ministry of Health, try to involve the target population again in active life by providing a safe and common environment and respecting individual capacities and resources by applying case management methodologies further described below.

62 EVS Foundation./Tilburg University: European Values Study 2008, 4th wave, Integrated Dataset. GESIS Cologne, Germany, ZA4800 Data File Version 1.0.0 (2010-06-30) DOI:10.4232/1.10059.

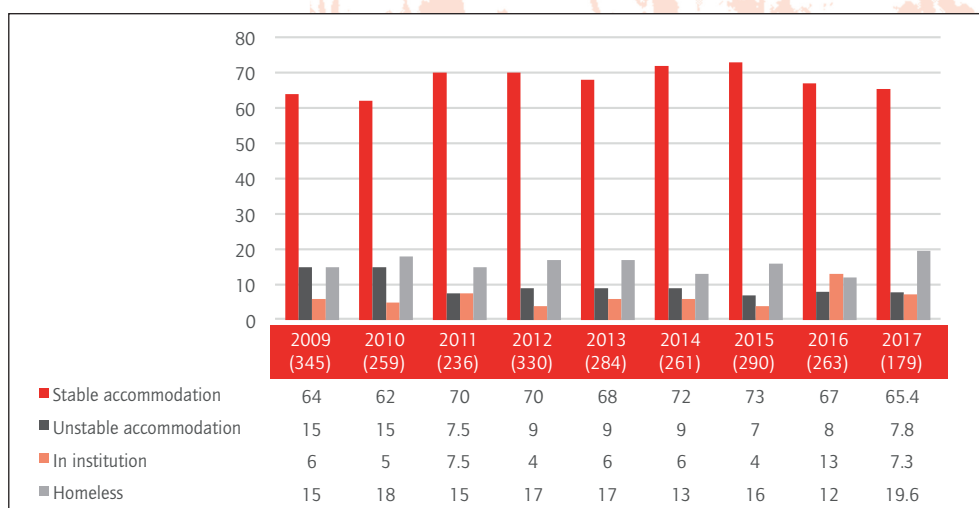


Drug use among socially excluded groups

Homelessness

Housing status of registered drug users has markedly improved over time and tends to stabilise over the last years. Since 1995, the proportion of persons disposing of a stable accommodation has more than doubled. Comparable to 2016, in 2017 65.4% of high-risk drug users (HRDU) report a stable housing situation (RELIS 2017 data). This evolution may be linked to an increased awareness of the housing problem and the set-up of new housing networks for socially deprived people by the Ministry of Health and specialised agencies. Recent figures also tend to confirm that although specialised accommodation offers have been further developed, the current economic situation has created an even higher demand for this type of housing.

Fig. 8.1: Last known housing situation of high-risk drug users (2009-2017) (valid %)



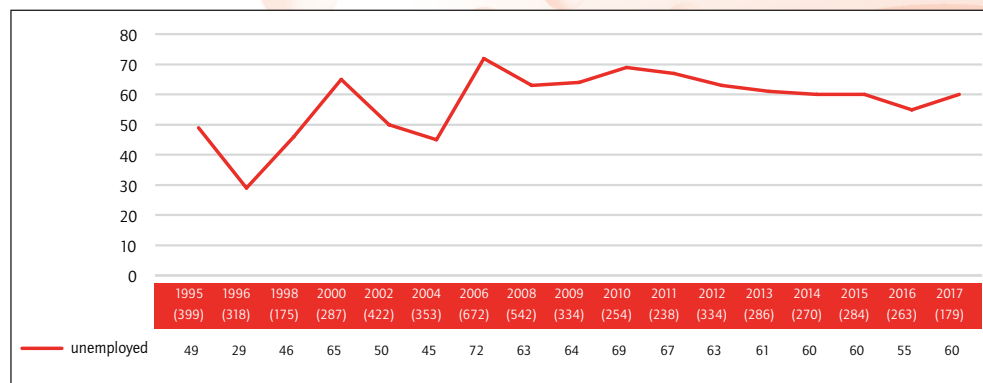
Source: RELIS, 2018 (2017 data)

Unemployment and financial situation

The **professional inactivity rate in HRDUs** (shows a weak decrease between 2011 and 2016, with a slight increase in 2017 (60%). However, an in-depth analysis shows that the proportion of active respondents reporting a stable job situation seems to stabilise around 15-16% over the last years (e.g. long-term contract; 14.5% in 2017). In 2016, an increase of the proportion of active respondents was observed (18%), comparable to the proportion of active respondents in 2017 (20.6%). The national unemployment rate, seasonally adjusted, in the active general population has been fluctuating between 4.9% and 7.2% since 2009 (mean rate of 5.5% in 2017), revealing that unemployment in HRDUs is an important issue (STATEC, 2018).

The RMG (Guaranteed Minimum Income; 37.4%), financial resources from parents and/or heritage (6.2%) and a proper salary (17.3%) represent the main sources of primary income among HRDU. Between 1997 and 2017, strong variations have been observed in relation with these three revenue sources. Concerning secondary income sources, 5.1% referred to 'illegal activities'⁶³.

Fig. 8.2: Unemployment rate in high-risk drug users (1995-2017)

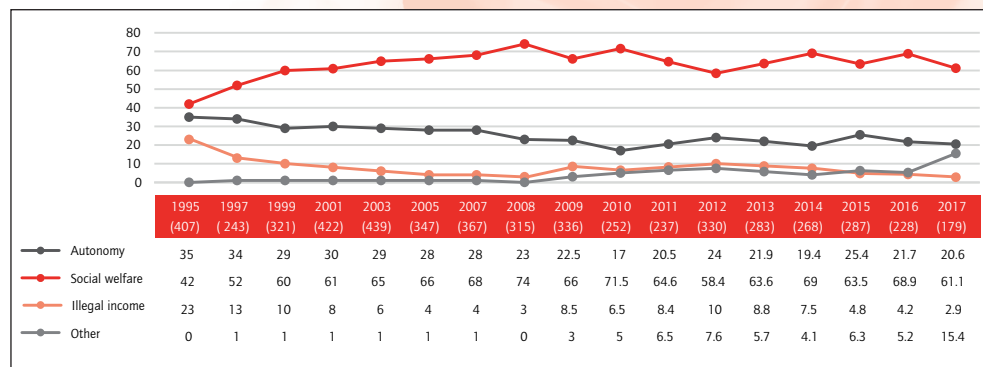


Source: RELIS, 2018 (2017 data)

Data on revenues confirm observed trends in occupational status:

- a fairly stable majority of indexed drug users rely on social welfare (social aids, unemployment or pension benefits). The Guaranteed Minimum Income (RMG) constitutes the primary source of revenue of HRDU (37.4% in 2017). In 2017, 17.3% reveal a **stable income**.
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 2013.

Fig. 8.3: Primary source of income among high-risk drug users (1995-2017)



Source: RELIS, 2018 (2017 data)

Educational level

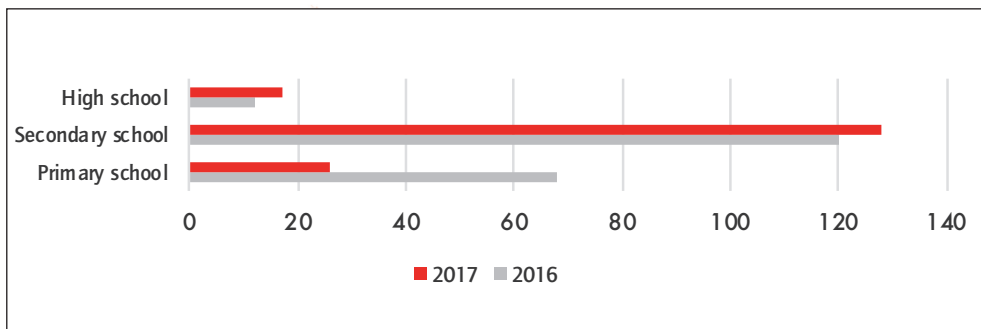
The study of 'School leave in Luxembourg'⁶⁴ (2006) surveyed a population of 37,347 secondary school students during 1st November 2004 and 30 April 2006. A total number of 2,422 students left school without a professional certification (temporary stay offs from school have also been taken into consideration). The study refers to a proportion of 6.5% of 'school leavers'. This proportion figures 3.6% if one is considering the total number of students having been reached but did not reintegrated a school in Luxembourg. Concerning this category of school leavers, composed of students attending courses abroad, being employed, following

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



professional insertion measures and those without occupation (N=1,357), the situation was as follows: 41.2% of students who dropped school have integrated the job market (work or professional insertion measure), 39.8% didn't work nor went to school and 19% attended school courses abroad. In general, boys, youngsters from abroad and aged more than 15 years (age of school obligation in 2006) are more vulnerable to the risk of early school leave.

Fig. 8.4: Educational level of RELIS respondents



Source: RELIS, 2018 (2017 data)

Regarding HRDU, the **educational level** of the latter, low and mostly incomplete, has been showing a creeping deterioration since 1999 according to baseline data from RELIS. An increasing proportion of respondents start secondary school without bringing their studies to term. The average age at the end of studies shows a global increasing tendency over the last 7 years and currently situates at 18.3 years. Lower levels are particularly observed as regards acquired secondary and high school diploma.

SOCIAL REINTEGRATION

Housing

Social reintegration measures, and in particular improvement and diversification of housing offers for drug addicts, have been one of the priorities of the 2000-2004 national drugs action plan. The 2005-2009 drugs action plan has foreseen the expansion of existing projects and the implementation of new decentralised reintegration measures based on the previously described principle of progressive reintegration through capacity building and the improvement of the social abilities and environment.

In the framework of the 2000-2004 action plan, the Ministry of Health, jointly with the City of Luxembourg opened a **night shelter** (called 'Nuetseil') **for drug addicts** in December 2003 which has evolved in an integrated low threshold care centre for drug addicts (Abrigado) including day and night shelter offers, accommodation and a supervised drug injection facility.

An offer called 'Les Niches' functions as a social real estate agency for drug addicts. Around 56 flats and apartments are rented by a drug-counselling centre and provided to drug addicts in need by means of tailor made renting contracts. One of the medium term aims of the project is to allow demanding drug addicts to take over the renting contract on basis of their own financial means and thus dispose autonomously of a stable accommodation. The project is jointly financed by the Ministry of Health, the National Fund against certain forms of criminality, and the City of Luxembourg (VDL). The vast majority of real estates are rented

by the JDH from private proprietors; the remaining ones belong to the National Housing Fund (Fonds de Logement) or to municipalities.

A network of **supervised housing facilities** for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone are operational since September 2002 and are situated in the vicinity of the main centre in order to take advantage of training and social reintegration facilities offered by the Centre Thérapeutique de Manternach (CTM). The CTM also offers educational aid in several domains as well as professional training opportunities. In total, 25 persons can benefit from the referred offer that builds upon apartments and houses situated in various municipalities.

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

In all programmes, apartments are subcontracted by the NGO/agency to clients and the former are liable to the actual proprietors. This avoids immediate conflict situations in case a client has transitional problems to pay the monthly rent. Rents are also typically lower than general real estate market prices. In the framework of these programmes, beneficiaries are also offered the possibility of financial management and follow-up in case of debts for instance. In the medium and long term, residents may be able to sign a proper rental contract or move to an autonomous housing. The supervised housing projects have allowed thus far to stabilise most of beneficiaries, to avoid relapse and to create the necessary conditions for a socio-professional (re)-integration.

Education, training

Aiming professional reintegration, a series of residential drug care centres offer language courses in order to provide clients with basic language skills (if necessary) or to improve their writing skills.

'D'Stëmm vun der Strooss' association ('Street voice' association) primarily takes care of homeless people providing them with low threshold facilities and offering social and professional reintegration activities such as literacy courses (provided by volunteers) and workshops (in journalism and radio broadcasting) held by professionals.

Employment

Another reintegration project run by the referred association is the therapeutic writing board, where homeless people are given the opportunity to **editing, printing, publishing and distributing an in house magazine**. This activity is supervised by professionals (one educator and one pedagogue). Addressing social matters is supposed to help clients to regain a sense of responsibility and to increase the level of acceptability in the general public (therapeutic aim). Another aim is sensitizing a wider public and helping homeless people familiarize with new technologies. HRDU constitute a significant fraction of their clients.

Additionally, clients are offered task and job opportunities in the laundry service called '*Schweessdrëps*' (*Drop of sweat*) which covers the South of the country and is specialised in washing sports teams' uniforms. Besides these two main work-opportunities, the service also offers a therapeutic workshop called '*Dressed for success*'. The service has been managed by clients (offering them a job opportunity and responsibility). Their main task is to organise (collect, wash, store, etc.) clothes offered by donors.

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



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

INTRODUCTION

The main source of information for this chapter is the Judicial Police Service (SPJ), Specialised Drug Department (section stupéfiants), in Luxembourg.

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

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

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

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

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

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

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

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

Judgement by which the accused person is found guilty.

- '*Détention*' (Eng. *Imprisonment*) :

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

DRUG-RELATED CRIME

The National Focal Point (NFP) in Luxembourg from the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) processes anonymous nation-wide data on drug-related offences provided by the law enforcement agencies required for the editing of the national report on drugs and to fulfil international data requirements (EMCDDA, UNODC, etc.).

Drug law offences

As can be seen in Table 9.1, the total number of arrests for drug-related offences has increased discontinuously until 2010, and then decreased until 2014. A slight increase was observed in 2015 and 2016, whereas in 2017 a decrease occurred. Cannabis was the most frequent substance involved in drug-related arrests, followed by cocaine and heroin in 2017.

Table 9.1: Arrests by type of reporting institution (2001-2017)

Year	ARRESTS													
	2001	2003	2005	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
S.P.J.	7	25	26	49	32	20	15	33	6	11	3	31	16	12
Police	45	82	94	79	102	92	166	97	119	128	138	165	206	158
Customs	40	28	35	41	54	33	48	51	44	36	26	21	12	13
Total	92	135	155	226	188	145	229	181	169	175	167	217	234	183

Source: Specialised Drug Department of the Judicial Police (SPJ), 2018 (2017 data)

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP) has been stabilising between 2001 and 2008. From 2012 to 2015, the number of referred police records has been increasing anew (2010: 2,546 records, 2015: 3,385) but records have been decreasing the past two years with 2,624 police records in 2016 and 2,525 records in 2017, respectively.

From 2003 to 2008, one observes a significant decrease in drug law offenders, but obviously a new increase in 2009 (1,963) and 2010 (2,530). In 2011 and 2012, a decrease is observed as regards the number of drug law offenders (1,782) as well as for the number of arrests (169). In 2016, the number of arrests was still increasing (234) while the number of offenders showed a decrease (2,566). The number of arrests decreased again in the year 2017 (183) with 1,969 individual offenders reported by the Specialised Drug Department of the Judicial Police.

Table 9.2 records the total number of law enforcement interventions and number of 'prévenus' at the national level ensured by respective law enforcement actors that are the Specialised Drug Department of the Judicial Police (SPJ), Police and Board of Customs from 1997 to 2017. Compared to previous years, the number of drug law enforcement records and individual drug law offenders has slightly decreased in 2017.

Table 9.2 Number of national law enforcement interventions (1997-2017)⁶⁵

Year	DRUG LAW ENFORCEMENT RECORDS															
	97	99	2001	2003	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
S.P.J.	137	343	216	239	190	177	110	121	134	165	44	17	9	80	45	21
Gendarmerie	255	782	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Police	177	189	1,126	1,326	824	998	881	1,465	1,969	1,643	1,526	1,849	2,651	3,192	2,531	2,358
Customs	236	173	113	95	186	197	228	328	443	477	232	203	156	113	48	146
Total	805	1,487	1,455	1,660	1,200	1,286	1,219	1,914	2,546	2,225	1,802	2,069	2,816	3,385	2,624	2,525

⁶⁵ The general activity report of the Government of the Grand-Duchy of Luxembourg can be downloaded from: http://www.gouvernement.lu/publications/informations_gouvernementales/rapports_activite/index.html



Year	OFFENDERS															
	97	99	2001	2003	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
S.P.J.	182	434	321	369	248	203	128	121	131	164	44	17	9	77	44	14
Gendarmerie	335	916	1,272	1,753	1,007	1,160	1,009	1,459	1,960	1,632	1,517	1,846	2,623	3,158	2,481	1,825
Police	280	283														
Customs	408	306	182	148	320	324	350	325	439	407	221	200	147	110	41	130
Total	1,205	1,939	1,776	2,270	1,575	1,687	1,487	1,963	2,530	2,210	1,782	2,066	2,792	3,345	2,566	1,969

Source: Specialised Drug Department of the Judicial Police (SPJ), 2018 (2017 data)

In 2017, the population of drug law offenders was composed of 85.8% **males**, a proportion that has been varying between 79% and 90% during the past decade. Since 1997, **non-natives** (59% in 2016; 63.6% in 2017) have been representing the majority of drug law offenders. In 2010, the percentage of minors (< 18 years) among drug law offenders increased (9.2% in 2010) and this increase is confirmed by the most recent figures (11.2% in 2014, 9.7% in 2015; 10% in 2016; 12.4% in 2017 compared to 4.9% in 1994 and 8.7% in 2000).

Table 9.3: Socio demographic data on drug law offenders ('prévenus') (1992-2017)

AGE	1992	1994	1996	1998	2000	2002	2004	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
0-14	6	1	3	7	21	15	24	8	11	8	7	26	19	23	14	23	12	28	22
15-19	320	169	270	249	413	647	334	279	318	282	323	484	494	404	431	616	437	562	410
20-24	527	403	447	321	497	650	510	415	480	436	594	677	602	422	545	580	694	634	531
25-29	371	309	304	220	354	388	278	323	321	274	421	551	419	303	363	494	524	407	293
30-34	159	186	191	187	208	219	250	188	216	205	257	318	301	273	319	470	693	362	248
35-39	52	65	80	76	113	177	190	136	162	134	157	233	175	160	181	253	469	245	160
≥ 40	46	21	42	78	108	82	126	181	165	129	189	209	197	181	209	347	516	327	228
unknown	50	20	31	32	44	40	95	43	14	19	15	32	3	16	4	9	0	1	77
TOTAL	1,531	1,174	1,368	1,170	1,758	2,218	1,808	1,575	1,687	1,487	1,963	2,530	2,210	1,782	2,066	2,792	3,345	2,566	1,969
Male	1,248	938	1,138	958	1,415	1,905	1,581	1,319	1,484	1,263	1,645	2,144	1,900	1,562	1,773	2,428	2,906	2,266	1,689
Female	256	209	173	193	241	292	181	218	190	206	283	367	301	220	286	364	439	300	209
Gender unknown	27	27	57	19	44	21	49	38	13	18	35	19	9	0	7	0	0	0	71

Source: Specialised Drug Department of the Judicial Police (SPJ), 2018 (2017 data)

Table 9.4: Distribution of drug law offenders ('prévenus') according to first offence and underage status (1992-2017)

	1992	1994	1996	1998	2000	2002	2004	2006	2008	2010	2011	2012	2013	2014	2015	2016	2017
First offenders	697	382	508	422	608	828	585	471	546	949	913	720	854	1,066	1,069	938	1,047
Offenders underage	96	57	102	79	154	145	103	72	83	178	141	145	171	237	104	182	245
TOTAL (Prévenus')	1,531	1,174	1,368	1,170	1,758	2,218	1,808	1,575	1,487	2,530	2,210	1,782	2,066	2,792	3,345	2,566	1,969

Source: Specialised Drug Department of the Judicial Police (SPJ), 2018 (2017 data)

Regarding first drug law offenders, a total number of 828 offenders was reported in 2002 and 1,047 in 2017 (53.2%; 44.1% previously drug law offenders and 2.7% missing values). This number shows an increase compared to 2016 (938 offenders).

Other drug-related crime

The routine data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items based on self-report. The following results summarise the situation observed in 2017:

- 78.8% of drug users indexed⁶⁶ by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime (74% in 2016);
- An increased proportion (53.1%) of the total HRDU population shows multiple law enforcement contacts (49% in 2016);
- The proportion of records for other reasons than presumed offences against the drug law (e.g. **petty crime** such as criminality linked to drug supply) has been decreasing since 1997 (38%) and has been fairly stable in recent years, except for 2010, where data on 'interpellations' for other reasons reported an important increase (2006: 34%; 2009: 35%; 2010: 65%). The proportion of records for other reasons than presumed offences against the drug law lies between 21 and 44.2% for the past 6 years (2012: 28%; 2013: 21%; 2014: 30%; 2015: 31%; 2016: 43%; 2017: 44.2%);
- In 2016, 21% (n=38) of indexed HRDU already served at least **one prison sentence** during lifetime. In 2017, this proportion increased towards 50.8% (n=91) in 2017. The proportion of HRDU having served more than one prison sentence at the time of reporting reached almost one-third among the RELIS population in 2017 (36% in 2016; 29.6% in 2017).

PREVENTION OF DRUG-RELATED CRIME

The involvement of major cities in the management of drug-related problems and nuisances is developing. So-called municipal 'prevention committees' that include local authorities, police forces and specialised NGOs are in place in major cities. The setup of national drug consumption room also enhanced the involvement of municipal authorities. The Ministry of Health created a management group that is mandated to evaluate developments with regard to the consumption rooms and to react promptly to emerging problems. The national drug action plan clearly emphasises the importance of a collaborative involvement of major cities in the management of public safety and order, urban nuisance and hygiene problems related to drugs to guarantee the necessary decentralisation of DR offers and SR interventions.

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



As far as preventive measures targeting youngsters are concerned, a mechanism has been put in place in 1996 aiming at underage and juvenile drug use offenders and in order to prevent recidivism. The service **Impuls** (Impuls - Aide aux jeunes consommateurs de drogues - Solidarité Jeunes a.s.b.l.) is financed by the Ministry of Health and intervenes in case a minor of age and youngsters have been running in conflict with law enforcement forces with respect to a drug-related offence. In this respect, the Youth Solidarity team may be considered as a crisis situation manager, offering their services to drug offenders referred by judicial and penal institutions. The available services are free of charge.

The intervention team, in direct collaboration with Youth magistrates and competent law enforcement actors, offers a large variety of services with the primary aim to prevent minor aged drug offenders to enter in the criminal justice system. Interventions are based on a holistic approach of the problem, including the involved person him/herself and his/her family. Youth Solidarity directly reports on intervention progress to the demanding authority. Client statistics show an increasing demand for this kind of intervention from both the criminal justice system and the social oriented institutions. According to the annual report from Impuls (2017), factors that may explain the increased number of clients over the years are mostly related to addiction and co-morbidities related to cannabis consumption and rising THC levels, but also interfamilial difficulties. As Table 9.5 indicates, a majority of the minors are referred to the Impuls by the criminal justice system, followed by self-referral (20.2%), schools (11.5%) and others (18.7%).

The use prevalence of ecstasy-type products has been increasing since 2015 (5.3%) and 2016 (9.6%). In 2017, the proportion of clients reporting to have used XTC/MDMA increased to 18.9%, whereas 10.6% reported use of cocaine revealing that these types of drugs are becoming more popular among adolescents. Moreover, in 2017, almost all clients report use of alcohol, tobacco and/or cannabis.

Table 9.5: Clients core statistics IMPULS 2003 – 2017

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Number of clients (old and new) (n)		231	267	249	322	352	357	432	461	416	489	490	574	695	571	530
Referral from the criminal Justice system (%)		37.2			46.2	44.4	43.4	44.1	50.8	49.7	46.3	47.3	60.2	53.3	51.2	49.6
Gender distribution (%)	Female	31.6	31.9	31.3	30.1	24.4	30.5	24.3	29.4	29.8	33.1	30	26.75	22.54	21.8	26.4
	Male	68.4	68.1	68.7	69.9	75.6	69.5	75.7	70.6	70.2	66.9	70	73.25	77.46	78.2	73.6
Age distribution (%)	< 14	9.5	4.9	2.0	4.7	4.6	5.9	4.6	4.6	5.3	3.5	4.4	4.6	3.2	3.7	1.9
	14-15	38.1	30.0	22.9	27.9	25.6	24.9	25.8	29.8	30.1	26.9	26.5	28.4	24.5	29.6	21.5
	16-17	39.8	46.4	43.4	46.9	46.6	50.4	52.4	47.5	46.4	49	53.6	42.9	42.1	41.4	42.8
	> 17	12.6	18.7	20.5	16.5	18.5	15.9	17.2	18.1	18.2	20.6	15.6	24.1	30.2	25.3	33.8
	Unknown			11.2	4.0	4.7	2.9	0	0	0	0	0	0	0		0
Main substance involved (%)	Cannabis	83.1	72.3	71.5	73.3	67.7	69.4	72.8	74.2	73.8	76.8	81.4	78.7	78.6	89.0	87.9
	Heroin	3.5	4.5	5.6	3.7	2.5	1.7	1.6	1.1	0.3	0.8	0.0	0.0	0.5	0.5	1.6
	XTC/Cocaine	1.3	2.2	0.4	1.6	1.1	0.6	0.9	0.8	1.0	0.4	0.2	1.3	5.3	9.6	29.5*
	Legal drugs	2.6	3.0	2.4	3.1	5.1	7.8	6.2	5.4	8.2	9.9	4.4	4.8	18.3	1.9	4.7
	Hallucino gens														2.45	5
	Polydrug		1.9	3.2	3.7	5.4	4.5	5.8	5.1	5.3	3.6	0.0	4.6	65.5	66.4	/
	Other	1.3	3.3	2.0	2.5	2.5	2.5	1.7	1.1	1.2	0.6	1.8	0.8	2.7	1.1	/
	None	8.2	10.6	10.4	10.2	9.6	8.7	6.1	9.7	7.3	7.2	5.5	4.6	3.4	4.0	/
	Alcohol														84.5	85.3
	Tobacco														84.8	81.3
	Unknown	0.0	2.2	3.7	2.5	6.1	4.8	4.9	2.6	2.9	0.7	6.7	5.2	0.2	0.8	/

Source: Service Impuls - Aide aux jeunes consommateurs de drogues (Solidarité Jeunes a.s.b.l.), 2018 (2017 data)

Note: * In 2017, 18.9% of all clients reported XTC/MDMA use and 10.6% reported use of cocaine.

INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Alternatives to prison

The Grand Duchy of Luxembourg counts two state prisons at the national level; the Centre Pénitentiaire de Luxembourg (CPL) situated in the vicinity of Luxembourg City and the Centre Pénitentiaire de Givenich (CPG) implemented in the East of the country.

The CPL is a conventional prison, whereas the CPG may be considered as an alternative to a strict penitentiary regime as it is defined as a semi-open prison established in a fairly rural setting. During daytime, inmates follow a professional activity or participate in one of the centre's workshops (agriculture, animal breeding, kitchen, horticulture, woodwork, locksmith's and duties). After work, they return to their individual cells for the night. Every block has its own living room, kitchen, bathroom and laundry allowing inmates to live in more or less autonomy. The creation of a third prison in the South of the country has been approved by law in 2014⁶⁷. It is currently under construction – the 'Centre Pénitentiaire d'Uerschterhaff' (CPU) – and it should be operational in 2022.

National prisons have a total capacity of 710 beds (597 in CPL and 113 in CPG). Both prisons have separated male and female sections. In 2017, the total number of prisoners was 700 (707 in 2016; 670 in 2014). On average, in 2017, the CPL had 617 prisoners (occupation rate of 103.4%) and the CPG had 83 prisoners (occupation rate of 73%, hence a decrease of 13.5% compared to 2016).

The gender ratio in prison is stable. In 2017, only 5.4% of inmates were female (a slight decrease compared to 2016 – 5.9%). On January 1st 2017, the mean age of all inmates was 36 years (stable). Age class 30 to 40 years is most represented (36.3%), followed by the age group of 40 to 50 years (24.1%), and 0.6% of inmates were minor of age in 2017. The national detention rate in 2017 decreased to 118.50 inmates per 100,000 inhabitants (123.39 inmates per 100,000 in 2016). In total, 67.5% of inmates are natives from EU Member states (41.3% Luxembourgish) and 32.5% are non-natives from countries outside the EU. The number of European vs. non-European inmates has decreased continuously since 2012.

National prison data indicate that drug law offences are the most frequent offences leading to imprisonment. More specifically, in 2017, 22% of the male (25.9% in 2016) and 26.1% of the female (30% in 2016) admissions were related to drug law offences. About one-third of all prisoners have had previous law offences or have been previously in prison.

Inmates have the opportunity to participate in the 'DEFI' programme (see below under 'Reintegration of drug users after release from prison') working outside for a minimum wage (so called "RMG" which signifies the Guaranteed Minimum Income). Others follow a semi-liberty regime (they live at the CPG but have an individual and external work contract).

The 'injonction thérapeutique' is another alternative to prison (only possible in case of offences for *personal possession* or *use* of illicit substances): the offender is proposed to undergo treatment instead of a prison sentence. In other cases, community services ('TIG: travaux d'intérêts généraux') may also be an alternative (depending on the gravity of the offence and the sentence). The sentence may be suspended if the 'prévenu' agrees to undergo treatment ('sursis probatoire'). This said, these two alternatives are applicable in case of drug possession or use only (not for cases of production, dealing or trafficking of illicit substances), as in the Grand-Duchy of Luxembourg a drug addict is not considered a criminal but a person in need of psycho-social and medical help.

67 Loi du 24 juillet 2014 relative à la construction du centre pénitentiaire d'Uerschterhaff (Mémorial A – N° 144, August 1st 2014). (Vote 24.07.2014, Entry in force 01.08.2014)



A further alternative to prison available in Luxembourg is the electronic tag. In November 2006, the Minister of Justice presented the introduction of the electronic tag as an alternative to incarceration.

In an experimental phase, this system was exclusively meant for prisoners:

- whose sentence was less than one year;
- who did not represent a danger;
- who are socially integrated and residing in Luxembourg;
- who were working or undergoing training.

DRUG USE AND PROBLEM DRUG USE IN PRISONS

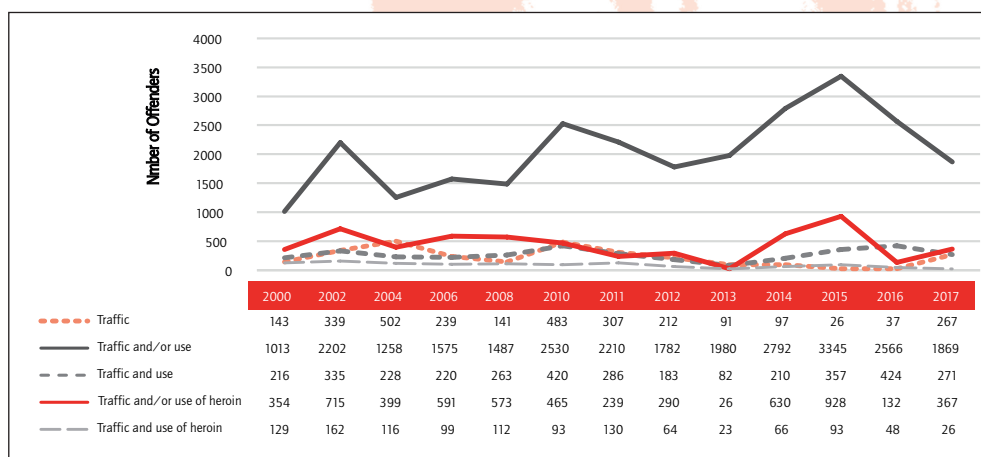
A study on prevalence of viral hepatitis A, B and C and HIV in problematic drug users of illicitly acquired drugs conducted in 2007 (Origer & Removille, 2007) addressed drug use and drug-related harm in prison settings. Referred to the total study sample (N=246), 56.1% of respondents who have had prison experience during the past ten years reported illicit drug use in prison; 30.5% reported intravenous drug use. 26.7% of lifetime IDUs inmates reported needle sharing in prison, which is sensibly lower than the rate observed in 1998 by Schlink (1999). Among all settings (inpatient, outpatient treatment, low threshold, etc.), prevalence rates of HIV, HBV and HCV were highest in persons recruited in prison settings.

Efforts have been made to increasing prevention and medical treatment in prison settings. Nevertheless, due to a lack of recent research studies, it is unknown how many people currently use drugs in prison settings, and which types of drugs are used.

DRUG USE PRIOR TO IMPRISONMENT

Drug use prior to imprisonment for the years 2000-2017 is shown in Figure 9.1, representing a summary of overall offenders involved in seizures. Great variations were reported in recent years. These variations can, however, not be attributed to observed changes in criminal justice policies with the exception of the years 2014 and 2015, when increased police interventions led to an increase in the detection of offences.

Fig. 9.1: Number of offenders involved in seizures according to type of offence (2000-2017)



Source: Specialised Drug Department of the Judicial Police, 2018 (2017 data)

RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS

Table 9.6: Number of general admissions and the number of admissions according to drug-related convictions (DELIT 'STUP') in both national prisons from 1989 to 2017

YEAR	1989	1990	1992	1994	1996	1998	2000	2002	2004	2006	2008	2010	2012	2013	2014	2015	2016	2017
New entries (Total)					685	796	767	794	1.078	1.043	990	927	950	818	904	951	962	974
New "STUP" entries	163	244	157	288	292 42.6%	167 21%	161 21%	101 12.7%	92 8.5%	243 23.3%	332 33.5%	232 25.02%	306 32.21%	226 27.63%	223 24.67%	240 25.24%	306 31.81%	240 24.64%

Source: CPL, CPG, 2018

Drug treatment in prison

Following the law of 27 July 1997 concerning the modification of the penitentiary organisation⁶⁸, a pilot project named 'Global Drug Care Programme in Prison' (2000-2005 – TOX project) was set up by a group of experts assigned by the Ministry of Justice in 1999. The concept was designed to implement, among other objectives, primary prevention measures with regard to drug consumption and infectious diseases. The overall aim of the project was to integrate drug dependant inmates into a medico-psycho-social drug care network in order to reduce recidivism, risks and criminality after release from prison. The implementation of the project had to be adapted to the two different prison settings. Financing is ensured by the Ministry of Justice.

The TOX programme takes care of the drug dependant inmates in the two state prisons of Schrässig (CPL) and Givenich (CPG). This service is run by a multidisciplinary staff. The basic principles of the TOX programme in the CPG are the voluntary participation, the cooperation, the transparency, the quality of service, the determination of realisable objectives and the empowerment of participants. Additionally, the programme TOX also prepares inmates to enter a second treatment option available in prison: a drug-free programme called 'Charly'. The programme provides a drug-free zone, where inmates can serve their sentence, or part of it, under certain conditions. Staying drug free and accepting to participate in psychosocial interventions are part of the admissions criteria.

A special programme targeting exclusively women exists and becomes operational when a minimum number of women enrol. Otherwise, individual offers are available for the female population.

Detoxification treatment is either provided in-house under the responsibility of the prison medical unit, or by external detoxification units of general hospitals according to strict rules and procedures. CPL has signed conventions with national hospital to ensure psychiatric care and out-of-prison medical care if required.

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

⁶⁸ 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.



Opioid substitution treatment is also provided in prison. The Service de Médecine Psychiatrique Pénitentiaire (SMPP) is in charge of OST within prison. More detailed figures on this type of treatment can be found in respective sections. Three scenarios may occur:

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

The main substitution opiates prescribed in prison are liquid methadone (chlorhydrate of Methadone), and to a lesser extent buprenorphine (Suboxone®). Benzodiazepines are prescribed as well. Inmates have the opportunity to maintain substitution treatment or to reduce doses gradually.

Official figures show that with the exception of minors and people who stay less than 24 hours at the Penitentiary Centre, 16% (n=197) of the inmates who entered CPL and 17% of the inmates who entered CPG (n=33) in 2017 received drug substitution treatment, representing a total of 230 (205 in 2016) persons. At CPL, an average of 71 people per day and at CPG an average of 6 people per day were receiving substitution treatment in 2017, respectively.

Table 9.7: Number of prisoners receiving opioid substitution treatment (2016-2017)

YEAR	2016		2017	
Prisons	CPL	CPG	CPL	CPG
Methadone	155	17	175	29
Subutex ®	2 (SUBOXONE + METHADONE) / 22 (SUBOXONE only)	0 (SUBOXONE + METHADONE) / 11 (SUBOXONE only)	1 (SUBOXONE + METHADONE) / 22 (SUBOXONE only)	4 (SUBOXONE only)
Total (persons)	177	28	197	33

Source: Activity report Comité de Surveillance SIDA, 2017, 2018

The average dose of distributed methadone was 24 mg per day (minimal dose 2 mg and maximum dose 100 mg) whereas the average dose for Suboxone® was 8.3mg per day (minimal dose 1mg and maximum dose 16mg). The average duration of treatment episodes in 2017 was 145 days. A total number of 58 patients interrupted OST during their prison stay.

Of clients in treatment units in prison, all of them were male (95.3% in 2016). The mean age of treatment demanders in prison is 35.6 years (35.2 years in 2016). In previous years, the mean age of female inmates was consistently lower. Respectively, 75% (37% in 2016) of inmates in treatment are natives versus 25% (63% in 2016) of non-natives. The population of non-natives remains for the vast majority of Portuguese nationals, followed by Italian citizens.

Regarding the educational level of the inmates in treatment, 25% (68%) have completed primary school, and 50% (29% in 2016) have completed secondary school. In total, 25% (16% in 2016) of clients in treatment units in prison experienced one or more overdoses. As far as the sharing of used syringes is concerned, 37.5% (50% in 2016) reported that they never shared syringes during their lifetime.

Prevention and reduction of drug-related harm

Activities of the previously referred to TOX-programme in prison are built upon three pillars:

- **Psychosocial prevention:** psychosocial care of drug-addicted inmates, in order to prepare their future after release from prison and to reduce risks of relapse and recidivism – intensive programme without drugs to prepare post-release ambulatory therapy and/or individual preparation for release.
- **Prevention of STDs and health education:** this health service is proposed in individual and collective settings.
- **Coordination of interventions:** the drug-addicted platform was created in order to coordinate interventions of involved professionals.

The TOX programme (implemented in the CPL and the CPG) has established psycho-educational activities of individualized and specific rehabilitation. Inmates have the possibility to participate in various modules and activities that are in line with their therapeutic plan. The combination of therapeutic care with other activities allows preparation of inmates towards socio-professional reintegration.

The CPG offers the following support programmes:

- Therapeutic follow-up (it is possible to set up ambulatory or stationary therapy after the period of incarceration);
 - Sport and physical activity;
 - Relaxation;
 - Tobacco use reduction;
 - External psycho-pedagogical activities;
 - Speaking groups;
 - Social skills groups;
 - Relapse prevention groups;
 - Education / training regarding the prevention of overdoses.

Each participant from the CPG has the opportunity to prepare the psychosocial rehabilitation through a continuity of monitoring provided by the PTOX team.

Moreover, in the context of a specific project, the health manual “Ma santé en toute liberté” has been developed and distributed to all newcomers to the CPG. For more information on the project please consult the following links:

- a) <https://www.oeuvre.lu/initiatives/actions-addictions/>
- b) https://msan.gouvernement.lu/fr/actualites.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Bcommuniques%2B2016%2B07-juillet%2B14-projets-lutte-addictions.html



Concerning the support for the CPL, the group is focusing on two axes:

- Health development and specific psycho-educational practice for the drug-addicted inmates within a collective pavilion without drugs (specific entourage of at least 4 months with an optional prolongation);
- Follow-up of the drug free section together with the "Program Charly" started in May 2007, as preparation for multidisciplinary and intensive therapy. In the "Program Charly" 8 clients have the opportunity to benefit from a program of intensive preparation for therapy within the *Charly block*.

The PTOX principally includes the following therapies:

- Therapeutic follow-up (it is possible to set up ambulatory or stationary therapy after the period of incarceration);
- Relapse prevention groups;
- DBT Groups (Dialectics Behaviour Therapy);
- Art therapy;
- Therapeutic cooking workshops;
- Self-esteem group;
- Relaxation.

Psychosocial care in prison meets a significant demand. As far as the CPL is concerned, in 2017, 1,437 individual psychosocial counselling sessions were held (2012: 901 counselling sessions). The CPG reports a total number of 519 individual psychosocial counselling episodes. In total, 232 prisoners were followed-up in the CPL and 92 in the CPG.

PREVENTION, TREATMENT AND CARE OF INFECTIOUS DISEASES

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

In 2017, 947 HIV tests have been carried out (933 in 2016) of which 25 tests were positive (18 in 2016). In total, 21 men and 4 women had a positive testing result (vs 16 men and 2 women in 2016) and 16 (13 in 2016) co-infections (HIV/HCV) were diagnosed. To prevent further contamination, vaccination against hepatitis B and A is recommended to those who present a negative serology.

A structured syringes distribution programme has officially been launched in 2005 in the framework of the global drug care programme in prison. In order to enrol, inmates have to send a written request to the prison's MD. After counselling, the inmate is handed out a kit containing 2 syringes which may be exchanged at the nursery. As the consumption and possession of drugs are illegal, those inmates in possession with a syringe kit, are exempted from sanctions for detention of injection paraphernalia. In 2017, 23 kits (31 in 2016) were distributed and 1,372 (1,612 in 2016) syringes were exchanged. The programme is under medical secrecy and a series of changes are currently under discussion to increase the coverage and impact of the programme.

Ascorbic acid, filters, sterile physiological water, antiseptic wipes and small plasters are available at the two nurseries. Condoms are also available at different discrete spots of the prison (at the two nurseries, TOX-programme and at the psychiatric ward).

In order to meet specific needs in terms of infectious diseases in prison settings, the creation of a specialised transmittable disease counselling offer (COMATEP) involving prison administration and CHL has become operational in 2011.

Medical care

Regarding medical care, in 2017, 366 people were seen in specialised medical consultation in 2017. In addition, 187 people had a non-invasive examination to determine fibrosis hepatic (Fibroscan®) and 131 inmates underwent an ultrasound examination. A total, of 52 persons started treatment for a communicable disease at the penitentiary centres, of which 29 HCV treatments, 3 HCB treatments, 12 HIV treatments, 2 Syphilis treatments, and 6 latent tuberculosis treatments. With regard to vaccinations, each prisoner is offered vaccination if indicated (including hepatitis A and B) and a vaccination card is provided to the patient.

Prevention

Prevention work in prison is done by the TOX program of CHNP and the HIV Berodung of the Luxembourg Red Cross. Interested inmates can also receive information on the medical service, which ensures secondary prevention in the first place. Every prisoner who enters CPL is invited within the first few weeks of incarceration to participate in two information sessions on hepatitis (session given by a two members of the TOX Program) and HIV / AIDS (session in the presence of a member of the HIV Berodung and a member of the TOX Program). In total in 2017, 424 people were invited to participate in HIV / AIDS information groups and 51 groups were organised and 285 people participated (participation rate 67.2%). Moreover, 420 people were invited to participate in information groups on hepatitis, and 50 groups were organised and 278 people participated (participation rate 68.9%). The language barrier is a major problem in prison. Overall, the Program Prevention Nurse TOX had 179 individual interviews with 126 people on communicable diseases. Condoms and information brochures are also provided to prisoners.

Safe tattoo project

In March 2017, a 'Safe Tattoo' project had been set up at the CPL. This project is a peer-to-peer project and provides the opportunity to do a tattoo in appropriate hygienic conditions, and thus prevent the transmission of communicable diseases such as HIV, hepatitis B and C. The Safe Tattoo project is subject to strict regulations. Interested inmates may apply to become an official tattoo artist and can undergo specific training. Since the start of the project, nine tattoo artists have been trained of whom currently seven are active. In total, 69 persons got a tattoo since the implementation of the project.

Prevention of overdose-risk upon prison release

Overdose incidents following prison release is a documented reality that has also been addressed by national research. For instance, the Origer & Dellucci study conducted in 2002 recommended the following measures to prevent overdose risk following an in-depth longitudinal analysis of drug-related death nationwide:

- Opening of supervised injection rooms according to the national drugs action plan (1);
- Medical controlled heroin distribution programme (foreseen by the national drugs action plan) (2);
- First aid training courses provided to users and their relatives and partners (3);
- Gender and ethnic specific interventions (4);
- Provision of morphine receptor antagonists to users and selected persons (5);
- Creation of 'transition centres' for ex or current PDU leaving institutional settings (6);
- Development of reintegration programmes for prisoners (7).

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



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

REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

The CPL runs a proper psychosocial and educational department (SPSE). Jointly with the SCAS and the prison guards' association, it has set up a project called **'DEFI'** (Challenge) that aims at the development of therapeutic means, training facilities, socio-professional reinsertion measures and indebtedness management, during prison journey and after the prison release phase.

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

10. DRUG MARKETS

INTRODUCTION

Drug markets are of changing nature. They rely on factors such as supply mechanisms, on the economic situation of the country they develop in and on the efficiency of law enforcement strategies. Availability and supply indicators should be interpreted with caution as they rely on the interplay of all these factors. Law enforcement authorities, the National Laboratory of Health and special surveys have provided data for the present chapter. Law enforcement agencies in collaboration and specialised drug units provide data on drug-related law enforcement activities, prosecution data (in collaboration with the public prosecutor's office) and new trends. The National Health Laboratory, the 'Laboratoire National de Santé' (LNS), is involved in the provision of drug purity data and toxicological analysis data on New Psychoactive Substances (NPS). Ad hoc surveys, for instance in specialised NGOs, allow for additional data such as price of street drugs, new consume or traffic pattern.

Overall, the national drug market has become of increasingly aggressive nature in terms of selling techniques (e.g. dealers approach potential clients and not vice-versa, the dealers insist on selling). New and more organised distribution networks have developed in recent years and operate in an obviously professional way and by doing so, have significantly increased drug availability and in particular the supply of cocaine and cannabis. Various groups joined to improve their drug distribution strategies whereas previously none of these criminal groups actively searched contact with other groups. Moreover, it has been noted that traffickers tend to delocalize their selling points to locations or settings less visible to police as for instance private flats, bars or motorway rest areas in order to meet their clients halfway and sell gross quantities.

In recent years, trafficking practices in the vicinity of the main railway station area of Luxembourg City have been escalating and residents of the area mobilized, which has resulted in an increase in police presence, interventions, controls and arrests, partly explaining the increase in drug-related supply reduction data reported. Typically, involved dealers carry small quantities of drugs hidden in their mouth ready to be swallowed promptly (mostly cocaine) in case of police controls. Initially drugs of high quality are sold at low prices. Progressively, however, the quality and diversity of sold drugs have been decreasing. The national drug market has been flooded by a high proportion of low quality injection drugs (mostly including cocaine), which has induced major changes in consume patterns of national drug users.

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

With regard to heroin trafficking, no predominant profile of nationality has been reported. A large number of drug traffickers come from North Africa by transiting through Belgium. Numerous traffickers have changed from heroin to cocaine and currently are also involved in cannabis traffic.

Attention should be paid to the striking differences in maximum and minimum purities as well as to a high maximum concentration of THC in cannabis products seized in Luxembourg in recent years. Over the last 10 years, purity of cocaine has been generally decreasing and average heroin purity has also been following a discontinuous downward trend. Prices move within increasingly broader ranges for heroin, cocaine and cannabis, which is partly due to increasing differences in quality levels of street drugs. Quality ranges of street drugs tend to increase which suggest more diversified distribution mechanisms and may explain the important price variations observed during recent years.



Cocaine availability on the national market is high and increasing and consumption among adolescents of cocaine and MDMA/ecstasy seem to increase as well. The number of seizures of cannabis, cocaine and MDMA have been increasing over the past years, though only cannabis and cocaine equally show a rise in seized quantities. In terms of seized quantities, important variations have been observed for heroin since 2000. The number of seizures also has been showing great variations during the same period, especially for cannabis.

The perceived illicit drug availability in the general population is high and follows a weak increasing trend. Available indicators suggest that users increasingly acquire illicit drugs on the national market.

AVAILABILITY AND SUPPLY

Perceived availability of drugs

In addition to availability indicators from law enforcement sources, perceived availability of the general public provides further insight in the current situation. Both, the 2004 Flash Eurobarometer 158 survey 'Young people and Drugs' and the 2002 Eurobarometer 57.2 survey inform about the level and the evolution of illicit drugs availability in the Grand-Duchy of Luxembourg in former years.

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

QUESTION a: Is it easy to get illicit drugs?								
	Near where I live		In or near my school/ college		At parties		In pubs/clubs	
	2002	2004	2002	2004	2002	2004	2002	2004
Luxembourg	62.2	66%	60.5	63%	74.7	74%	73.2	70%
EU	61.9	63%	54.9	57%	76.0	79%	72.3	76%

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

In May 2008, the Directorate-General Justice, Liberty and Security of the European Commission published a public opinion poll named 'Young people and drugs among 15-24 years olds' (N°233) within the scope of Eurobarometer surveys. Questions were included on the ease of access to illicit drugs, alcohol and tobacco:

The following Table presents the results of the question: "How difficult would it be for you to get hold of any of the following substances if you wanted to?"

Table 10.1 bis: Ease of acquisition of drugs in Luxembourg (2008)

	Ease of access to heroin (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
Luxembourg	44	33	14	9	2
EU27	42	30	16	7	5
	Ease of access to cocaine (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	37	30	22	9	3
EU27	35	26	22	11	5
	Ease of access to ecstasy (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	34	31	25	9	2
EU27	31	25	26	12	5
	Ease of access to cannabis (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU	17	11	30	41	1
EU27	19	15	31	32	4
	Ease of access to tobacco (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU		1	10	88	
EU27	1	2	15	81	
	Ease of access to alcohol (if desired)				
	very difficult	fairly difficult	fairly easy	very easy	dk/na
LU		1	5	94	
EU27	1	2	17	80	

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

Concerning heroin, youngsters from Luxembourg considered it slightly more difficult (77%) to obtain or to have access to heroin than the European average (72%). Similar to the EU average, only 23% of interviewees thought that getting hold of heroin was easy.

Even if heroin was the substance considered to be most difficult to get hold of, also cocaine was quoted by 67% of young people from Luxembourg as more difficult to obtain than did the EU average (61%).

Ecstasy was considered being more difficult to obtain in Luxembourg (65%) compared to the EU average (56%). Only 34% of youngsters from Luxembourg considered the access to ecstasy as easy (EU average: 38%).

Concerning cannabis, less youngsters from Luxembourg (28%) declared the access to cannabis to be difficult than the EU average (34%). Four out of ten youngsters (41%) found it very easy to obtain cannabis (EU average: 32%, three out of ten).

Luxembourg's youngsters considered the access to licit substances as tobacco and alcohol as easier than the EU average. Concerning tobacco, 88% of youngsters from Luxembourg found the access very easy compared to the EU average (81%). Moreover, the access to alcohol was referred to as very easy (LU: 86%, EU: 80%).

In summary one may note that a majority of Luxembourg's youngsters are of the opinion that licit drugs are very easily available in contrast to illicit drugs seen as very difficult to obtain with however the exception of cannabis.

In May 2011, the Eurobarometer study 'Youth attitudes on drugs' (N°330) provided results summarised in Table 10.1 ter. Although answer categories are slightly different, results clearly show that acquisition of illicit drugs is perceived to be more difficult in 2011 if compared to 2008.



Table 10.1 ter: Ease of acquisition of drugs in Luxembourg (2011)

2011	Ease of access to heroin (if desired)					
	impossible	very difficult	fairly difficult	fairly easy	very easy	dk/na
Luxembourg	30	35	24	8	2	1
EU27	24	36	22	8	5	5
LU	Ease of access to cocaine (if desired)					
	22	33	32	9	2	2
EU27	19	28	26	14	8	5
LU	Ease of access to ecstasy (if desired)					
	21	33	31	9	2	4
EU27	20	28	25	14	8	4
LU	Ease of access to cannabis (if desired)					
	12	10	23	27	25	3
EU27	11	13	15	28	29	4
LU	Ease of access to tobacco (if desired)					
		2	2	14	82	
EU27		2	2	14	81	1
LU	Ease of access to alcohol (if desired)					
		3	3	15	79	
EU27		1	2	14	82	1

Source: Flash Eurobarometer N°330, 2011

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

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

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

Source: Flash Eurobarometer N°401, 2014

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

Even if heroin was the substance considered to be most difficult to obtain, also cocaine was considered by 53% (55% in 2011) of young people from Luxembourg as more difficult to have access to compared to the EU average (47%; stable). Ecstasy was considered being more difficult to obtain in Luxembourg (54% stable) compared to the EU average (48% stable). Only 15% (11% in 2011) of youngsters from Luxembourg considered the access to ecstasy as easy (EU average: 23%; 22% in 2011). Access to cannabis was perceived slightly easier in the EU (58%; 57% in 2011) than in Luxembourg (56%; 52% in 2011). Two out of ten youngsters (22%; 25% in 2011) found it very easy to obtain cannabis (EU average: 29% stable).

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

In summary, one may note that a majority of Luxembourg's youngsters are of the opinion that licit drugs are very easily available in contrast to illicit drugs seen as difficult to obtain with, however, the notable exception of cannabis.

Origins of drugs

The national production of illicit drugs appears to be irrelevant in terms of quantities and quality. Over recent years, no clandestine drug-manufacturing laboratory has been dismantled at the national level. Law enforcement sources⁶⁹ indicate that currently the majority of illicit drugs consumed on the national level originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). Until the beginning of the nineties, most of the persons involved in illicit drug distribution were consumers who supplied themselves in the Netherlands or acquired limited extra quantities of drugs in order to sell them within restricted local networks. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market.

Drug trafficking patterns

The expansion of more structured distribution networks by organised criminal associations has been reported earlier. Typically, involved dealers carry small quantities of drugs hidden in their mouth ready to be swallowed promptly in case of police controls. Initially drugs of high quality have been sold at low prices. Progressively, however, the quality and diversity of sold drugs have been decreasing. The national drug market has been flooded by a high proportion of low quality injection drugs, which has induced major changes in consume patterns of national drug users.

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

SEIZURES

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

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



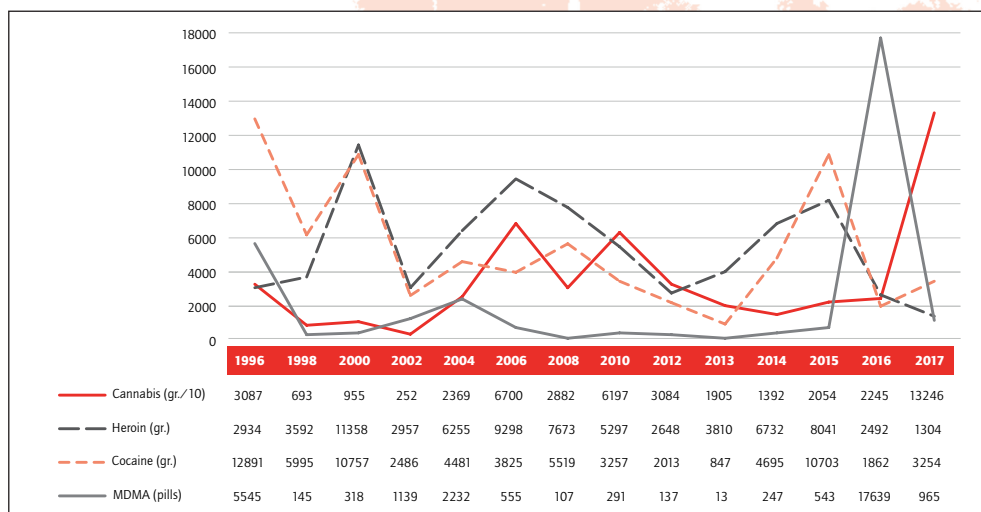
Quantities and numbers of drug seizures

Striking variations have been observed as to the quantity of illicit substances seized since the beginning of the nineties. A longitudinal data analysis indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002⁷⁰. Since 2002, however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. However, this trend was not observed in 2009 and 2010 for heroin. Cocaine seizures (quantity) are highly variable since the beginning of the nineties.

Notwithstanding the quantities of cannabis and cocaine seized, the number of seizures has grown discontinuously since 1990. This suggests that more seizures of smaller quantities have been reported. Since 2008, the number of cannabis and cocaine seizures has clearly increased, while the number of heroin seizures discontinuously decreased. Markedly, the number of cannabis seizures has risen from 167 to 1,311 between 1994 and 2017 (1,048 in 2016) with a record of its quantity seized in 2017.

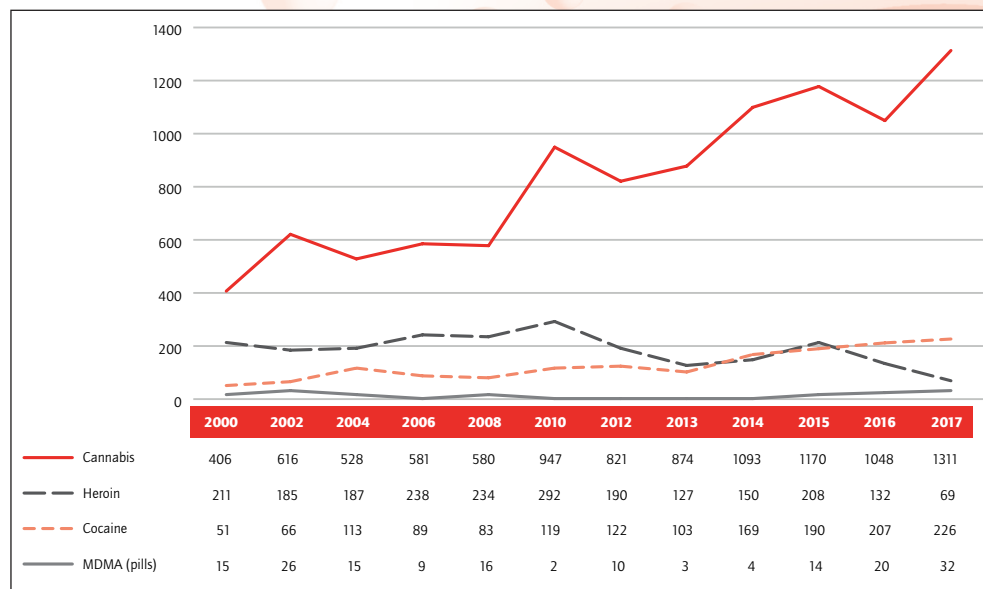
Crack (cocaine-base) seizures have not been reported to date by national authorities. In 2017, 226 cocaine seizures were reported by the National Judicial Police and more than 3 kg of cocaine were seized. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. After years of rather modest XTC type pill seizures, 2009 data revealed consistently higher amounts of seizures. In 2011 and 2012, however, the MDMA seizures showed again a decrease. In 2013, seizures of XTC type pills were very low, whereas an increase was observed in 2014, 2015 and 2016. The year 2016 stands for an historical record in MDMA quantities seized, as a total of 17,639 pills were seized within 20 seizures. In 2017, however, the quantity of seized MDMA pills decreased to a total number of 965 pills within 32 seizures. Overall, quantities of seized cocaine and MDMA remain high in the past years, whereas the quantity of heroin tends to decrease over the past two years.

Fig. 10.1: Total quantities of national yearly seizures: heroin, cocaine, ecstasy type (1996 - 2017)



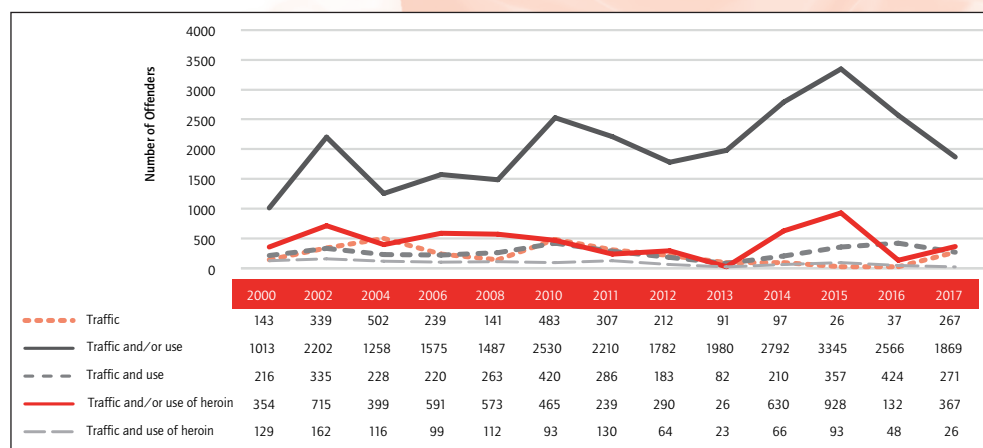
Source: Specialised Drug Department of the Judicial Police, 2018 (2017 data)

Fig. 10.2: Total number of national yearly seizures: cannabis, heroin, cocaine, MDMA (2000 - 2017)



Source: Specialised Drug Department of the Judicial Police, 2018 (2017 data)

Fig. 10.3: Number of offenders involved in seizures according to type of offence (2000-2017)



Source: Specialised Drug Department of the Judicial Police, 2018 (2017 data)

The total number of persons involved in traffic and/or use of illicit drugs has followed a constant upward trend until 2002 and showed a decreasing trend line until 2013 followed by a marked increase in 2014 and 2015 and a slight decrease in 2016 and 2017 (2017: 1,868, 2016: 2,566, see Figure 10.3). However, in 2017, a new rise of drug law offences involved in traffic has been observed (n=267). With the view on traffic and/or use of heroin specifically, numbers vary significantly since the year 2000, with the lowest number of drug law offenders reported in 2013 (n=23).



Number of illicit laboratories and other production sites dismantled

The last time the dismantling of a synthetic drug manufacturing laboratory was reported by law enforcement dates back to 2003. Since then, no further laboratory seizure on the national territory was reported. According to police records, single cannabis growing fields are found on a fairly irregular basis. Local cultures of cannabis remain rather insignificant in terms of quantity and national production is limited to small indoor cannabis cultivations (mostly for personal use and not primarily meant to procure economic profit). Sporadically, low scale domestic indoor cannabis cultivation facilities (typically not exceeding 10-50 plants) are detected at the national level.

PRICE/PURITY

Price of drugs at retail level

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen from 1998 to 2002/2003 but broader price ranges as well as higher maximum prices for cocaine, heroin and cannabis have been observed since 2004, which is due to a high variability of purity. Typical street retail cannabis (resin and herbal) is currently sold for 8-15 € per gram, cocaine average price per gram is currently around 95 € and heroin around 55 €, indicating a slight increase in heroin and cocaine prices over the past years.

Table 10.2: Price per unit evolution of illicit drugs at the street level in Luxembourg (2000-2017)

	2000	2002	2004	2006	2008	2010	2012	2013	2015	2016	2017
Cannabis											
Hashish	7.4	7	7.3	8	8-10	4-10	5-17	6-15	8-10	8-13	8-13
Marijuana	6.2		7.3		5-10	7-25	5-25	12-20	8-25	8-17	8-14
Cocaine	90	50	20-120	30-100	70-100	50-250	40-250	40-133	50-200	40-150	58-150
Heroin (brown)	74.4	50	82	50-90	60-80	20-250	20-100	18-100	11-100	16-100	20-100
ATS	n.a.	25	n.a.	5	20	20	15-20	10	n.a.	13-15	13-15
Ecstasy	10.7	7	10	5	5-15	5-15	5-25	5-10	5-13	7-15	7-15
LSD	n.a.	n.a.	10	n.a.	5-15	12	10-20	10	15	10-15	13-15

Sources: Specialised Drug Department of the Judicial Police (2000-2018), Abridado (2008-2018)

Price: expressed in EURO at street level

For cannabis, cocaine & heroin (since 2009) and amphetamines, price per gram is indicated.

For heroin and cocaine, minimum prices refer to traffic units (until 2008). Maximum and average prices refer to street retail quantities.

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

Purity/potency of illicit drugs

Over the last 10 years, average purity of cocaine has been generally decreasing, although in 2017 a new rise has been observed (2006: 58.8% / 2016: 44.4% / 48.4% in 2017). Average heroin purity has also been following a discontinuous downward trend over the past years (28.2% in 2005, 9.6% in 2012; 11% in 2016 and 12.1% in 2017). Nevertheless, regarding recent years, heroin purity seems witness a certain stability (see Table 10.3). Attention has to be paid to the striking differences in maximum and minimum purities as well as to a historically high maximum concentration of THC in cannabis samples seized in Luxembourg. In 2016, the maximum concentration of THC in herbal cannabis was 23.8% and 34.9% for resin cannabis, whereas

in 2017, the maximum concentration of THC was 24.8% for herbal (mean 12.3%) and 42.9% for resin cannabis (mean 21.4%), respectively. This reveals that the maximum concentration of THC in resin cannabis has increased by 8% compared to 2016.

Of concern are also the differences in maximum and minimum purities of other substances. For instance, heroin and cocaine show very high maximum purity rates. These values should however be considered with caution since the sampling may contain intermediary seizures, not ready for street consumption and to which cutting agents were supposed to be added. High maximum concentration of THC in cannabis, particularly in resin samples, seized in Luxembourg have been observed in recent years

Table 10.3: Purity of drugs at street level (2000-2017)

	2000	2002	2004	2006	2008	2010	2011	2012	2013	2014	2015	2016	2017		
Pur. (%)															
	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	AVRG.	MIN.	MAX.	AVRG.
Cannabis (THC)	8.03	7.96	6.94	7.36	9.82	11.32	10.99	9.09	8.7	11.59	11.99	10.90	2.3	42.9	16.9
Hashish					9.75	11.84	11.28	9.10	8.5	11.22	11.33	14.31	0.0	24.8	12.3
Marihuana					10.3	7.30	9.54	9.24	9.8	16.98	17.09	9.92	2.3	42.9	21.4
Cocaine	60.25	62.99	62.37	58.80	52.00	46.92	46.74	44.45	41	38.1	41.63	44.43	0.7	95.1	48.4
Heroin (brown)	17.59	9.97	17.07	15.80	16.10	24.02	10.08	9.60	13.9	13.52	11.93	11.04	0.0	52.8	12.1
ATS		15.09	9.44	7.1	18.2	10.43	15.58	17.03	23.1	11.44	25.13	16.16	6.1	42.2	17.5
Ecstasy ⁷¹ (MDMA)	35.5	71.11	29.77	26.44	23.52	53.14	77.88	42.89	77.3	53.55	42.29	49.69	16.6	94.3	56.4

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé, Division Toxicologie, 2018 (2017 data)

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

For cannabis, purity refers to percentage of THC.

In 2011, Schneider and Meys⁷² published a paper on analysis results of illicit cocaine and heroin samples seized in Luxembourg from 2005 to 2010.

Abstract: We assessed drug purity, frequency of appearance and concentration ranges of adulterants of 471 illicit cocaine and 962 illicit heroin samples seized in Luxembourg from January 2005 to December 2010. For cocaine samples the mean concentration was lowest in 2009 (43.2%) and highest in 2005 (54.7%) but no clear trend could be observed during the last 6 years. 14 different adulterants have been detected in cocaine samples, from which phenacetin has been the most abundant in terms of frequency of appearance and concentration until 2009. In 2010 the veterinary anthelmintic drug levamisole has become the most abundant adulterant detected in cocaine samples, its concentrations however remained low (1.5-4.1%). The mean heroin concentration was 26.6% in 2005, a decline has been observed in 2006 and the concentrations have been relatively stable since then (15.8-17.4%). Paracetamol and caffeine were by far the most abundant adulterants detected in heroin samples.

⁷¹ Ecstasy : dose in mg/pill

⁷² Schneider, S., Meys, F. (2011). Analysis of illicit cocaine and heroin samples seized in Luxembourg from 2005-2010. *Forensic Sci. Int.* 212(1-3), 242-246. doi:10.1016/j.forsciint.2011.06.027



PART B:

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ANNEX II

RELEVANT DATA BASES AND INFORMATION SYSTEMS

a. RELIS drug monitoring system

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

The main objectives of RELIS are the following:

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

The RELIS data collection procedure is based on a **standardised extensive data protocol** including 23 core items and over 60 sub-items. The standard protocol, including 95 per cent of the Pompidou protocol's items, has been last modified in 2009 in order to reach compatibility with the TDI (Treatment Demand Indicator) standard of the European Monitoring Centre for Drugs and Drug Addictions. 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 high-risk 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 high-risk 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 three 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 Luxembourg Institute of Science and Technology (LIST) (formerly CRP-Henri Tudor). The solution found is time and cost effective because it relies on a simple HP calculator that runs an attributor-to-code transcription programme based on a multiple-step algorithm.

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



One of the main benefits of the described procedure is that no personal data can be inferred directly from the identification code. The indating and encoding procedures are carried out at the very level of the field institutions. Thus, NFP is provided with individualised data (reporting protocols) without any reference to identifying information or attributors on the indexed persons in line with the new European law on data protection, 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 – Luxembourg Institute of Health, Laboratory of retrovirology;
- Early warning system on new synthetic drugs.

b. Register on drug law offenders (SPJ)

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

c. General Mortality Register (GMR)

The GMR is run by the Health Statistics Department of the Directorate of Health. The main impediment towards refined data provision on drug-related deaths and the application of the EMCDDA promoted DRD standard has been the 3-digit ICD coding applied by GMR until 1997. In 1998, ICD-10 standard was first applied by GMR. Currently, drug-related death data are extracted from GMR by means of a separate extraction routine. An integrated software based on the DRD ICD-10 standard allows to extract DRD cases from the GMR according to EMCDDA standards.

d. Special Overdose Register (SR) of SPJ

The SR is a paper-based register on acute drug-related deaths run by the SPJ. Over the past years, NFP relies on computer-based indexing procedure (SPSS®) of drug-related deaths by means of a comprehensive data form. NFP is maintaining a standardised database on acute drug-related deaths from 1985 to 2017. Anonymous drug-related death data is encoded at the SPJ and transmitted to the NFP according approved standards.

e. AIDS and HIV register (LIH)

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

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

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

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

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

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

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

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

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

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



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

In October 1995, a **new drug help line** was created, under the responsibility of the CePT. Given its easy access and the anonymity it guarantees, phone help lines often represent the first step with regard to further orientation or treatment demand proceedings and as such are able to provide high quality data on recent trends in drug use. The national Drug Help Line has been included in the EWS system in the course of 1999. In 2008, the drug phone help line has been replaced by a drug help on-line and email service (frono@cept.lu) run by CePT (Fro No).

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

g. Documentation Centres (NFP / CePT)

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

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

CLDDT is linked to the **Centre de Documentation du Centre de Prévention des Toxicomanies** run by CePT since 1996. The CePT documentation centre mainly focuses on primary prevention, training and evaluation in the fields of licit and illicit drugs. The current stock approaches 3,500 documents or media supports. Queries are handled manually and no computer-based consultation facilities are provided.

ALPHABETIC LIST OF RELEVANT INTERNET ADDRESSES

<https://www.arcus.lu/profile/27/quai-57-suchtberodungsstell>
<http://www.cept.lu>
<https://www.chem.lu/specialites-et-services-de-support/psychiatrie-esch>
<https://www.chl.lu/>
<https://www.chdn.lu/>
<https://www.chnp.lu/>
<http://www.cnds.lu>
<http://www.cnds.lu/abrigado/drogenkonsumraum/>
<http://www.croix-rouge.lu/de/contactez-la-croix-rouge-luxembourgeoise/aidsberodung/>
<http://www.ec.europa.eu/health>
<https://ec.europa.eu/eurostat/web/microdata/european-health-interview-survey>
<http://www.emcdda.europa.eu/http://www.emcdda.europa.eu/about/partners/reitox-network>
<http://www.etat.lu>
<http://www.gouvernement.lu>
<https://hbhc.uni.lu/>
<http://www.im-puls.lu>
<http://www.jdh.lu>
<http://www.legilux.public.lu>
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