



Luxembourg

Country Drug Report 2017

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THE DRUG PROBLEM IN LUXEMBOURG AT A GLANCE

Drug use

in young adults (15-34 years)
in the last year

Cannabis

No data



No data

Other drugs

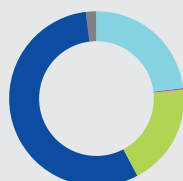
MDMA No data
Amphetamines No data
Cocaine No data

High-risk opioid users

No data

Treatment entrants

by primary drug



● Cannabis, 23 %
● Amphetamines, 0 %
● Cocaine, 19 %
● Heroin, 56 %
● Other, 2 %

Opioid substitution treatment clients

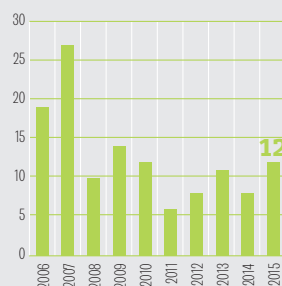
1 078

Syringes distributed

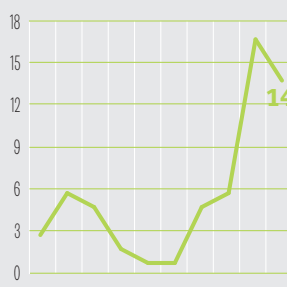
through specialised
programmes

361 392

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offenders

3 345

Top 5 drugs seized

ranked according to quantities
measured in kilograms

1. Herbal cannabis
2. Cocaine
3. Heroin
4. Cannabis resin
5. Amphetamine

Population

(15-64 years)

389 371

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

About this report

This report presents the top-level overview of the drug phenomenon in Luxembourg, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

National drug strategy

In Luxembourg, the National Strategy and Action Plan on Drugs and Addictions 2015-19 addresses illicit drugs, alcohol, tobacco, psychotropic drugs and behavioural addictions (e.g. gambling and device-mediated addictions) (Figure 1). The strategy is built around the two pillars of drug demand and drug supply reduction and the four transversal themes of harm reduction, research and information, international cooperation, and coordination. Its overall objective is to contribute to achieving a high level of protection in terms of public health, public security and social cohesion. This high-level objective is, in turn, supported by six sub-objectives across the strategy's pillars and transversal axis. The implementation of the strategy is supported by a 60-point plan that spreads the actions across the pillars and transversal areas.

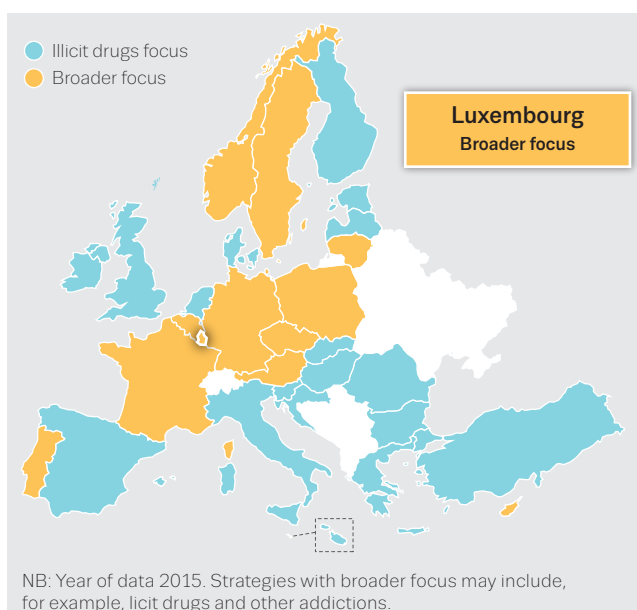
Like other European countries, Luxembourg evaluates its drug policy and strategy using routine indicator monitoring and specific research projects. In 2014, an external mixed-methods evaluation of the 2010-14 National Strategy's implementation was completed and used in the development of the current National Strategy 2015-19.

National coordination mechanisms

At the national level, the Inter-ministerial Commission on Drugs (ICD) coordinates the activities of different ministries involved in the drugs area. The Commission is chaired by the National Drug Coordinator, who is appointed by the Minister of Health. The Commission is composed of senior delegates from the main governmental departments, the Ministry of Health and invited experts, and it constitutes the top advisory level with respect to coordination and orientation of drug 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 area of demand reduction, the Ministry of Justice and the Ministry of Interior Security are responsible for supply reduction and the Ministry of Foreign Affairs is responsible for international cooperation.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



**The National Strategy
and Action Plan on Drugs
and Addictions 2015-19
addresses licit and illicit
substances and
behavioural addiction**

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments to expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the majority of drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

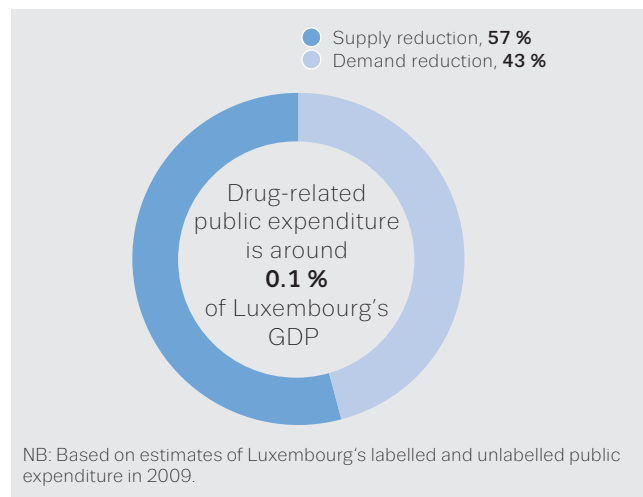
In 2009, the National Drug Coordinator set priorities for the 2010-14 National Action Plan on drugs, identifying concrete actions and planned budgets. Additionally, the government annually approves several drug-related budgets. In Luxembourg, estimates of total expenditures are also available; these are based on a well-defined methodology established in 2002.

In 2009, total public expenditure was estimated at 0.1 % of gross domestic product (GDP). Unlabelled expenditure represented 65 % of the total of more than EUR 38 million. Most expenditure related to public order and safety (almost EUR 22 million) and health (almost EUR 16 million) (Figure 2).

Monitoring of the evolution of annual budget allocated for drug-related activities by the Ministry of Health indicates that the budget almost doubled from approximately EUR 6.6 million in 2006 to EUR 12.4 million in 2015.

FIGURE 2

Public expenditure related to illicit drugs in Luxembourg



Drug laws and drug law offences

National drug laws

In 2001, the national drug law was amended to decriminalise cannabis use and possession for personal use. Thus, these became illegal activities attracting a fine only; prison sentences are imposed only if there are aggravating circumstances (e.g. use in schools or in the presence of minors) (Figure 3). Users of other illicit substances risk imprisonment for between eight days and six months and/or a fine. Prosecution may be halted or penalties reduced in cases where a drug user has taken steps to seek specialised help.

The law does not differentiate between small-scale and large-scale drug deals or distribution. Sentences for both currently range from one to five years' imprisonment and/or a fine, while a prison sentence of 5-10 years is imposed if the distributed drug has caused severe damage to health (e.g. an incurable disease). If the drugs had fatal consequences for the user, punishment for the distributor can be increased to 15-20 years' imprisonment.

New psychoactive substances (NPS) are regulated and controlled by the same legal instruments as 'established' illicit drugs. NPS may be added in the national lists of controlled substances by means of an accelerated legal procedure.

Since 2013, there have been large year-on-year increases in the number of drug law offenders: in 2015 a total of 3 345 drug law offenders were reported

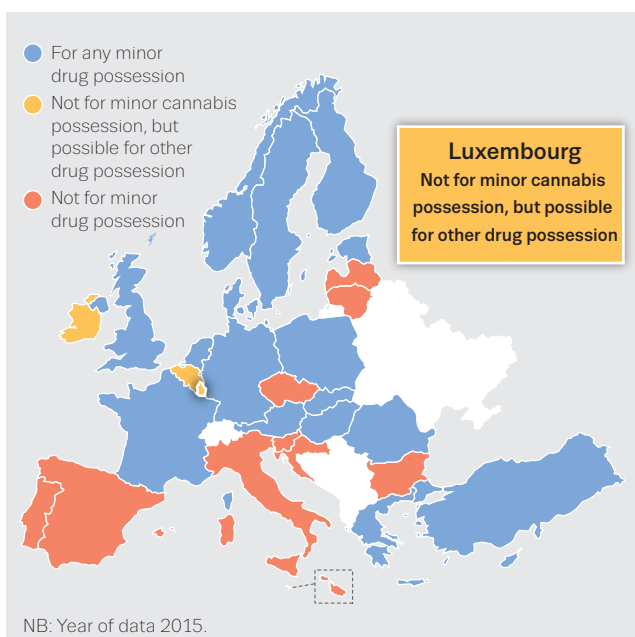
Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

After a period of relative stability from 2006 to 2008, the number of drug law offenders increased in 2009 and 2010 before decreasing again in the following two years. Since 2013, there have been large year-on-year increases in the number of drug law offenders: in 2015 a total of 3 345 drug law offender were reported. This is more than double the amount of drug law offenders in 2006, which was a total of 1 575. These increases are attributed to an enhanced police activity in several urban drug-selling 'hotspots' since 2014.

FIGURE 3

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



Drug use

Prevalence and trends

The European Health Interview Survey (EHIS) was launched in 2013 and contained some questions on the use of illicit drugs and NPS; however, the data was not reported to the EMCDDA by the end of 2016.

As far as national school surveys conducted in Luxembourg are concerned, comparable data from the Health Behaviour in School-aged Children (HBSC) show a decrease in the prevalence of any illicit drug use from 1999 to 2010 among students aged 12-18 years. In-depth analysis shows an overall decline in prevalence between 1999 and 2006 and a subsequent stabilisation, with the exception of cocaine, which has shown an increase, particularly in those aged 15-16 years.

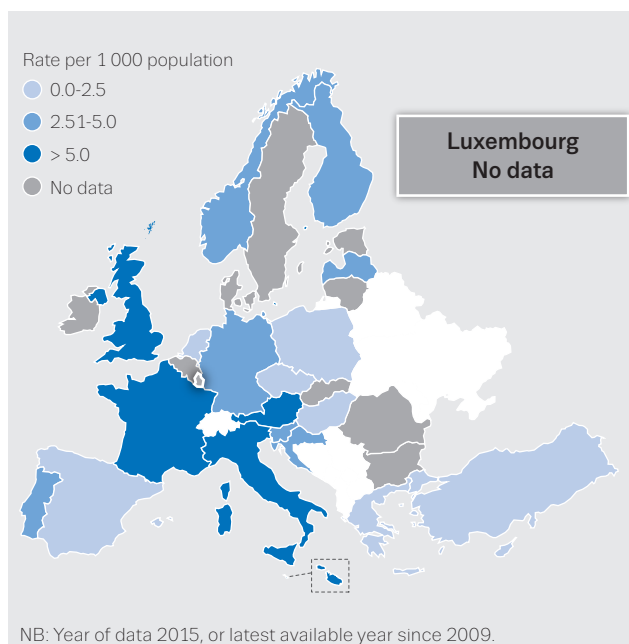
Although cannabis remains the illicit drug most used by young people aged 12-18 years, a clear decline in lifetime prevalence of use has been observed since the start of this century. Last-year and last-month cannabis use prevalence rates declined substantially between 1999 and 2006, and appear to have stabilised since then.

Information on the use of NPS is available from the 2014 Eurobarometer. The data indicated that 7 % of 15- to 24-year-olds had used some kind of NPS in their lifetime, close to the European Union average of 8 %.

The Health Behaviour in School-aged Children study indicates an overall decline in illicit drug use among 12- to 18-year-olds between 1999 and 2006, and a subsequent stabilisation in illicit drug use levels, with the exception of cocaine

FIGURE 4

National estimates of last year prevalence of high-risk opioid use



High-risk drug use and trends

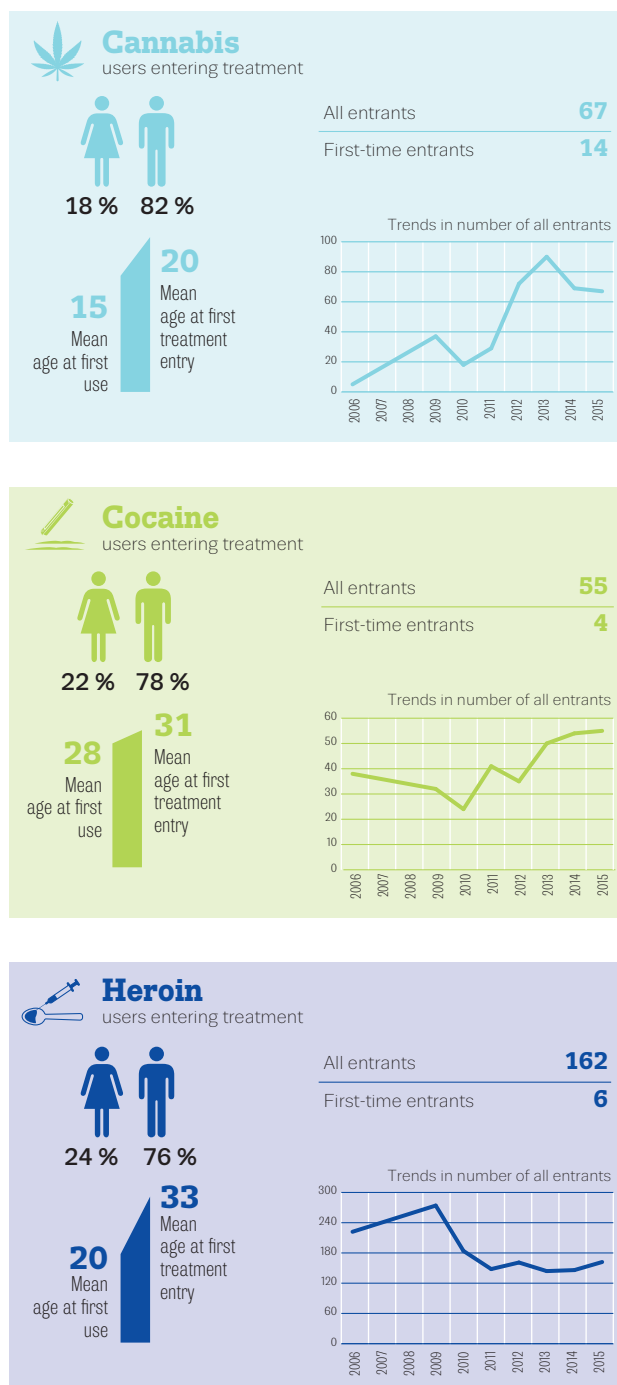
Studies reporting estimates of high-risk use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 5).

The most recent estimate of high-risk drug use in Luxembourg dates back to 2007, when approximately 1 900 heroin users were reported (Figure 4). The prevalence rate of injection drug use in the national population aged 15-64 years was 5.7 per 1 000 population in 2009 and has remained stable since 2003. In recent years, a new trend of cocaine injecting has emerged in the country.

Data from specialised treatment centres indicate that most people enter treatment for primary use of opioids (mainly heroin) or cannabis. Slightly fewer than half of all opioid users entering treatment injected their primary illicit drug. The number of injectors among treatment clients has decreased over the past 10 years. Almost one quarter of heroin users entering treatment in 2015 were female (Figure 5).

FIGURE 5

Characteristics and trends of drug users entering specialised drug treatment centres in Luxembourg



NB: Year of data 2015. Data is for all treatment entrants, except for age at first use which is for first time entrants.

Drug harms

Drug-related infectious diseases

Data on drug-related infectious diseases are collected at the national level through the National Retrovirology Laboratory and complemented by the information obtained through the multi-sector national network RELIS (based on self-reports) and specific studies. Data suggest that proportion of new human immunodeficiency virus (HIV) infection cases associated with drug injecting was declining between 2004 and 2013. In 2013, six new cases were reported. However, since then, an increase in new (HIV) cases linked to drug injecting has been observed. In 2014, a total of 17 new cases of HIV infection were reported among PWID, and the number decreased to 14 cases in 2015 (Figure 6).

The RELIS data also point to an increase in the HIV prevalence rate in 2015, with the self-reported prevalence rate for HIV and HCV infection at 8 % and 56 %, respectively. In 2015, an increase in the prevalence of acquired immunodeficiency syndrome (AIDS) was identified among problem drug users (6 % compared with 1 % in 2014) and drug treatment clients (7 % compared with 1 % in 2014).

Drug-related emergencies

No data on drug-related emergencies are available for Luxembourg. However, RELIS data on previous non-fatal and medically assisted emergencies for drug overdose self-reported by problem drug users are available.

FIGURE 6

Newly diagnosed HIV cases attributed to injecting drug use

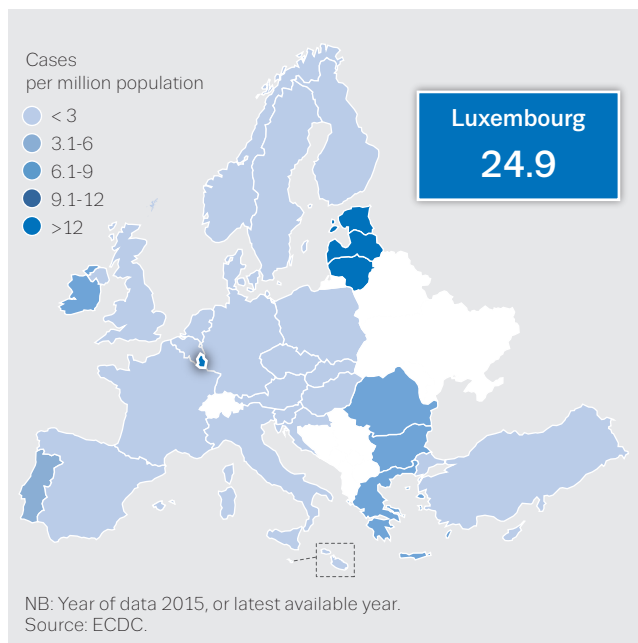
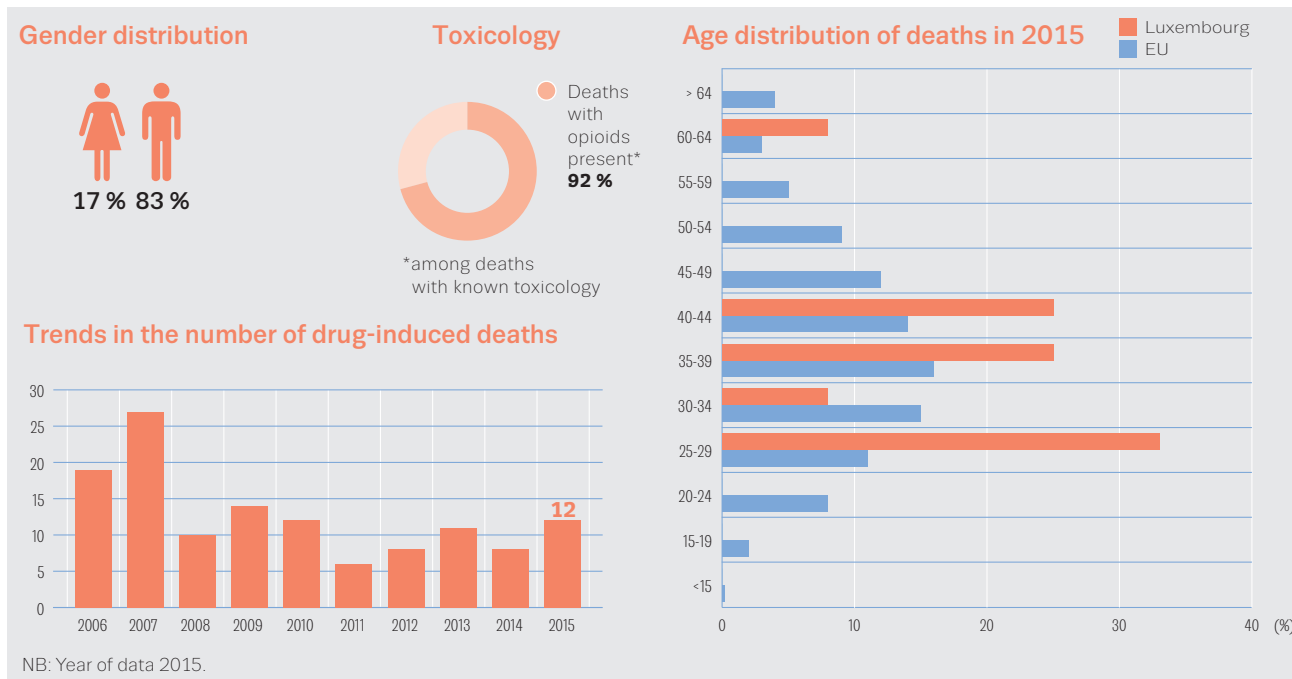


FIGURE 7

Characteristics of and trends in drug-induced deaths in Luxembourg



Drug-induced deaths and mortality

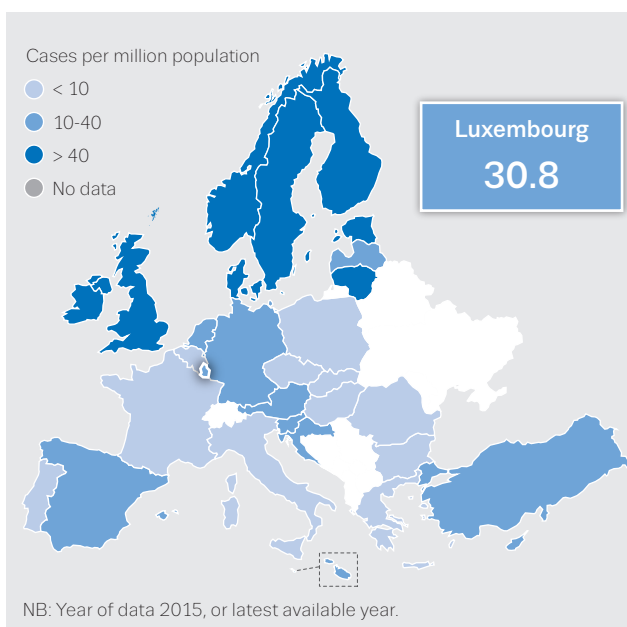
Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

In Luxembourg, the Special Registry data indicate a stable situation with regard to absolute numbers of drug-induced deaths in the country in recent years. Toxicological reports for the period 1992-2015 show that heroin is the substance most frequently involved in drug-related deaths, followed by prescription drugs, usually taken in combination with other licit or illicit substances. The majority of victims are male (Figure 7). The mean age of victims has increased over the past 20 years.

The drug-induced mortality rate among adults (aged 15-64 years) in Luxembourg was 30.8 deaths per million in 2015, which is higher than the most recent European average of 20.3 deaths per million (Figure 8).

FIGURE 8

Drug-induced mortality rates among adults (15-64 years)



Prevention

The National Strategy and Action Plan on Drugs and Addictions 2015-19 identifies prevention as a main intervention area and aims to reduce initiation of drug use, delay the onset of drug use and encourage protective actions and healthy lifestyles in the general population and at-risk groups. The planning and implementation of drug prevention is under the authority of governmental actors and results from collaboration between the Ministry of Health, the National Drug Coordination Office, the Division of Preventive Medicine of the Directorate of Health and the National Drug Addiction Prevention Centre (CePT).

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

Universal prevention is mainly implemented in schools, although drug-related information and prevention modules are not mandatory in school curricula. School-based programmes are usually implemented through joint cooperation between the government and non-governmental organisations (NGOs), and teachers are offered specific training. Trained psychologists look out for problems or behaviours in relation to substance use that is still at a very early stage (Figure 9).

The national approach is partly based on the hypothesis that adolescents who are physically fit and mentally stimulated, and who live in a stable, supportive environment with empathic parents, are less likely to experience problems related to the use of drugs. Annual 'adventure weeks' aim to give young people the opportunity to experience group dynamics, conflict management, risk assessment, and a feeling of solidarity within a group of socially and culturally diverse people. The programme aims to reduce risk factors and enhance protection factors by focusing on the young people and their environment.

Recent developments include the launch of the CePT Toolbox to assist with the implementation of school-based prevention activities, and the publication of recommendations for educational professionals on how to tackle cannabis in the school environment. Training modules on how to communicate with young people about psychoactive substances in non-formal environments have been developed for professionals working with this group.

In 2015, an introductory course on prevention was run at the University of Luxembourg and the Police Academy;

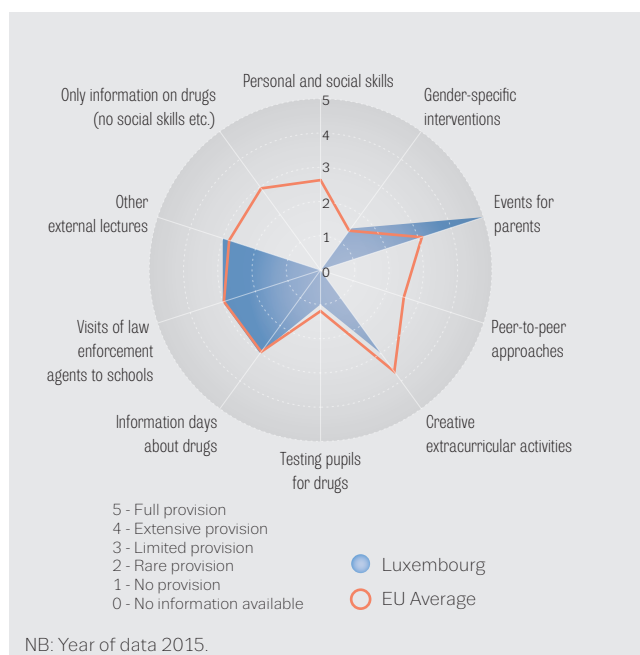
several training courses on psychoactive substances, and different methods and tools available for the prevention of dependencies were also held.

Selective prevention focuses on avoiding social exclusion and crisis interventions in schools, but activities are also carried out in recreational settings and with high-risk groups, such as polydrug users and those who show excessive use of alcoholic-mix drinks, and at-risk families. 'Choice' is an early intervention programme for juvenile first-time offenders. Since October 2014, Choice has been extended to young people up to 21 years of age. Selective prevention is carried out in recreational settings and events such as music festivals, art performances, adventure days, theatre, media materials, seminars, travelling exhibitions and travel experiences. MAG-Net Party operates information points that provide information, earplugs, condoms, soap, breath testing and drinking water in recreational settings to minimise health risks. In 2014, a new service, DrUg CheCKing (DUCK), was launched in the framework of MAG-Net Party activities, to check the quality of substances used in recreational settings with the primary preventative aim of gaining greater access to these consumer scenes. The Youth and Drug Help Foundation offers psychosocial help to drug-dependent parents and their children, and provides intervention to strengthen the parenting skills of drug-using mothers.

With regard to indicated prevention, early detection is a priority for children exhibiting high-risk behaviour in school settings and at home, and further interventions are provided through psychiatric care services.

FIGURE 9

Provision of interventions in schools in Luxembourg (expert ratings)



Harm reduction

In Luxembourg, reduction of drug-related harm and risk has been highlighted as an important activity of the National Strategy 2015-19.

A legal framework for the harm reduction measures, such as needle and syringe exchange, supervised injection rooms and the possibility to introduce medically assisted heroin distribution, was established in 2001, although some harm reduction interventions had already been initiated and developed previously.

Harm reduction interventions

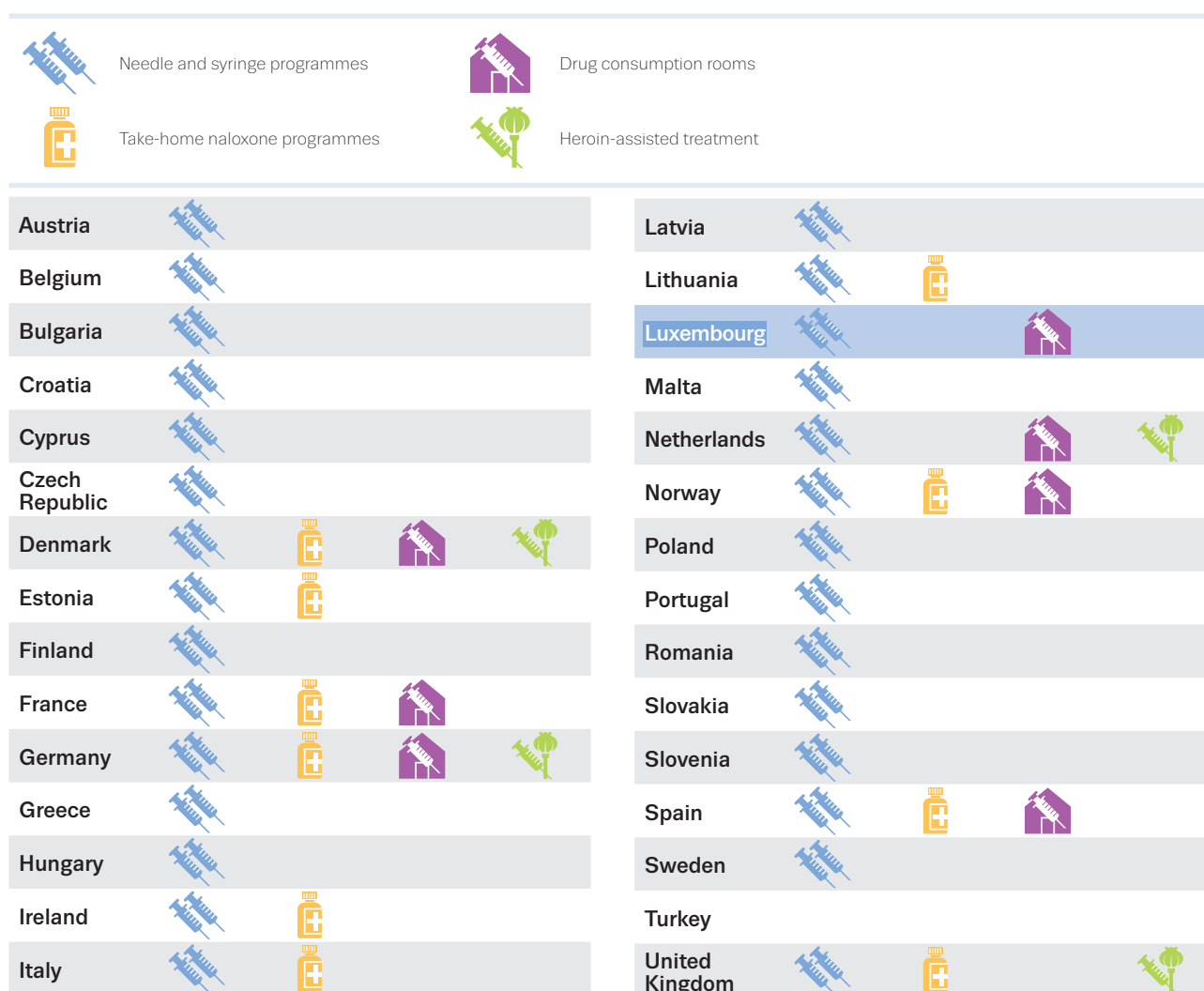
The national needle and syringe programme in Luxembourg is decentralised and consists of five fixed sites and three vending machines situated in the towns most affected by injecting drug use. Clean syringes are

available from drug counselling centres, drop-in centres for sex workers and at-risk populations, at low-threshold centres and in prison. In addition to needles and syringes, testing for blood-borne infectious diseases, vaccinations and counselling on safe use practices are also provided. In 2012, a mobile medical care unit was launched as an additional service, facilitating the provision of primary medical care at low-threshold agencies.

The number of sterile syringes distributed in the framework of the national needle programme has increased since it was first implemented in 1993, when approximately 76 000 syringes were distributed; it reached a peak in 2004, when approximately 435 000 syringes were handed out. Syringe demand decreased thereafter, and in 2015 approximately 361 400 syringes were distributed (including in prisons and from vending machines).

FIGURE 10

Availability of selected harm reduction responses



NB: Year of data 2016.

A supervised drug injection room opened in 2005 and has been integrated into a low-threshold emergency centre for drug users (Figure 10). By 2015, a total of 1 605 clients had signed the facility's mandatory user contract, and more than 56 000 injections were supervised by trained staff during that year. In 2012, the facility opened a room where drugs can be inhaled under supervision (blow room). The creation of an integrated low-threshold centre with a supervised drug consumption room in the southern part of the country in 2018 is part of the governmental programme.

**In 2015 approximately
361 400 syringes were
distributed through
the needle and syringe
programmes**

Treatment

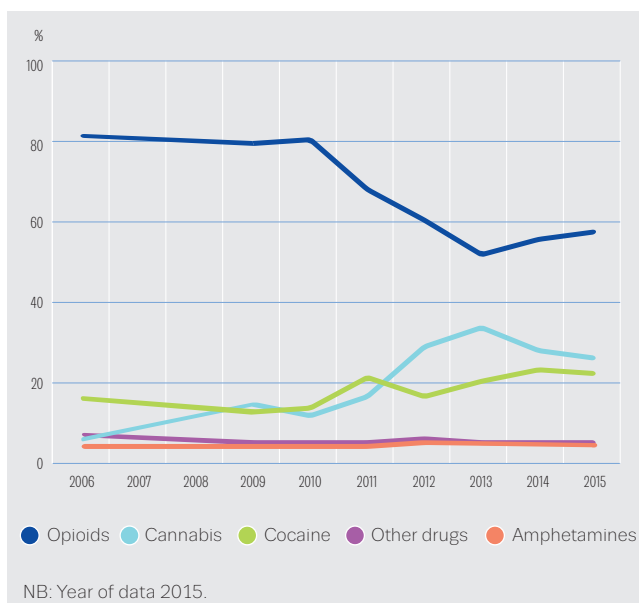
The treatment system

The current national strategy and its associated action plans envisage further expansion of the national treatment system by adopting a more holistic concept of dependence treatment, which covers both licit and illicit substances. Over the past years, counselling and specialised care networks have been developed, which has enabled drug users to start treatment at an earlier stage in their drug career.

Specialised drug treatment infrastructure in Luxembourg relies on government support and control and is provided through specialised outpatient treatment facilities, low-threshold agencies, hospital-based drug treatment units and a therapeutic community. Treatment units are available in prisons. Treatment is decentralised and is most commonly provided by state-accredited NGOs. Most of these specialised agencies have signed an agreement (i.e. convention) with the Ministry of Health that guarantees their annual funding. While outpatient treatment is provided free of charge, inpatient treatment is covered by health insurance. The overall management of these agencies is ensured by a 'coordination platform', which includes three members of the institution and at least one representative from the competent ministry. All major decisions must be approved by the coordination platform. All institutions work in close collaboration and could be viewed as an interdependent therapeutic chain. A number of collaboration agreements between agencies were signed in 2008 and 2009 to ensure throughcare and rational use of available resources. With the exception of detoxification departments, all treatment units or agencies accept any drug-using patient, irrespective of the type of substances that are involved. Detoxification treatment is provided by five different hospitals, in their psychiatric units. The programme provided by the residential therapeutic community is divided into three progressive phases and the duration varies from three months up to one year. The programme offers special treatment opportunities to pregnant females, drug-using couples and mothers with children. An outpatient centre and a non-specialist residential centre admit young problem drug users. A dedicated psychosocial and medical care programme is operational in national prisons (Programme Tox).

FIGURE 11

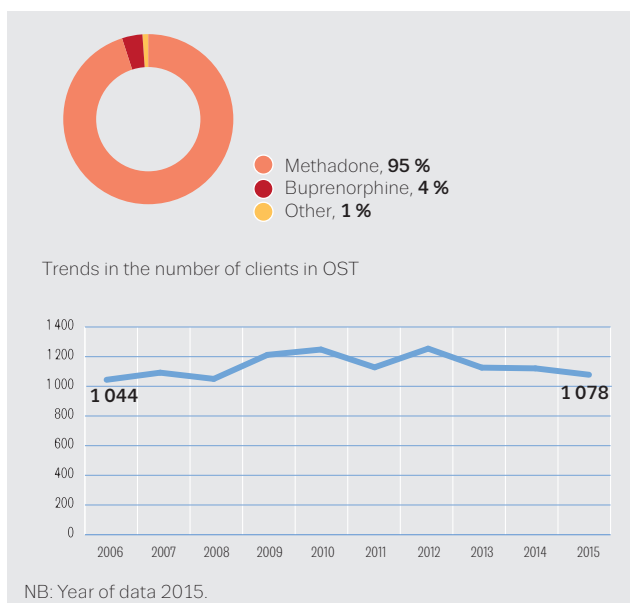
Trends in percentage of clients entering specialised drug treatment, by primary drug, in Luxembourg



Office-based medical doctors play an important role in the delivery of opioid substitution treatment (OST), but OST is also provided by specialised agencies. The pharmaceutical types of OST registered in Luxembourg include methadone, buprenorphine, morphine-based medications and heroin (within the framework of a pilot project). The costs of OST is partly covered by individuals' health insurance, while the state covers pharmaceutical costs and pharmacy fees.

FIGURE 12

Opioid substitution treatment in Luxembourg: proportions of clients in OST by medication and trends of the total number of clients



Treatment provision

The majority of clients entering treatment in Luxembourg during 2015 were treated in outpatient settings, but prisoners also accounted for a large proportion of clients. While opioids, mainly heroin, are the primary substance used among all treatment clients, the proportion of clients entering treatment as a result of opioid use has decreased since 2010 (Figure 11).

The number of patients receiving OST by prescription from independent and licensed practitioners has remained stable in recent years. The majority of clients receive methadone maintenance treatment and the others receive buprenorphine-based treatment (Figure 12).

Drug use and responses in prison

In Luxembourg, drug use among prisoners has been assessed and the drug related problems, including mental health disorders, social problems and infectious diseases, were found to be manifold compared with the general population.

According to a study published in 2007, over half of problematic drug users (56 %) who had been in prison in the past reported illicit drug use during imprisonment, with around one third reporting injecting drug use. Just over one quarter of prisoners who had ever injected drugs reported needle sharing in prison, which is lower than the rate observed in 1998. Rates of HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) infection were higher among respondents who were recruited in prisons and had ever injected drugs than among those who were recruited in outpatient or inpatient treatment settings.

Health strategies and policies for prisons were established in Luxembourg in 1997 and a pilot project, Global Drug Care Programme in Prison, was set up in 1999. In 2007, the project became a routine programme in national prisons (Programme TOX). The programme was designed to implement primary prevention measures and address illicit drug use and infectious diseases. The basic principles of the TOX programme are voluntary participation, cooperation, transparency, quality of service, determination of realisable objectives and empowerment of participants.

The implementation of health responses in prison is centred around three pillars: psychosocial care, coordination of interventions and prevention of sexually transmitted diseases. Health responses for prisoners include detoxification treatment and psychosocial guidance. Detoxification treatment is either the responsibility of the prison medical unit or is provided by external units of general hospitals in accordance with strict rules and procedures. Psychosocial and therapeutic care is provided by both staff of the prison medical unit and specialised external agents from accredited drug agencies.

Opioid substitution treatment is provided to prisoners who were receiving it prior to incarceration and may be followed by maintenance, dose reduction or detoxification treatment. It may also be initiated in prison. In 2015, a total of 173 prisoners received OST.

A special programme targets female prisoners exclusively and becomes operational when a minimum number of females enrol. Drug-free zones are also available.

A structured syringe distribution programme was officially launched in 2005. In 2015, 40 kits were distributed and around 2 000 syringes were exchanged. Other harm reduction interventions include the provision of ascorbic acid, filters, sterile physiological water and antiseptic wipes. Continuity of care and resocialisation measures are ensured by the intervention of social workers from external field agencies.

**In 2015, a total of 173
prisoners received opioid
substitution treatment**

Quality assurance

The selection of projects or programmes retained in the framework of implementation of the current National Action Plan is based upon a six-criterion matrix comprising relevance, opportunity, feasibility, cost–benefit/quality factors, quality assurance mechanisms and measurability of results or impact.

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 providers. General guidelines on requirements, human resources and target population of a treatment setting are specified by the grand-ducal decree of 10 December 1998 regarding the accreditation of services in the medical, social and therapeutic fields. All specialised drug treatment services are dependent on government support and control. Specialised agencies need formal accreditation from the Ministry of Health to offer their services and to be eligible for a governmental convention that guarantees their annual funding.

The quality standard certification requires NGOs to undertake necessary evaluation measures of their activities by means they deem adequate. Drug treatment agencies have developed individual evaluation strategies, mostly in collaboration with external evaluators. The external evaluation of the drugs action plan also helps to assess the functioning of and gaps in the national drug-related response.

Continuous drug-related training is offered by several specialised agencies; in addition, the University of Luxembourg offers special courses in the framework of social work or education studies.

The governmental quality standard certification, as visualised by the law ‘ASFT’ of 8 October 1998, represents the main instrument of a standardised quality control of drug treatment providers

Drug-related research

The current National Drug Action Plan 2015-19 explicitly refers to research as an integrated part of the transversal axes of demand and supply reduction. Research domains include a wide variety of areas. In 2014 and 2015, focus was placed on research addressing drug-related mortality. In the course of 2016, priority was given to the European Health Interview Survey (EHIS), as no representative general population survey on drug use had been conducted prior to EHIS. Future research priorities include indirect epidemiological indicators and problem drug use/high-risk consumption prevalence estimations; supervised injection rooms; comorbidity/dual diagnosis in drug users; and wastewater drug analysis.

A serology-based research on viral hepatitis prevalence among drug users was launched in collaboration with the Luxembourg Institute of Health and the Centre Hospitalier du Luxembourg. The survey will allow follow-up development of hepatitis prevalence data from the last comparable survey in 2007 and provide valuable data for the drafting of the first national action plan against hepatitis.

The national focal point to the EMCDDA is the national reference centre for drug-related research. It also manages most of the available funds in this area, provided by the National Research Fund and the National Fund against Certain Forms of Criminality. Other relevant actors include the National Prevention Centre for Drug Addiction, university departments, the Oeuvre Nationale de Secours Grand-Duchesse Charlotte and external experts. The national focal point also disseminates research information through its website and presents new research studies to the national press. Research findings play an important role in training programmes for professionals in this area.

In the course of 2016, priority was given to the European Health Interview Survey, as no representative general population survey on drug use had been conducted prior to it

Drug markets

The majority of illicit substances consumed in Luxembourg arrive from the Netherlands (cannabis production and transit of other drugs), Belgium (MDMA/ecstasy and amphetamine-type stimulants production) and Morocco (cannabis). Cocaine found on the national market originates from Latin America and mostly transits from the south of Europe. Heroin is trafficked into the country via the traditional Balkan route, more specifically its northern branch.

In recent years, more organised criminal distribution networks have been developing nationally, contributing to a significant increase in drug availability, and particularly in the supply of cocaine and cannabis.

Following a reduction in quantities of heroin seized, similar to other European countries in 2012, the annual amounts seized have recently been picking up, though these remain comparatively very small. No clear trend has emerged from the data regarding cannabis — either herb or resin — or cocaine.

Regarding the reported number of seizures, seizures of heroin are generally stable (between 150 and 300 annually) whereas seizures of cocaine have increased steadily since 2000 (from 50 to a maximum of 190 in 2015). Over the same period, an increase in seizures of cannabis resin has been observed. The number of seizures of herbal cannabis also continues to increase (Figure 13).

Retail price and purity data of the main illicit substances seized are shown in Figure 14.

FIGURE 13

Drug seizures in Luxembourg: trends in number of seizures (left) and quantities seized (right)

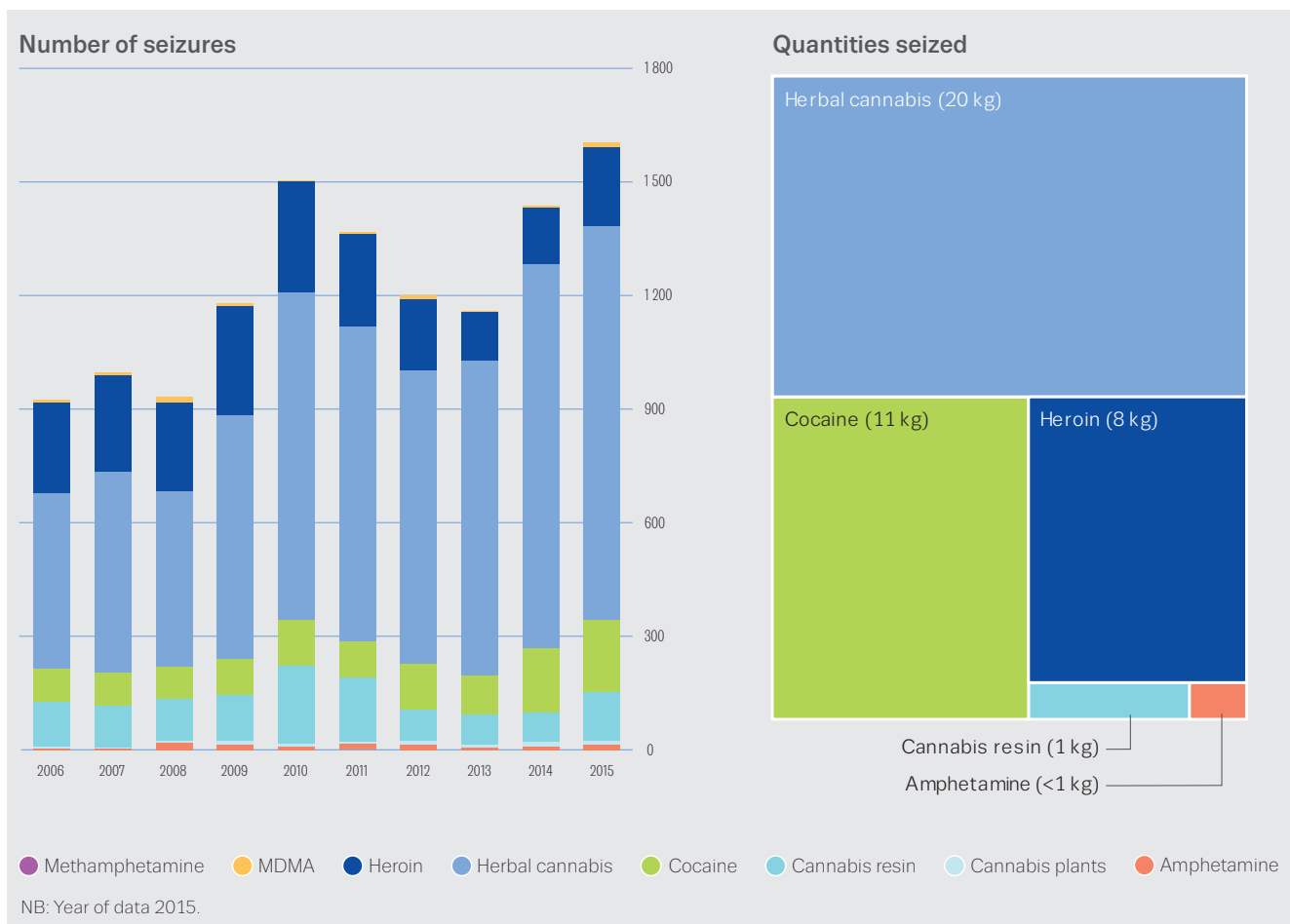


FIGURE 14

Price and potency/purity ranges of illicit drugs reported in Luxembourg



NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum. Year of data 2015.

KEY DRUG STATISTICS FOR LUXEMBOURG

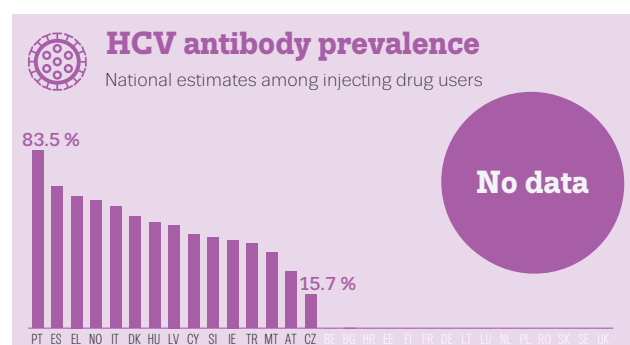
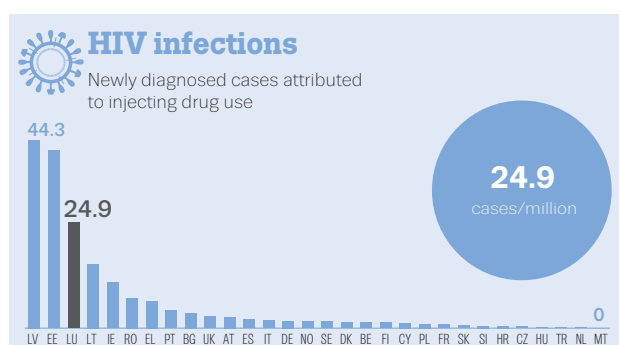
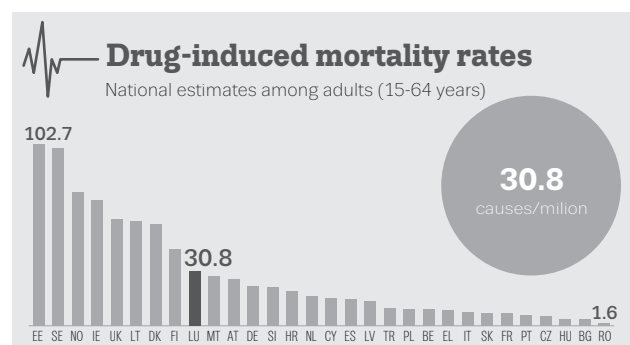
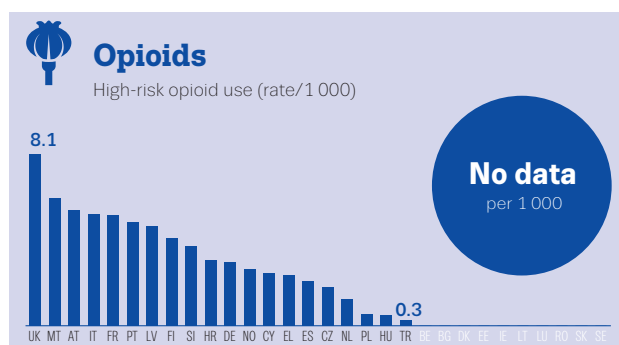
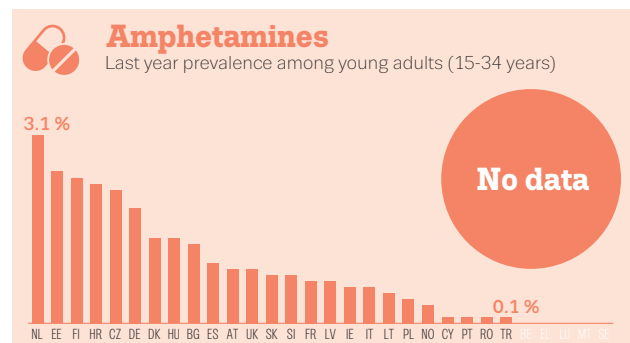
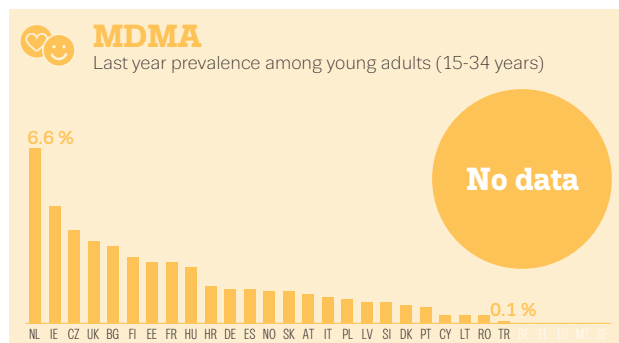
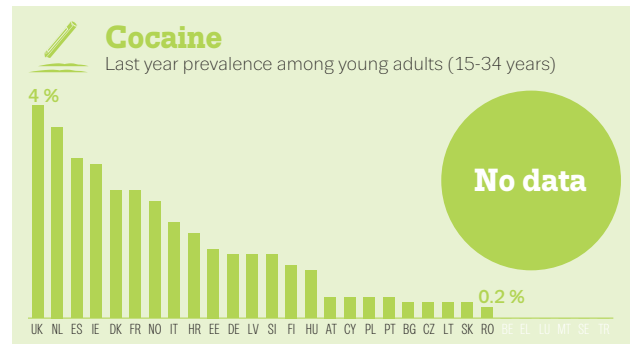
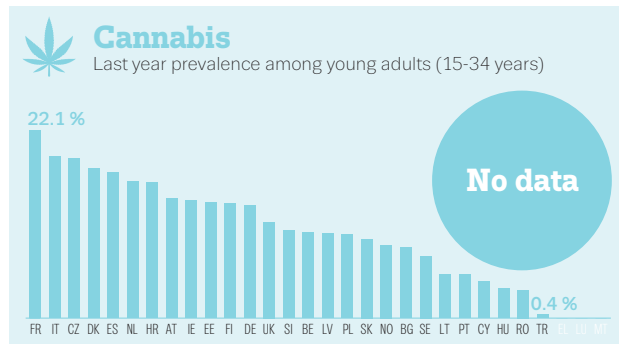
Most recent estimates and data reported

	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	6.5	36.8
Last year prevalence of use — young adults (%)	No data	No data	0.4	22.1
Last year prevalence of drug use — all adults (%)	No data	No data	0.3	11.1
All treatment entrants (%)	2015	23	3	71
First-time treatment entrants (%)	2015	58	8	79
Quantity of herbal cannabis seized (kg)	2015	19.8	4	45 816
Number of herbal cannabis seizures	2015	1 040	106	156 984
Quantity of cannabis resin seized (kg)	2015	0.8	1	380 361
Number of cannabis resin seizures	2015	130	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	< 1-38.6	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	0.6-40.8	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	8.3-25	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	8.3-10	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	0.9	4.9
Last year prevalence of use — young adults (%)	No data	No data	0.2	4
Last year prevalence of drug use — all adults (%)	No data	No data	0.1	2.3
All treatment entrants (%)	2015	19	0	37
First-time treatment entrants (%)	2015	17	0	40
Quantity of cocaine seized (kg)	2015	10.7	2	21 621
Number of cocaine seizures	2015	190	16	38 273
Purity (%) (minimum and maximum values registered)	2015	0-100	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	50-200	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	0.8	6.5
Last year prevalence of use — young adults (%)	No data	No data	0.1	3.1
Last year prevalence of drug use — all adults (%)	No data	No data	0	1.6
All treatment entrants (%)	2015	0	0	70
First-time treatment entrants (%)	2015	0	0	75
Quantity of amphetamine seized (kg)	2015	0	0	3 796
Number of amphetamine seizures	2015	13	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	2.5-97.1	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	No data	No data	1	139.8

	Year	Country data	EU range	
			Minimum	Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	0.5	5.2
Last year prevalence of use — young adults (%)	No data	No data	0.1	6.6
Last year prevalence of drug use — all adults (%)	No data	No data	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	2015	0	0	2
Quantity of MDMA seized (tablets)	2015	543	54	5 673 901
Number of MDMA seizures	2015	14	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	1.2-95.7	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	5-12.5	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	No data	No data	0.3	8.1
All treatment entrants (%)	2015	56	4	93
First-time treatment entrants (%)	2015	25	2	87
Quantity of heroin seized (kg)	2015	8	0	8 294
Number of heroin seizures	2015	208	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	0-40.4	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	11-100	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	24.9	0	44
HIV prevalence among PWID* (%)	2015	8.2	0	30.9
HCV prevalence among PWID* (%)	No data	No data	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2009	5.7	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2015	30.8	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2015	361 392	164	12 314 781
Clients in substitution treatment	2015	1 078	252	168 840
Treatment demand				
All clients	2015	290	282	124 234
First-time clients	2015	24	24	40 390
Drug law offences				
Number of reports of offences	2015	3 345	472	411 157
Offences for use/possession	No data	No data	359	390 843

* PWID — People who inject drugs.

EU Dashboard



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.



About our partner in Luxembourg

The headquarters of the national focal point in Luxembourg are located within the Luxembourg Institute of Health (LIH). As a scientific research institute in the field of public health, LIH is a common welfare institution, which is partly financed by the National Administration. A series of synergies between the national focal point and specialised departments of the LIH allow for effective experience sharing and management of technical, logistical and administrative activities.

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