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NATIONAL REPORT ON DRUGS IN SOCIETY

FRANCE

PART 1 NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

The Interministerial Mission for the Fight Against Drugs and Drug Addiction [*Mission interministérielle de lutte contre la drogue et la toxicomanie*] (MILDT) has the task of looking after, on behalf of the Permanent Interministerial Committee for the Fight Against Drugs and Drug Addiction, the implementation of the public policy decisions reached by the latter. On the basis of proposals put together by the MILDT, a three-year (1999-2000-2001) plan to fight against drugs and prevent dependence has been adopted by the government.

This plan notes certain points to be addressed:

- the methods of consumption of psychoactive products are changing,
- users are increasingly adopting multiple consumption behaviours (consumption of several substances, e.g. ecstasy and alcohol),
- care facilities are unequally distributed across the national territory,
- there is no common approach to drugs and drug addiction,
- the social and professional support at the time of reception into care remains inadequate.

Starting from these points, the plan defines some broad lines of policy. Certain general priorities become clear, in particular:

- the development of a monitoring system for the use of licit and illicit psychoactive substances with an emphasis on work in the social sciences (studies and research) and the organisation of the available information to inform public policy,
- the distribution of reliable, scientifically validated data to the general public in order to give the answers required regarding the drug situation,
- the extension of preventive measures to address all aspects of psychoactive products use behaviour (rather than concentrating on the substances alone, as at present),
- the development of a common approach with regard to psychoactive products amongst all professionals and others active in the field of prevention in order that public policies and new approaches that are adopted can be understood and shared by all those involved in their implementation,
- the extension of the risk and damage reduction policy to cover all aspects of use behaviour,
- the establishment of a system of early medical and social care response (before users of psychoactive substances become dependent) in order to provide users with a support adapted to their needs,
- the integration of a public health attitude into the public security system, starting from an adaptation of criminal policy, whether with regard to users held for questioning or those placed in detention,
- the strengthening of the action taken against trafficking, making more means available to act against both local and international traffic, money laundering (law of 1996 on living on the earnings from drugs) or the sources of chemical precursors,

- the development of French activity in the international arena with a global approach aiming at a balance between reduction of supply, reduction of demand and reduction of risk, this will involve a redefinition of geographical priorities and favour the development of actions for demand and risk reduction.

With the new **prime ministerial circular[1] of 13 September 1999** both the principle and the necessity of local co-ordination are reaffirmed while the mission of the *departmental* project manager is more precisely and strongly defined to the extent that a process of decentralising funding and localising action is set in motion.

Chosen from amongst the members of the prefectorial body (director of a prefect's office, sub-prefect of the town) or amongst the managers of the decentralised state services, he is responsible for local policy in this area and co-ordinates the activities of the various state services in the *department*. He receives a mission letter from the Prefect which legitimises his position with regard to colleagues and institutional partners. The major decisions on policy implementation are taken in the steering committee on drug control and prevention of dependence; this body is chaired by the Prefect with the assistance of the project manager. It is to meet every three months.

There is thus a regular meeting of all the decentralised service managers, judicial authorities and local community representatives to co-ordinate their activities and decide on their funding.

These recent movements in public policy have given rise to the implementation of public actions and mechanisms with associated human, administrative or financial involvement. In order to assess the achievements and results arising out of these general movements, the necessary steps have been taken for monitoring and evaluation at both national and local levels. The main information gathered is discussed in part 3, devoted to the interventions carried out.

1.2 Policy implementation, legal framework and prosecution

Legal framework

The **law of 31 December 1970** has constituted the legal framework for French policy to fight against drugs for about 30 years. This law represses the use of and traffic in narcotics while making a clear distinction between these two aspects of the problem. It also guarantees free care and anonymity to users wishing to submit to treatment. Since 1970, the repression of traffic has been reinforced on several occasions by increases in the penalties incurred or by the introduction of new offences (offer and transfer, money laundering). The repression of use, on the other hand, the subject of continuing debate, has not been changed through all these years.

However, this relative continuity from the legislative point of view should not be allowed to hide the fairly significant changes in the implementation of the law, at least as expressed through the circulars and other texts drawn up by the administrations in charge of justice and health.

The law of 1970 has been the subject of numerous presentations and analyses. Without dwelling on its origins, we shall briefly recall the objectives of this law:

1 Prime Minister's Circular No. 4.629/SG of 13 September 1999 regarding the fight against drugs and prevention of dependence, gazette of 17 September 1999, Health Department bulletin No. 99-37 of 26 October 1999 (NOR: PRMX9903743C)

- the severe repression of trafficking,
- to lay down the principle of the repression of narcotics use while proposing a therapeutic alternative to direct repression,
- to guarantee free care and anonymity to users wishing to submit to treatment.

The list of narcotic products covered by this law is set down in a decree issued by the minister responsible for health on the basis of advice from the chairman of the French Agency for the Safety of Health Products in accordance with international regulations.

With regard to trafficking, the penalties laid down are particularly heavy when compared to those for other offences. The police services are able to proceed beyond the normal limitations of common law: Police custody can be for 4 days rather than 48 hours and night searches are permissible. Article L.3421-1 of the Public Health Code punishes the illicit use of narcotics with a maximum penalty of one year's imprisonment or a fine. Furthermore, article L.3411-1 provides that the user is placed under the supervision of the health authority. These texts underline the dual status of the user, who is considered, under the law, to be at once an offender and ill. The user can escape punishment if he submits to the mandatory treatment that is proposed by the prosecutor.

For the user, the circulars emanating from the Ministries of Justice and of Health have, as time goes on, placed more emphasis on the therapeutic alternative or, on the other hand, on repression where the use is in connection with trafficking. The succession of laws passed since the end of the 1980s chiefly concern the repression of trafficking and acts in connection with narcotics trafficking, either by imposing more severe penalties or by creating new offences. Thus, with the law of 16 December 1992[2], the penalties can extend to life imprisonment and a fine of 50 million francs for certain dealings. At the same time, special attention is being paid to the repression of money laundering or falsification of declarations or evidence of the origins of the resources of dealers and traffickers (law of 31 December 1987[3], law of 23 December 1988[4], law of 12 July 1990[5], law of 13 May 1996[6]). This last law also makes it punishable to be unable to justify resources corresponding to one's standard of life if one has a standing relationship with a narcotics user or dealer ("living on the earnings from drugs"). Furthermore, the manufacturing and trading of "precursors", products that can be used to manufacture narcotics, are controlled (law of 19 June 1996[7]). Finally, as a part of measures taken for road safety, the law of 18 June 1999[8] provides for the systematic investigation of drivers involved in fatal accidents to detect the presence and dosage of narcotics. These analyses will form the basis of a study that should be able to evaluate the role played by narcotics in this type of accident. The conclusions are expected at the end of 2004.

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2 Law No. 92-1336 of 16 December 1992 bringing into force the new penal code, Gazette of 27 December 1992 (NOR: JUSX92400040L).

3 Law No. 87--1157 of 31 December 1987 regarding the fight against narcotics trafficking and modifying certain provisions of the penal code, Gazette of 5 January 1988 (NOR: JUSX8700015L).

4 .Finance act for 1989, No. 88-1149 of 23 December 1988, article 84, Gazette of 28 December 1988, p.16320 ff. (NOR: ECOX880121L).

5 Law No. 90-614 of 12 July 1990 regarding the fight against money laundering, Gazette of 14 July 1990, p.8329-8332 (NOR: ECOX9000077L).

6 Law No. 96--392 of 13 May 1996 regarding the fight against money laundering and narcotics trafficking and international co-operation in matters of seizure, Gazette of 14 May 1996, p.7208 ff. (NOR: JUSX9400059L) and circular CRIM No. 96-11G of 10 June commenting on the law of 13 May 1996 regarding the fight against money laundering and narcotics trafficking and international co-operation (NOR: JUS D 96 30084C).

7 Law No. 96-542 of 19 June 1996 on the control of the manufacture and trading of substances, Gazette of 20 June 1996, p.9207 ff. (NOR: INDX9500023L).

8 Law No. 99-505 of 18 June 1999 including various measures regarding road safety and crimes against the agents of transport system operators, Gazette of 19 June 1999, p. 9015 ff. (NOR: EQUX9800010L).

Implementation of Prevention Policy

During the 1990s, the political debate on prevention has become more structured: It has consolidated around a behavioural approach to the use of psychoactive substances, which has progressively taken the place of the more instrumental, product-oriented approach taken since 1970. In this, the political discussion has corroborated the practice of many professionals, who had already been persuaded that their interventions should not be focused on any single product. The modification of the prevention concept (and, consequently, of its objectives) has been stimulated by certain developments observed during the last ten years in drug use practices and the social groups concerned:

- the growth in the number and use of new substances and, especially, the development of multiple consumption,
- the growth in the number of socially well integrated users and those whose consumption is apparently well controlled,
- the increasing social acceptance of drug use so long as it does not endanger the individual or those around him,
- the development, since the appearance of aids, of a health concept founded on individual responsibility.

The plan of 14 September 1995 for the fight against drug addiction announces the preparation of a reference document on the objectives to be pursued and preventive methods to be used against drug use: the Parquet report (Parquet, 1997). This report formalises the bases of a discussion on prevention that seeks to unify the thinkings of the various bodies, both public and private, engaged in prevention. In so doing, it presents a coherent approach.

Discussion of prevention: Parquet report (1997)

The Parquet report underlines the fact that the developments in the drug problem – as mentioned above – require more pragmatic solutions: it is no longer possible to sustain an approach to prevention based exclusively on abstinence as was the line taken during the last two decades. On the other hand, the progress made in understanding the neurobiological mechanisms connected with the intake of substances acting on the mental state reveal that certain metabolic processes are common to licit and illicit substances. The scientific literature also underlines the connection between certain psychosocial and environmental factors and the intake of various substances.

The report therefore proposes an approach to prevention that favours the consideration of user behaviour and the similarities between dependence mechanisms. It addresses psychoactive substances, a generic term that covers illicit drugs, alcohol, tobacco and psychotropic medicaments. The behavioural approach maintains a distinction between use, abuse or harmful use and dependence that was already to be found in the international classifications to which reference is made (in particular, the tenth version of the international classification of diseases – CIM 10 – of 1992 or the fourth version of the diagnostic and statistical manual of mental disturbances – DSM IV – of 1994). These definitions have, in fact, the advantage of introducing the psychopathological and behavioural aspect of a rupture with the habitual behaviour of the subject.

While the traditional objective – which aims at the avoidance of initiation into the use of psychoactive substances – is maintained, the measures must go further in also preventing the transition from use to harmful use or dependence. The primary preventive strategy is to intervene in accordance with a prepared plan in order that various objectives can be

established that are adapted to the specific needs of the population concerned. The explicit statement of these objectives makes it possible to avoid a breakdown in the action taken. In this scheme of things, the prior evaluation facilitates the meshing of the efforts applied and the study of the adequacy of the preventive response to the realities of the drug scene.

Finally, the development of a common approach favours the continuity and cohesion of the lines taken by the various persons and bodies who act in the field of prevention: the state services, the professionals, the media, consumer groups, or other community groups.

Prevention in the three-year plan 1999-2001 of the MILDT

Prevention is a major part of the current plan as is shown in its title: "Three-year Plan for the Fight Against Drugs and the Prevention of Dependence" (MILDT, 2000). In this programme document, the MILDT adopts the majority of the "ethical" and organisational recommendations made in the Parquet report.

The interministerial guidelines in the matter of prevention can be summarised as follows:

- contribute to the growth in professionalism of those involved in prevention. Although numerous actions have been carried out in the field of prevention, they have remained dependent on the good will and dynamism of those acting locally, no particular competence being demanded. The primary objective is to provide professionals with the necessary tools to identify risk behaviour at an early stage,
- develop committees on education for health and citizenship [*comités d'éducation pour la santé et la citoyenneté*] (cesc) in educational establishments[9]. This development should give young people the benefit of at least one preventive programme during their school career,
- improve access to counselling facilities for adolescents and their parents,
- restate the preventive objectives of the judicial treatment of drug users (circular of 17 June 1999),
- develop a preventive approach for specific circumstances such as the intervention of pair groups in sports associations and the establishment of a risk reduction policy for concerts, festivals or *rave parties*, which also targets alcohol consumption.

Furthermore, this plan maintains the need for local co-ordination in the application of these guidelines.

Departmental prevention programmes

The three-year plan announces an administrative organisation of local public preventive action, which give impetus to the co-ordination of the actions supported by the decentralised state services and the associations. It takes form through the departmental prevention plans, which must restate at a local level the broad lines defined by the three-year plan. They are to be drawn up (definition of objectives that can be evaluated, identification of competent protagonists etc.) by the departmental "drugs and dependence" project manager of each department, who is supported in this by the steering committee on drug control and prevention of dependence (a multipartite organism, made up of representatives of the decentralised state services, community groups, social organisations and other professionals). In particular, it should implement this programme in close collaboration with the local representative of the Ministry of National Education and the Ministry for Youth and

[9] See the section on preventive measures "National Education".

Sport in order to ensure continuity of the preventive measures wherever young people, the primary target group of this policy, are to be found.
In 2001, 18 departmental programmes have been implemented, 11 have been published and should be put into effect this year and 34 are being drawn up. Finally, 5 departments have not yet made a start on drawing up their programmes. The state of progress in the 32 remaining departments is not known at present.

Urban Contracts, CLS and CEL

In parallel to the departmental programmes, there are horizontal contractual frameworks making it possible to address the "drug question" through broader approaches to general education or unified development.

The Urban Contracts have as objective the "development of a well balanced town permitting a harmonised integration of all its components". Introduced in 1993, on the basis of the XIIth Urban Development Plan (2000-2006), the Urban Contracts are the sole framework of concerted action through which the state, the local communities and their partners undertake to implement policies for defined areas to prevent their degradation and all forms of social and urban exclusion. They define the political framework within which the other provisions under common law – which contribute wholly or in part to the achievement of their objectives – must be implemented. Thus, the Local Security Contracts [*contrats locaux de sécurité*] (CLS) and Local Education Contracts [*contrats éducatifs locaux*] (CEL) formalise and establish the operational bases of the "prevention and security" and "education" aspects of the Urban Contracts.

The CLS, drawn up by the local authority councils for the prevention of delinquency are signed together by the Mayor, the Prefect and the Public Prosecutor and optionally by the Chairman of the Council and the Director of Education. The Drugs and Dependence project managers take part in the preparation and implementation of the CLS for the question pertaining to their domain.

Bringing together institutions (amongst others, the schools inspectorate and the departmental directorate for youth and sport), parents, associations and elected representatives, the CEL define the responsibilities of each individual involved in attaining the objectives of local education project. They should guarantee the coherence of the measures undertaken and the existence of a participatory mode involving young people and associating their families with the projects. The strategic approaches encouraged by the CEL correspond, in a general way, to the consolidation of such recognised preventive measures as avoiding the use or harmful use of psychoactive substances: knowledge and control of one's body through various physical activities and health education, improvement of school results, learning about community life and citizenship, for example.

Seventy one percent of Urban Contracts include a specific "Drugs and Dependence" item that reappears in 54% of CLS and 21% of CEL. These contracts often constitute (to a lesser extent in the case of the CEL) partnership frameworks for the implementation of the departmental policy for the prevention of dependence.

Integration of the question, "drugs and dependence" in urban policy contracts in 2000

	Proportion of contracts in which the Drugs and Dependence project manager participates in the steering committee	Proportion of contracts constituting additional funding for Drugs and Dependence preventive actions.
Urban Contracts	57%	68%
Local Security contracts	47%	25%
Local Education Contracts	29%	21%

Source: OFDT-MILDT (OFDT, 2001)

Since 1998, the Regional Health Policy Committees have brought together the financial partners in these projects and thus aim to ensure a coherent approach, especially with regard to prevention. The Urban Health Workshops, introduced in December 1999 after pilot projects in Seine-Saint-Denis and the Provence-Alpes-Côte d'Azur region, are another area in which the state, local communities and the population act in concert in the fields of primary prevention, access to treatment, reception into care and recovery support.

Regional programmes relating to health and access to treatment

Many provisions for care and preventive actions in connection with dependence are included in the measures elaborated by the Regional Health Programmes [*programmes régionaux de santé*] (PRS) or the Programmes for Access to Prevention and Treatment for Persons in a Position of Insecurity [*programmes d'accès à la prévention et aux soins pour les personnes en situation de précarité*] (PRAPS, one in each region). The PRAPS differs from the PRS in that it is imposed by law for a period of three years whereas for the more voluntary PRS the lines of action are defined each year to meet the specific needs of the region. Seven PRAPS have defined prevention and the reception into care of dependents as a priority objective. For at least 11 of the 26 PRAPS of the first generation (2000 to 2002), alcohol is a matter of priority and also designated as such by the PRS. These two types of programme associate the departmental and regional levels of the social and health sectors (state services, local communities, regional hospitalisation agency, social bodies, complementary health insurances etc.). The work of the two types of programme is determined by a single process: the lines of work proposed by the departments are submitted to the Regional Health Policy Committees, who set the priorities while ensuring that the various provisions are complementary: PRAPS, PRS, regional health organisation plans, reception-accommodation-rehabilitation plan, departmental rehabilitation programmes etc.

Demand Reduction Policy Implementation

In the course of the 1990s, there have been important changes in medico-social attitudes, which show themselves, in particular, in the adoption of a policy of risk reduction and substitution. The main change of direction came with the adoption of the plan of 21 September 1993, even if it was approached at the time with a great deal of prudence. It recommends, in particular:

- the improvement of the reception into care of drug users, not only in the specialised facility but also in the general care facility (increase in the number of accommodation places, improvements in the reception into care in hospital and the setting up of town-hospital-addiction networks linking professionals in the town with those in the hospital for the reception into care of addicts),
- the development of risk reduction facilities,
- the establishment of substitution treatments,

- the majority of the recommendations made in 1993 were confirmed and further developed later. In fact, the plan of 14 September 1995 followed in the lines of the previous plan as did that of 1999-2001, now in course (MILDT, 2000).

Improvement of reception into care

The health policy guidelines, as defined in the three-year plan of 1999, place a particular emphasis on an early reception into medico-social care centred rather on harmful use (before users become dependent), diversified and adapted to the needs of those showing addictive responses to one or more psychoactive products. Furthermore, the objective is to offer responses that are no longer based on the products but upon the consumption behaviour. As defined in the new guidelines on prevention, the medical approach must be able to provide responses appropriate to the notions of use, abuse, harmful use and dependence, whatever the product consumed (alcohol, tobacco, psychotropic medicaments or illicit drugs).

With these new alignments, the plan highlights the progress to be made in two directions:

- improve the organisation of the existing facilities for reception into care in order to increase the possibilities of reception, medico-psycho-social follow-up and treatment of those showing addictive behaviour as well as developing the national coverage of the facilities,
- improve the coherence of the care on offer so that actions of prevention, care and rehabilitation are better articulated and co-ordinated.

In this respect, several measures have been taken: some concern the organisation of care without specifically targeting addiction; others address dysfunctions detected in the reception into care of addicted patients, especially at the level of hospital facilities (including psychiatric structures and outpatient care). The provisions recently adopted and presented below reinforce, in their general lines, the earlier government provisions regarding the treatment of addiction.

With the **circular of 15 June 1999** regarding the organisation of hospital care for addicted persons, the health authorities first wished to recall the principles of reception and reception into care in public health establishments as already laid down in the circular of 1996 regarding the reception into care of addicts: the hospital must be in a position to offer addicted patients a global reception into care that addresses their somatic and psychic problems and, at the same time, it must develop a specialised reception into care, based more on liaison teams and addiction care. This new circular draws particular attention to the following five objectives: the improvement of reception into care in hospital emergency departments, the development of the possibilities of hospitalisation for withdrawal treatment, assessment and addiction treatment, the initiation or the pursuance of a monitoring of the problems connected with dependence, guiding the patient to the appropriate and competent bodies, the training of hospital staff and, finally, the development of tools for monitoring hospital activities relating to addiction.

The **circular of 8 September 2000** regarding the organisation of hospital care once again emphasises liaison teams and addiction care as the means of improving the reception and reception into care in hospital of harmful users and those dependent on one or more psychoactive substances. With this circular, the desire of the health authorities is to bring closer together the teams working in the areas of alcohol, drug and tobacco addiction in hospital establishments. This coming together should make it possible to make responses centred on the person and the behaviour rather than on the products alone. It also aims to promote co-operation, exchanges of know-how, and the sharing of therapeutic means and tools. By bringing these teams together, the health establishments will integrate themselves

in the general facilities for reception into care of dependents in order to make the best response to the demands placed on them and favour a medico-psycho-social follow-up.

Improvement in reception into care in the prison environment

The improvement of the health and social facilities for persons exhibiting addictive behaviour also involves the improvement of their reception into care in the prison environment. It is therefore necessary to mention here the recent developments in the applicable texts defined jointly with the MILDT by the tutelage and prison authorities for a new organisation of the services intervening in detention be it for treatment, socialisation or surveillance. Thus, the **interministerial letter** of 2001 lays down the guidelines regarding the reception into medical and social care of prisoners exhibiting a dependence on licit substances (notably, alcohol) or illicit substances or having an abusive consumption. It aims at a greater co-ordination of the services called on to intervene, whether in the prison itself or outside, and at a better organisation of local intervention methods, associating all those concerned in a clearly established project and around a named, responsible person.

The objectives of this reorganisation are the following:

- systematic detection of all situations of abuse and/or dependence, whatever the psychoactive substance,
- propose a reception into care adapted to the needs of the prisoner,
- develop prevention, especially that of the risks associated with substance use,
- favour adjustments of penalty,
- prepare for release.

The method chosen is based on the mobilisation of all the intervening partners in each penal establishment, including the external partners. Within each establishment, it is planned that a project group will be charged with drawing up and applying the new protocols for reception into care in the prison environment while respecting the objectives laid down in the specification attached to the interministerial letter.

In order to support this measure and ensure the success of the project, the administrations concerned have made the necessary provisions for an evaluation process to be carried through.

Strengthening the risk and damage control policy

The risk and damage control policy for consumption behaviours in general is clearly a priority guideline for 1999. In the **circular of 13 March 2000**, the objective of the authorities is to support the actions taken to reduce the risks for drug users. They are insufficient in number and do not appear to be well distributed throughout the French territories. New credits have been proposed by the authorities, either to contribute to the strengthening of existing "low threshold" programmes (syringe exchange programmes, *Sleep'in* shops) or to promote the establishment of new programmes or structures, especially in urban areas not yet covered or, again, the installation of automatic distributors of syringe in public places.

Development of the substitution policy

The interministerial plan of 1999 renews the support for the development of a policy of substitution with regard to persons dependent on opiates. The new provisions, which aim to reduce the disparities between methadone and buprenorphine in terms of duration and methods of prescription, supervision and delivery, have led the authorities concerned to re-examine the respective protocols in force and define more appropriate guidelines. The new

regulations for the two available treatments, methadone and buprenorphine, are shown below:

Regulatory framework for substitution treatments in France in 2000

Description	Buprenorphine	Methadone
Came into force	Early 1996	1994
Criteria for inclusion	Assessed as dependent on opiates by a medical practitioner	Assessed as dependent on opiates by a medical practitioner + urine test for opiates other than methadone
Prescription	Initiation and supervision in urban medical practice or a Specialist Care Centre for Drug Addicts. First prescription and continuation of treatment in course possible in prison environment.	Initiation in a Specialist Care Centre for Drug Addicts followed by the possibility of supervision in urban medical practice. First prescription possible in prison environment if Specialist Care Centre for Drug Addicts internal or external. Continuation of treatment in prison environment. Initiation of treatment in hospital envisaged.
Maximum duration of prescription	28 days	14 days
Posology	Recommended maximum of 16 mg/day but no constraints	Recommended maximum of 100 mg/day but no constraints
Delivery	Delivery in pharmacy in all cases. Delivery in batches for maximum periods of 7 days with the possibility of a single delivery for a maximum period of 28 days at the request of the doctor.	Administered under supervision in a Specialist Care Centre for Drug Addicts or issue of the medicament for up to 14 days. Maximum delivery in pharmacy, 7 days' supply.
Urine tests	Not anticipated	1 or 2 per week in the first 3 months then twice a month. As considered necessary by the doctor in supervised in urban practice. Always carried out in a Specialist Care Centre for Drug Addicts.
Payment for treatment	Common regulations if followed-up by the city services	Gratuity then common regulations if taken over by the city services

Source: DGS (information supplied by France Lert)

Since the **decree of 20 September 1999**, regarding the application of the regulations controlling narcotics to certain medicaments based on buprenorphine, the maximum issue of buprenorphine has been for maximum periods of 7 days with the possibility of a single issue for a maximum period of 28 days at the request of the doctor and for special reasons relating to the patient's situation.

The **decree of 8 February 2000**, regarding the fractionated delivery of medicaments based on methadone, fixes the maximum duration of prescription for this medicament at 7 to 14 days, but the maximum issue in pharmacy at 7 days.

A project is currently being drawn up that envisages the extension of the Authorisation to Place on the Market [*autorisation de mise sur le marché*] (AMM) to allow the first prescription to be issued by doctors practising in health establishments.

In line with the global approach, new substitution measures in connection with tobacco have been defined. Since January 2001, the free sale of nicotine substitutes is available throughout the French territories.

Penal Policy Implementation

Three circulars issued in 1999 have brought significant changes in the areas of fighting against trafficking and the judicial responses to drug addicts.

Recent provisions on trafficking

In June 1999, the Minister of Justice issued the state public prosecutors with new directives regarding the repression of trafficking that are contained in the **circular of 17 June 1999**. This circular first considers the conditions for the improvement of the co-ordination of public action in recalling the central role to be played by the Central Office for the Repression of Drug-related Offences [Office central pour la répression du trafic illicite de stupéfiants] (OCRTIS) and inviting the prosecutors' departments to set up a system for the co-ordination of the local repression services.

The circular then addresses the question of measures against the property of traffickers. It recalls that, in the case of the most serious trafficking offences, confiscation can apply to the entire property and not solely to the proceeds of trafficking. It also reminds us that the prosecutor has the right of seizure in order to ensure that the property of a person under investigation remains available for confiscation. It notes that in the absence of a satisfactory identification the property of traffickers and in the absence of precautionary seizure, the confiscation is most often limited to the goods seized at the time of arrest. The circular suggests that the prosecutors should make use of the law on living on the earnings from trafficking, which makes it a criminal offence for a person who habitually associates with users or a trafficker to be unable to demonstrate the origin of his resources or his standard of living.

Finally, the **circular of 11 October 1999 of the Interior Minister**, regarding the intensification of the fight against the use of and local trafficking in narcotics, requires, with regard to use, the development of prevention in schools and the implementation of appropriate repressive actions (police questioning, police custody, judicial procedures, etc) and, with regard to local trafficking, concerted action on the part of the various administrative and judicial authorities and greater use of the available judicial tools to improve the efficacy of the fight against local trafficking. This circular is in line with the approaches defined for repressive and judicial action in the three-year plan 1999-2001 (MILDT, 2000).

Recent provisions regarding use

In June 1999, the Minister of Justice issued a new directive to the public prosecutors regarding judicial responses to drug addiction.

The main idea behind the **circular of 17 June 1999** is the necessity to individualise the decisions of the justice system concerning the use of drugs, which makes a greater diversity of possible responses indispensable and, in particular, alternatives to prosecution and imprisonment. This text does not limit itself to the users of illicit drugs but also concerns itself with persons in difficulties with alcohol. According to this circular, a user who has committed no other offence in connection with his use should only be imprisoned as a last resort. In aiming to individualise the judicial decision, the Minister of Justice also seeks to institute methods of learning more about the state of health and social situation of drug users and

ensuring systematic health and social guidance of those charged for whom it is necessary (speedy social enquiry, a more detailed personal file etc.).

With regard to the arrest and police custody of simple users, the circular lays down that these should be limited to those who may cause damage or injury to others or to themselves. The circular asks that charging in the immediate proximity of "low threshold" structures should be proscribed. It also asks that the continuity of substitution treatment should be assured during custody.

The circular proposes that use of the mandatory treatment should revert to its original purpose. This measure should be used for heroin addicts and others making massive or repeated use of illicit products where the dependence on the product makes treatment a necessity.

The attendance phase (between starting proceedings and the hearing) should be used to make persons charged aware of their condition and persuade them to seek treatment.
In the sentencing and post-sentencing phases, the circular recommends greater use of suspended sentencing. This sets a precise period during which the accused must take responsibility for his actions.

The suspended sentence is the main "alternative sanction" that the courts can impose. This measure must also take account of all the difficulties of rehabilitation encountered by the person under sentence and requires the probation services to follow up with measures of social education.

Since parole with the obligation to seek treatment is falling into disuse, it is receiving new encouragement to the extent that it offers the advantage of better preparing imprisoned users for release. Release on license (partial release), also little used at present, is proposed in the circular as a method of preparing the prisoner for final release.

With regard to minors, the judicial response can take the form of criminal proceedings or of a civil procedure with educational support.

The circular reminds us, in particular, that many educative measures are possible in the framework of the ordinance of 2 February 1945 regarding juvenile delinquency: probation, court protection or commitment to an educational or health establishment.

The Departmental Conventions on Objectives [Conventions départementales d'objectifs] (CDO) constitute the principal instrument for the application of the circular of 17 June 1999.

These conventions, defined by the interministerial circular of 14 January 1993, make it possible to improve the reception into care of drug users and the promotion of actions to prevent the use of psychoactive substances within the framework of judicial measures.

In 1999, this provision was extended to encompass all the departments of France and make it a part of the revised framework of criminal policy towards users. This extension is a result of the wish to strengthen the partnership between the judicial authorities on the one hand and the departmental health and social authorities on the other in order to favour alternatives to prosecution, take a more systematic approach to the health and social guidance of the users of psychoactive substances and improve the reception into care of drug users at every stage of the criminal procedure, whatever the judicial status of the product consumed (narcotics, alcohol, medicaments put to incorrect use).

These conventions are signed by the departmental Prefects and the State Prosecutors. The departmental "Drugs and Dependence" project managers are responsible for the co-

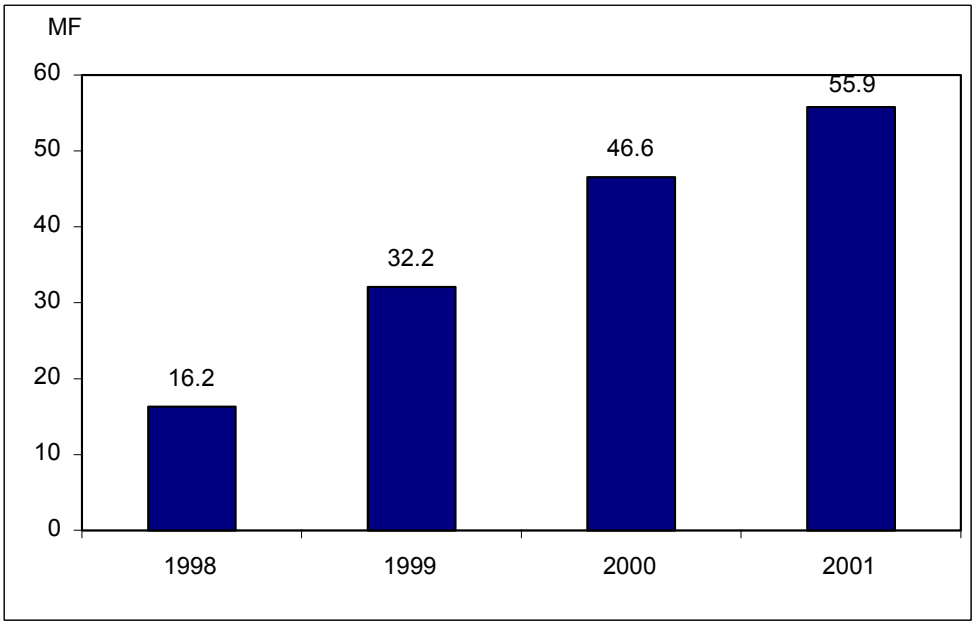
ordination and management of the provision. For their part, the prosecutors must work in close liaison with the services of the Ministry of Justice. The interministerial credits, previously passed by the MILDT to the Ministry of Justice, have thus been progressively re-deployed towards the provision of the Departmental Conventions on Objectives. The medico-social recess credits, traditionally devoted to mandatory treatments, will now be applied to any medical or social intervention carried out within the framework of these conventions. In particular, the health authorities have been invited to devote these credits to the maintenance of duty rooms for medical and social guidance in or close to the courts.

Status of the implementation of departmental conventions on objectives

Until 1998, the CDO were linked to the geographical priorities provided for in urban policy, limiting the measure to 30 departments. Since 1999, the coverage of the programme has been progressively extended to reach 93 departments in 2001.

We can also note a considerable increase in the credits granted to the Departmental Conventions on Objectives: they have more than tripled since 1998 (rising from 16.6 MF to 59.7 MF).

Credits granted to the Departmental Conventions on Objectives from 1998 to 2001 {124a}



Source: MILDT

With regard to those received into care, the proportion of those subject to obligatory attendance measures has grown from 25% in 1998 to 38% in 1999. The reception into care of minors is the other dominant element in the achievements for 1999, having reached 3,000 in that year, where they were less than 100 in 1998 (MILDT, 2001).

Thus, in 1999, minors represented 20% of those received into care through the CDO, prisoners and those released from prison 31% and those subject to obligatory attendance measures 38%. Amongst the measures announced within the framework of the CDO, it may be noted that mandatory treatments represent a minority (5.9% of measures) while other alternatives to prosecution (suspended sentence, classification with social, educational or medical guidance, etc.) are in the great majority with 26% of measures. Finally, the

alternatives to imprisonment (community service order and deferment) make up 12% of measures passed.

1.3 Developments in public attitudes and opinion

Some thirty surveys dealing to a greater or lesser extent with drugs and addiction have been carried out in France between 1988 and 2000. Most of them were commissioned either by the French Committee for Health Education [Comité français d'éducation pour la santé] (CFES) in preparation for or to measure the impact of prevention campaigns or by press organisations wishing to determine public opinion at a given moment. The last public opinion survey on drugs was carried out by the OFDT in April 1999 (2000 persons from 12 to 75 years of age, selected by the quota method and questioned by telephone). We summarise here the main results, pointing out the most important changes that they show over the decade.

Substances

About 95% of respondents are able to name one drug spontaneously, with an average of 3,7 substances named, above all cannabis and its derivatives (78%). The other substances most frequently identified are cocaine (54%), heroin (45%), ecstasy (39%), LSD (27%), tobacco (21%), alcohol (20%) and crack (12%). An increasing minority spontaneously names alcohol as a drug (20% in 1999 against 14% in 1997). This is probably connected with press campaigns based on the Roques report on the danger levels of substances, which placed alcohol on the same level as heroin. The increase in the number of spontaneous designations for tobacco is slightly smaller (21% in 1999 against 17% in 1997). A survey carried out in 1993 by the CFES shows that when substances are explicitly nominated, there is a high level of agreement that alcohol and tobacco are drugs (84% and 77% respectively).

The extent to which licit substances are just as much considered to be drugs as illicit substances is increasing.

Perceptions of the danger to health

Heroin and cocaine are considered immediately dangerous by a very large majority (about 85%). The perceived danger of experimenting with ecstasy is rather lower (76%). For more than half the sample, cannabis is dangerous as soon as it is tried, whereas one third considers its continued use to be without danger. The percentage of those who consider that cannabis use is no great threat to health has also increased between 1990 and 1996 but they are still in the minority (38%). In 1999 this trend was confirmed, only 12% considering that to smoke it from time to time is a danger to health.

The risk of dependence is considered much higher for heroin and cocaine (56% and 58% respectively consider that it exists from the first experimentation) than it is for cannabis (38%). With regard to alcohol and tobacco, more than three quarters of the French consider that they are only a danger to health above a certain daily consumption expressed in glasses or a number of cigarettes. 21% of those questioned consider tobacco to be dangerous from the outset as against 6% for alcohol. On average, the health risk is situated at 9 cigarettes per day or more and 4 glasses of alcohol per day or more.

When it is a question of ranking the substances, naming the most dangerous of heroin, cocaine, ecstasy, alcohol, cannabis, tobacco and "medicines for nervous conditions", the largest vote by some margin is for heroin (41%) with cocaine and ecstasy as runners up at 20% and 17% respectively.

Fears

In 1999, more than 80% of those questioned were afraid of illicit drugs other than cannabis (only 68% were afraid of cannabis). 55% were afraid of "medicines for nervous conditions" and about one third of tobacco and alcohol. Great differences in the level of apprehension with age were found amongst those questioned. For alcohol and tobacco as well as for the substances that particularly concern the younger generation (ecstasy, inhaled substances and hallucinogenic mushrooms), the proportion of those who expressed fear rose above the age of 18. For cannabis this progression is even more marked. Other products such as heroin, LSD, "medicines for nervous conditions", amphetamines or doping substances aroused fears that are less differentiated with age.

Even if the number of French favouring a **distinction between "hard drugs" and "soft drugs"** has increased slightly in the course of the 1990s, the change is hardly significant. It is found, above all, that a **fairly large majority remains hostile to the idea** (61% in 1997). In 1999, the distinction between these two groups of substances was still maintained but the boundaries are becoming more blurred. In fact, questions on the perceived danger of the products show that many see the possibility of hard or dangerous use of soft drugs (cannabis) or of legal substances (alcohol and tobacco).

The risk of escalation from cannabis to other illicit drugs

The theory of escalation from cannabis to the **other illicit drugs** seemed to be firmly anchored in public opinion in 1992, even if there was a clear difference of opinion between users and non-users of cannabis (80% rejection against 80% acceptance respectively). In 1999, seven out of ten in France said that they agreed with the idea, 13% tended to disagree and 14% disagreed altogether. The difference of opinion between users and non-users of cannabis, on the other hand, has diminished, although the level of general knowledge about drugs may play a role. The theory of escalation seems, therefore, to be less firmly anchored in public opinion than at the beginning of the decade.

Use and users

When asked about the principal dangers facing young people, the French often place drug abuse at the head of the list, even in surveys where this is not the central topic. Among the causes that might lead a young person to take drugs and the perceived vulnerability factors, the search for a missing sense of wellbeing (setbacks at school or at work, various problems, running from reality etc.) is quoted by a majority of those questioned and comes well ahead of peer pressure (18%). The idea of (defiant) transgression that could be put forward as an incentive factor is very rarely put forward (2%). The notion of pleasure appeared in a survey for the first time in 1997 and was suggested by 7% of those questioned. At the beginning of the decade, the legitimacy of experimentation with drugs was heavily contested (the rejection of this idea oscillated between 80 and 90% between 1990 and 1992).

Between 1990 and 1996, drug addicts were considered to be sick by a very large majority. This opinion did not prevent six persons out of ten, in the middle of the 1990s, from finding them "aggressive and dangerous". We thus see that, so long as the questionnaire does not place them in direct opposition, the notions of "sick person" and "delinquent" can coexist: **Thus, the classical cleavage between sick and delinquent does not adequately reflect the perception that the public can have of drug addicts**. Once the person questioned is offered additional alternatives (family problems, social difficulties etc.), allowing him to characterise addiction as a flight, the cleavage loses its immutable character.

Occasional smokers of cannabis are only considered drug addicts by a minority: in 1997, only 29% considered that someone who smokes a joint for pleasure from time to time is a drug addict; in 1999, 22% considered that such behaviour leads to dependence. The idea that drug addicts are responsible for what is happening to them was shared by less than half of those questioned in France in 1995, a slight drop from 1992. As before, this question is open to arbitrary definitions and leaves a wide range of choices open in the formulation of an answer. A person wishing to make a distinction between those who are dependent on opiates and regular users of cannabis might well have difficulty in answering this question.

Information

In 1999, there was a clear consensus (86%) on the usefulness of informing young people. The proportion of those who consider that it would be better not to discuss the matter has fallen during the 90s. Furthermore, youth education is considered sufficient by 71% of individuals and dangerous by 15%.

While only 8% of French consider themselves very well informed about drugs, a total of **58% consider themselves well informed**. More than two thirds (68%) of those age 18 to 24 consider themselves well informed while this goes for less than half (48%) of those age 65 to 75.

Prevention and care

The importance of public information as a key instrument of prevention is increasing, especially at school: this met with the approval of 86% in France in 1999, even though 15% considered it dangerous (this was the case of one third of those questioned in 1992). The preventive actions perceived as most effective combine the facilitation of dialogue with an aspect of proximity (local policies).

Amongst those measures submitted for approval in the same way as preventive actions and primary information were obligatory care and access to the best medical treatment for drug addicts. **The recourse to treatments with heroin substitute medicaments was considered effective by some 70% in France in 1996 and 1997, eight out of ten said they were in favour in 1999.** Without attracting the same popular approval, programmes involving heroin distribution under medical control and the medical use of cannabis attract a fairly high and growing level of support (39% for the first and 55% for the second in 1997, 81% and 67% respectively in 1999).

In 1996, it was observed that the good intentions of the French with regard to personal involvement with fighting drugs and drug addiction (68% prepared to participate in informative meeting on the topic) are diminished if the proposed action involves a closer

approach to users (59% would be prepared to participate regularly in mutual help groups, 56% to voluntarily devote two hours a week to assisting an association).

Public policy

In the surveys before 1999, the majority opinion gathered appears to be that it is **proper to prosecute and impose legal penalties on users** of heroin and cocaine (85% in favour), cannabis (about 70%) or alcohol (about 50%). However, the apparent result is very sensitive to the formulation of the question: three quarters of those questioned **did not agree with the idea that drug addicts should be punished**. In the same way, putting the emphasis on the person and his individual liberties rather than the legal aspects of use led one third of those questioned in 1999 to express their agreement with the proposition that the prohibition of smoking cannabis is an infringement of the right to dispose of one's body.

In 1999, a majority of French considered the prohibition of use to be legitimate although relatively ineffective. Almost half categorically rejected the idea of the **regulated use** of cannabis (as against three quarters for heroin). The **legalisation** (open selling) of cannabis met with very strong opposition: only 17% are in favour. Regulated use is thus the demand of the majority of the supporters of a revision of the law. The idea of putting cannabis on **sale under special conditions** won the support of one third of those questioned in 1999 (as against 12% for heroin), whereas the idea of unrestricted sale only won minority support, even if it is gradually becoming a less marginal position (17% in 1999 against 10% in 1992). It was men and young adults who were most frequently in favour of unrestricted sale. Finally, it may be remarked that, if opinion was split on questions regarding the prohibition of cannabis use, there was a much greater degree of consensus with regard to heroin use.

Obligatory care in connection with an arrest was very widely accepted (barely one in ten was against) Only a quarter of French, mainly older and little qualified, think it is possible to arrive at a **world without drugs**. If the resort to **substitution drugs** was looked on favourably by 81% of those questioned, the **sale of syringes without medical prescription** did not meet with the same level of acceptance (63% in favour). The **controlled heroin distribution** was a less well accepted measure than these last but, nevertheless, a majority of French were more or less in favour (53%). The level of agreement with these last three propositions was markedly higher amongst those who had already used cannabis and diminished with age. Finally, **the medical use of cannabis** was accepted by more than two thirds of those questioned (and more frequently by men than by women). On the whole, the measures taken in France in connection with the reduction of risks have met with increasing acceptance since the beginning of the 90s. Nevertheless, a majority remains in favour of prohibitive measures except where the authorisation is within a therapeutic framework; it is thus not only the substances but also the manner of their use that influence the opinions expressed on public policies.

The existence of an activity by the public authorities in aid of dependent users is acknowledged by some two thirds of those questioned (66%). However, 63% consider that it should be intensified and 21% that another approach is required. A very large majority (86%) consider it important to inform the young and the proportion that would rather one did not discuss the matter has fallen during the 90s.

1.4 Budgets and funding arrangements

This part refers to the credits (allocations of funds) from the various administrative budgets that are allocated directly to fighting drugs and the prevention of dependence.

The main expenditure on fighting drugs is from credits from the budget of the Ministry of Employment and Solidarity. To the credits specifically for this purpose must be added those in connection with the prevention of AIDS amongst drug users, which, essentially, is a part of the risk reduction provisions (chapter 47-18: "Programme and Provisions to Fight Against AIDS").

With regard to specific credits, the budget of the Ministry of Employment and Solidarity includes two chapters relating to the fight against drugs:

- chapter 47-15, Programmes and Provisions to Fight Against Addictive Practices, under the heading of Health Policy,
- chapter 47-16 Interministerial Action to Fight Against Drug Addiction. A part of the "Interministerial" credits is transferred to the interministerial partners, another part corresponds to decentralised credits (local actions, CDO, CIRDD). The remainder of the credits serves to finance the other activities of the MILDT (financing associations, GIP, others).

Specific credits in connection with the fight against drugs, passed in the budget proposals of 1990 to 2001

(in millions of francs)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Interministerial credits	250	250	247	247	237	216	231	231	295	237	278	298
Health and Urban credits	353	439	440	461	485	619	690	751	780	816	867	1 223
Total	603	689	687	708	722	835	921	982	1 074	1 052	1 145	1 521

Source: MILDT (data for 1990 to1998 published in Government Accounts, 1998)

Health credits

Health and Urban credits, on the other hand, have increased by 97% between 1995 and 2000.

Use of Health credits allocated to drug addiction* from 1998 to 2000

(in millions of francs)

Provision implemented	1998	1999	2000
Global contribution to the operation of the CSST	641,3	646,8	659,0
Funding of methadone	19,9	19,9	18,8
"Town" part of the 51 drug addiction-town-hospital networks	6,5	7,0	7,0
Youth and Parents support centres	33,9	42,3	43,8
Rehabilitation workshops	11,6	11,9	12,0
Prison leavers' units	5,0	5,0	5,2
So-called "low threshold" structures	15,5	19,8	20,7
Mobile proximity teams	-	1,5	3,0
Emergeny accommodation for drug users in a very insecure situation	-	-	20,7
Medical intervention at events	3,0	3,0	3,5
Training	4,7	3,4	3,0
Total	741,4	760,6	775,9

* chapters 47-15, articles 40 and 60

Source: MILDT

Interministerial credits

Relatively stable between 1992 and 1997, the Interministerial credits were significantly increased in 1998 and in 2001. In 1999, they were reduced, taking into account the large amounts brought forward from the previous year.

Interministerial credits from 1992 to 2000

(in millions of francs)

	1992	1994	1996	1998	1999	2000
Health, social affairs	59,5	45,9	68,1	65,5	66,2	21,9
National education and research	11,9	12,9	12,0	19,5	22,5	19,5
Youth and sport	10,1	9,2	17,2	13,7	16,9	14,9
Interministerial urban delegation	2,8	9,2	10,5	13,2	_	_
Justice	22,8	18,4	18,4	18,5	20,2	4,7
Interior (police)	23,8	27,6	19,0	18,5	16,5	8,6
Defense (gendarmerie)	9,8	11,5	8,8	10,7	9,6	7,2
Economy and finance (customs)	24,1	22,5	16,0	15,4	15,3	6,7
Foreign affairs	10,8	9,2	6,0	7,4	12,2	9,5
Co-operation	2,5	2,7	2,0	1,6	_	_
Others	0,8	0,9	-	0,6	1,6	1,8
Activities of the MILDT itself	55,1	48,0	52,5	77,7	110,6	183,3
Total	234,0	218,0	230,5	249,1	293,7	278,1

The differences between the tables in the amounts for a given item are explained by the credits passed in the budget proposal being carried forward (especially a part of the interministerial credits for 1998 that was carried forward to 1999).

Source: MILDT

The increase in "transferred" credits allocated to the actions of the departmental Drugs and Dependence project managers (local actions), to the CIRDD and to the CDO has been considerable since 1998. The generalisation of these provisions to cover most departments is at the origin of this increase.

Interministerial and decentralised credits of the MILDT from 1998 to 2000

(in millions of francs)

Provision	1998	1999	2000
CDO	16,2	32,2	45,0
Local actions	3,0	24,6	41,3
CIRDD	-	1,25	11,0
Total decentralised credits, MILDT	19,2	57,9	97,3
Total credits MILDT	77,7	120,4	183,4

AIDS credits

We may add the credits in connection with the prevention of AIDS amongst drug users as they largely correspond to the provision for risk reduction. These expenditures were estimated at 100 million francs in 2000, an increase of 60 million francs compared to 1995.

PART 2 EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

Overall view

- In France, person in five has experimented with cannabis. Only a small fraction of the population has experimented with other illicit drugs, let alone turned to current use. The use of drugs chiefly affects men and young adults.

- Heroin use is falling significantly. Several factors support such an assertion, in particular, a decreasing movement in comparison to previous years in three indicators: the arrests for heroin trafficking, the quantities seized, and the deaths from overdose. There are several possible explanations for this situation: heroin is suffering from an increasingly negative image with the young generations and, above all, is the victim of the rapid rise in substitution treatments since 1995. Nevertheless, certain opposing trends are making themselves evident. Observations in the field indicate a minority development of heroin use in techno circles,

- During the 1990s, cannabis use has, if anything, tended to rise. The tendency of cannabis use to become commonplace is much stronger among young people. Experimenting with it at the end of adolescence has passed the symbolic threshold of 50%.

- Without reaching the scale observed for cannabis, the use of other substances is developing, so that a diversification is seen in the substances tried and used, especially in the context of events and celebrations, by certain young people: hallucinogenic mushrooms, synthetic drugs and, to a lesser extent, cocaine. The appearance of these new substances and new contexts of consumption introduces a number of problems. To begin with, there is a lack or absence of information on the effects or risks connected with the use of the new substances that continue to appear on the synthetic drugs market. Furthermore, the growing practice of multiple consumption raises the problem of pharmacological interactions between the substances, which are, for the most part, unknown and of the consequences in terms of public health.

Analysis of trends in relation to social contexts

Reciprocal influences seem to be taking root between the circles of users frequenting the traditional care structures and the circles of users frequenting the dance scene - chiefly techno. The observations coming from the field tend to indicate an increase in these influences in terms of the circulation of products. Even if the two environments have their own characteristics in terms of consumption, the relatively closed frontier that separated them some years ago may be breaking down. It is thus that we observe the appearance, still limited, on the techno party scene of such substances as crack, heroin and medicaments including high-dosage buprenorphine (Subutex®) and Rohypnol®, characteristic of the urban environment. On the other hand, it would seem that products such as cocaine, ecstasy and LSD, formerly used essentially in the dance scene, are now turning up in circles that habitually are opiates users.

2.2 Drug use in the population

Principal results

The measure used to assess drug consumption

Before attempting to answer questions about the numbers of users and their characteristics, it is necessary to define what is meant by consumption. It frequently occurs that figures are set up against one another that relate to different definitions of consumption and so cannot be reasonably compared. Consumption is characterised by two fundamental parameters: the quantity consumed at any one time and the frequency of consumption.

In order to put the consumptions of various drugs into perspective, it is therefore necessary to define consumption levels. Four levels have been chosen for the present report:

- experimentation (having consumed the product at least once),
- occasional use,
- regular use,
- daily use.

With these four categories, we have a graduation of the seriousness or potential seriousness of the consumption. They are defined along the lines of the indicators currently used internationally: use of a product at least once in a lifetime, at least once a year, every day (or evening). These two scales fit over one another.

The various groups are not exclusive; regular users are a sub-set of occasional users who are, in turn, a sub-set of experimenters.

The resulting figures are indicative; there is a large margin of error. These data must be interpreted as a simple guide to the scale of the different modes of consumption of the various psychoactive substances and of their relative weights in the total consumption.

Alcohol is the psychoactive product most deeply embedded in the culture and in consumption practices. It is most frequently the object of experimentation and occasional use. When it comes to regular uses, it is outstripped by tobacco where for every two experimenters there is one "active" smoker who is nearly always a regular smoker (at least 1 cigarette per day) and in two cases out of three a heavy smoker (10 cigarettes per day or more).

Alcohol and tobacco use are far from being those causing the greatest damage, be it from the point of view of health, socially, or in the potential for dependence.

The use of psychoactive medicaments is in part for medical uses and in part resembles that of other drugs. The boundary between the two is difficult to draw. In the absence of adequate criteria for a clear delimitation, it is only possible to quote the available figures on total consumption. The greatest attention should, therefore, be paid to the changes in these figures.

Estimated numbers of drug users in mainland France in 1999

	Alcohol	Tobacco	Psychotropic medicaments	Illicit drugs	
				Cannabis	Other drugs
Experimenters	43 million	36 million	///	9.5 million	1.5 million
Occasional users [2]	41 million	15 million	8.4 million	3.3 million	220,000
Repeated users [3]	14 million	13 million	3.8 million	1.7 million	///
Daily users [4]	8.9 million	13 million	2.4 million	280,000	///

(extrapolated to cover the entire 15-75 age group in mainland France, about 44 million persons in 1999, from the results of a survey of the general population)

[1] *Experimenters*	*Alcohol*	*At least once*
	Tobacco	*At least once*
	Cannabis	*At least once*
	Other illicit drugs [5]	*At least once*
[2] *Occasional users*	*Alcohol*	*At least once per year*
	Tobacco	*Admit to being active smokers*
	Medicaments	*At least once per year*
	Illicit drugs [6]	*At least once per year*
[3] *Repeated users*	*Alcohol*	*At least 3 times per week*
	Tobacco	*At least one cigarette per day currently*
	Medicaments	*At least one sleeping pill or one tranquilliser once per week*
	Cannabis	*At least ten times per year*
[4] *Daily users*	*Alcohol*	*At least one glass per day during the last twelve months*
	Tobacco	*At least one cigarette per day currently*
	Medicaments	*At least one sleeping pill or one tranquilliser per day, more or less, during the last thirty days*
	Cannabis	*At least 30 times during the last thirty days*

[5] *Taking account of inhaled substances (glues, solvents), this number reaches 2.4 million.*
[6] *Taking account of inhaled substances (glues, solvents), this number reaches 300,000.*

Sources: Health Barometer 2000, CFES, Annual Report OFDT

The use of illicit drugs is measured on a scale quite different from that for the products quoted above. Even if experimentation with them is spreading, the number of declared or detectable users of these products is incomparably smaller than those for other products.

On the basis of these guide data, which should not be regarded as giving more than a rough idea, the later chapters of the report will seek to define the consumption levels more precisely and to find prevalence trends, product by product. With a view to providing a decision aid, it is more important to provide satisfactory appreciation of the trends rather than seeking great precision, often illusory, in the numbers.

General population

The use of illicit drugs amongst adults

Only by making surveys of a representative sample of French adults is it possible to appreciate the level of consumption and use behaviours for these products in the whole population. There is no reliable method of estimating the quantities of illegal drugs distributed in France.

These surveys, based on information supplied voluntarily, come up against several difficulties. Since an illicit product is concerned, one might think that not all replies are honest and that they are influenced by the greater or lesser social acceptability of the consumption.

Furthermore, it is very difficult to design a survey to correctly detect consumption amongst a small minority of the population. The annual use of cannabis is sufficiently large to be detected by these surveys but this is not the case for such products as heroin, cocaine or ecstasy. When the number of persons in the sample who admit to being users of these drugs becomes too small, it is no longer possible to reach any statistically significant conclusion on the level of consumption of these products in the whole population. Finally, the marginalised populations, who would apparently occupy a non-negligible position amongst drug users, are missed by the classical methods of survey at home or by telephone. This is why the estimation of the number of users of opiates and cocaine must be based on other methods.

Since the end of the 1990s, the establishment of a system of surveys of the general population has made it possible to make accurate observations of the levels of consumption of drugs and of cannabis in particular.

Measure of declared consumption

The use of psychoactive substances is described here for the age groups most concerned and for the whole 18-75 age group from the results of a survey of declared consumptions amongst a representative sample of the adult French population [In 2000, 21.6% of those between 18 and 75 years of age declared that they had already used an illicit substance at some time in their lives and 7.6% in the course of the last 12 months.

Prevalence of the use of illicit drugs according to declarations by adults aged from 18 to 75 years

Product	at any time	during the year
Cannabis	21.6%	7.6%
Cocaine	1.5%	0.2%
Heroin	0.7%	0.1%
Amphetamines	1.4%	0.1%
Ecstasy	0.8%	0.2%
LSD	1.5%	0.2%
Hallucinogenic mushrooms*	0.4%	-
Medicaments "as a drug"**	0.7%	0.1%
Inhaled products	2.7%	0.2%
Opium, morphine*	0.3%	-
Poppers *	0.1%	-

Source: Adult Health Barometer 2000, CFES, Annual Report OFDT

* The products indicated by this symbol were not explicitly proposed as were the other products but came to light in the reply to the question regarding "other drugs" for which only the question as to use at any time was put.

** Exact formulation of the question.

This declared consumption of illicit drugs is largely dominated by cannabis and chiefly concerns those under 45. This is why it is also interesting to relate the declared consumptions to the population between 18 and 44. In 1999, about one third of this population had already tried cannabis and about one in ten used it more continuously, either

occasionally or regularly. The declared experiments with drugs other than cannabis appear fairly marginal, even amongst those between 18 and 44.

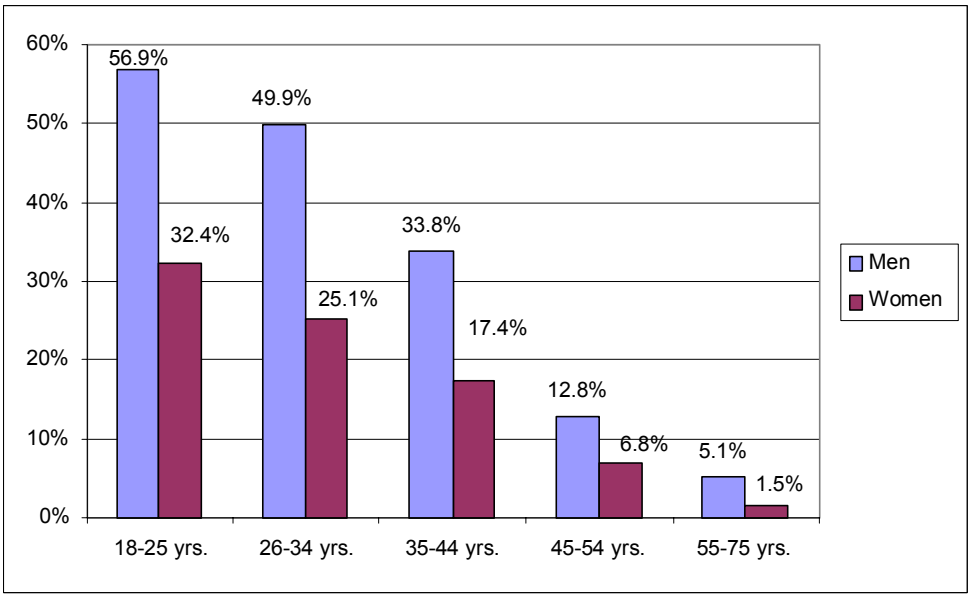
Changes in the declared consumption

According to the Adult Health Barometer survey, the use of cannabis increased significantly from 1992 to 1999. The surveys carried out amongst young people, chiefly in schools, confirm this development, which is also to be found in the Youth Health Barometer of 1998 (*cf.* the part on consumption amongst young people). All these surveys tend to confirm the observations made in the field: the use of cannabis is becoming commonplace.

Discriminating factors in the consumption

Experimentation with cannabis is strongly linked to age and to sex; younger persons and men declare themselves users of illicit drugs more frequently than older persons and women. The following diagram, taken from the Health Barometer 2000, illustrates this point well:

Experimentation with cannabis according to age and divided by sex



Source: Health Barometer 2000, CFES

School children and youth

The use of illicit drugs amongst adolescents in 1999: levels and trends

The initiation into consumption takes place most frequently during adolescence, making it of prime importance to closely observe the use behaviours of the young people.

Three types of survey yield information on this consumption. The first type addresses the general population and takes place by telephone as in the case of adults. The second takes place within the school framework where the pupils themselves fill in anonymous questionnaires. The third takes place on the Call to Preparation for Defence Day [*Journée d'Appel de Préparation à la Défense*] (JAPD) in a context specific to France (replacement of military service) and in which both girls and boys participate. The contexts and populations addressed in these three types of survey are therefore different. In particular, the surveys in school miss the young people who are not (no longer) in school and the absent pupils.

Further, it is likely that the family framework of the telephone survey engenders a degree of reticence whereas the presence of classmates in school may lead to an over-declaration of certain consumptions. The result obtained from these various survey methods do not, therefore, necessarily agree but can be considered complementary rather than competing: it is probable that the "real" prevalence is somewhere between the results of the three types of survey.

The most recent data are those from the Survey on Health and Consumption during the Call to Preparation for Defence [*Enquête sur la Santé et les Consommations lors de l'Appel de Préparation A la Défense*] (ESCAPAD) made in 2000 by the OFDT.

Frequency of experimentation with psychoactive products amongst the young people at the end of adolescence in 2000, by sex and age

(in %)

	Girls, 17 yrs.	Boys, 17 yrs.	Boys, 18 yrs.	Boys, 19 yrs.
Alcohol [1]	77.3	80.8	79.3	82.7
Tobacco	79.4	76.0	78.4	84.0
Cannabis	40.9	50.1	54.9	60.3
Psychotropic medicaments [2]	29.0	10.6	12.7	13.6
Hallucinogenic mushrooms	1.6	4.5	6.9	8.7
Poppers	1.3	3.4	4.8	8.3
Ecstasy	1.4	2.8	4.7	6.7
Inhaled products	3.3	4.9	6.6	6.3
LSD	0.8	1.6	2.8	4.8
Amphetamines	0.6	1.4	2.4	3.7
Cocaine	0.6	1.3	2.7	3.3
Heroin	0.4	0.9	1.4	1.3

[1] Consumption during the last thirty days.
[2] Heading used in the questionnaire: "medicaments for the nerves, to sleep".

Source: ESCAPAD 2000, OFDT

At the end of adolescence, after tobacco, alcohol, cannabis and psychotropic medicaments, the products that are most likely to be tried are hallucinogenic mushrooms, *poppers*, ecstasy and inhaled products with, to a lesser extent, LSD, amphetamines and cocaine. At the age of 17, these experiments are always more frequent amongst boys than amongst girls, except for psychotropic medicaments. For boys of 19, experimentation exceeds 5% for four other substances: hallucinogenic mushrooms, *poppers*, ecstasy and inhaled products.

At 17, 76% of girls and 75% of boys have tried at least two of tobacco, alcohol and cannabis. At this age, experimentation with all three of these substances is most frequent amongst the boys (47% as against 39%), whereas a greater number of girls have only experimented with alcohol and tobacco. Multiple experimentation becomes more frequent with age, reaching 83% at 19 years (and 57% for the combination of tobacco, alcohol and cannabis). It is very rare to have tried cannabis without having already tried tobacco and alcohol. Irrespective of age and sex, experimentation with all three of these products is more frequent than having tried only two, suggesting a close association between them.

Frequency of repeated use of alcohol, tobacco and cannabis amongst young people at the end of adolescence in 2000, by sex and age

(in %)

	Girls, 17 yrs.	Boys, 17 yrs.	Boys, 18 yrs.	Boys, 19 yrs.
Alcohol	5.5	16.0	17.5	22.3
Tobacco	40.2	41.9	45.6	50.9
Cannabis	12.6	23.8	28.5	32.7

Source: ESCAPAD 2000, OFDT

The repeated use of alcohol (at least ten times per month) and cannabis (at least ten times per year) are behaviours with a clear masculine bias whereas repeated use of tobacco shows little sexual differentiation. These behaviours all increase with age. For other substances, cases of repeated use are much rarer.

At 17 years of age, repeated multiple consumption is twice as frequent amongst boys (23% of boys as against 12% of girls); for both sexes, it is mainly tobacco and alcohol that are concerned. Tobacco is the psychoactive substance most frequently involved in repeated multiple use. Indeed, irrespective of age and sex, the rarest multiple use is that excluding tobacco (alcohol and cannabis). From 17 to 19 years of age, repeated multiple use grows to reach 34%.

Another survey was carried out in schools, ESPAD (European School Survey on Alcohol and Other Drugs), in 1999 by INSERM in partnership with the OFDT and the Ministry of National Education. The results are presented here for 14 to 18-year-olds.

Irrespective of age and substance, experimentation (having consumed a product at least once) is always more frequent amongst boys than amongst girls. Experimentation shows a marked increase with age and is always more frequent amongst boys. From 14 to 18 years of age, its prevalence rises from 14% to 59% amongst boys and from 8% to 43% amongst girls.

For the other illicit products covered by the questionnaire, the levels of experimentation are low: they are always below 5% except for inhaled products (glues, solvents etc.) and, to a lesser extent, for hallucinogenic mushrooms (amongst older boys). While experimentation rises with age for hallucinogenic mushrooms, it stagnates amongst boys and falls off amongst girls in the case of inhaled products. This last result is explained by the fact that experimentation with these substances tends to take place before the age of 14 so that its prevalence changes little with age. For girls, as for boys, three quarters of experimenters had taken an inhaled product for the first time before reaching the age of 15.

Illicit drugs: prevalence in relation to sex and age

Boys	14 yrs.	15 yrs.	16 yrs.	17 yrs.	18 yrs.
cannabis	13.8%	25.4%	38.0%	47.3%	58.9%
inhaled products	12.7%	12.1%	12.3%	12.5%	12.7%
amphetamines	3.6%	2.8%	2.9%	2.8%	3.1%
LSD or hallucinogenics	1.3%	1.0%	1.4%	1.8%	3.2%
crack	2.8%	2.4%	2.0%	1.5%	1.9%
cocaine	2.8%	1.5%	2.0%	1.7%	3.1%
heroin	2.3%	1.4%	1.0%	0.9%	1.9%
ecstasy	2.8%	2.3%	3.5%	3.6%	4.7%
mushrooms (psilocybe sp. etc.)	2.1%	2.1%	4.2%	6.2%	7.4%
Girls	14 yrs.	15 yrs.	16 yrs.	17 yrs.	18 yrs.
cannabis	8.0%	18.9%	31.6%	38.1%	42.8%
inhaled products	10.3%	10.6%	8.9%	8.5%	8.0%
amphetamines	1.2%	1.7%	1.8%	1.9%	1.2%
LSD or hallucinogenics	0.3%	0.6%	1.0%	1.2%	1.1%
crack	0.7%	1.7%	2.1%	1.3%	0.4%
cocaine	0.6%	0.7%	1.7%	1.2%	1.5%
heroin	0.4%	0.8%	1.3%	0.5%	0.8%
ecstasy	0.7%	1.7%	2.3%	1.9%	2.2%
mushrooms (psilocybe sp. etc.)	0.6%	1.5%	2.1%	2.3%	3.1%

Source: ESPAD 1999, INSERM-OFDT-MENRT.

The figures for 1999 can be compared with those from the INSERM 1993 schools survey, also for the 14 to 18 year-olds. For cannabis, the increase is very clear, the prevalence of experimentation having doubled from one survey to the other (from 15% to 33%). If this increase is related to age and sex, it can be seen to be particularly marked at the age of 18. In 1999, 59% of boys and 43% of girls of this age admit to having already taken cannabis as against only 34% and 17% in 1993. For other psychoactive substances, the low levels of prevalence sometimes make comparisons unreliable. However, the general level of experimentation does seem to be rising, especially for inhaled products. A more refined analysis of the figures suggests that this increase chiefly concerns the youngest boys.

Experimentation with illicit drugs amongst those aged between 14 and 18, 1993-1999

Product	INSERM 93 (n = 6518)	ESPAD 99 (n = 9657)
Cannabis	14.6%	33.1%
Cocaine	1.1%	1.6%
Heroin	0.8%	1.1%
LSD or hallucinogenics	1.7%	3.6%
Amphetamines	2.3%	2.2%
Inhaled products	6.0%	10.7%

Source: INSERM 93 and ESPAD 99, INSERM, OFDT, MENRT

Measuring levels of use above mere experimentation is hardly possible for substances other than cannabis and inhaled products. For the other substances, repeated use is very rare; the majority of those who have tried one of these products do not repeat the experience. The choice of indicators of repeated use is dictated here by the data available in 1993 in order to allow comparison with 1999. In 1993, at 18, 15% of boys had consumed cannabis 10 times or more. In 1999, this proportion is exceeded from the age of 16 (19%), and it reaches 35% at 18. For girls, the levels of use are lower but the developments are similar; in 1993, at 18, 6% had taken cannabis 10 times, this prevalence already being exceeded at 15 (6%) in 1999 and reaching 22% at 18. That cannabis is becoming commonplace is not, therefore, limited to experimentation.

For inhaled products on the other hand, the rise is less marked, especially for girls. At the age of 18, in 1999, 5.4% of boys and 3.5% of girls had consumed an inhaled product at least three times as against 2.5% and 2.3% respectively in 1993.

Cannabis and inhalants: level of use by sex and by age, 1993-1999

Boys	14 yrs.	15 yrs.	16 yrs.	17 yrs.	18 yrs.
1993: cannabis, 10 times or more	1.2%	3.5%	6.3%	11.8%	14.8%
1999: cannabis, 10 times or more	3.3%	8.9%	18.7%	29.5%	35.4%
1993: inhalants, 3 times or more	2.2%	2.7%	3.0%	3.3%	2.5%
1999: inhalants, 3 times or more	4.8%	5.2%	5.5%	5.8%	5.4%
Girls	14 yrs.	15 yrs.	16 yrs.	17 yrs.	18 yrs.
1993: cannabis, 10 times or more	1.1%	2.3%	5.0%	6.4%	5.8%
1999: cannabis, 10 times or more	2.1%	6.4%	12.1%	18.2%	21.9%
1993: inhalants, 3 times or more	1.7%	1.9%	1.2%	1.9%	2.3%
1999: inhalants, 3 times or more	3.7%	4.8%	2.7%	3.1%	3.5%

Source: INSERM 93, ESPAD 99.

Specific groups

The surveys carried out amongst those called to selection centres show that a significant proportion of young men between 18 and 23 have consumed drugs. While cannabis remains the leading substance consumed, the 1996 survey shows that a significant number have tried ecstasy.

Medical tests have made it possible to study the agreement in this survey between the declarations made and the real consumption of cannabis. For declarations of consumption during the previous month, under-declaration was detected in 40% of cases and over-declaration in 50% (individuals who had declared consumption but whose tests were negative). This characteristic is apparently due to the special context of the selection procedures where some seek to hide their consumption while others invent it in the hope of re-education. In total, since over-declaration more than compensates under-declaration, the figure obtained is a slight over-estimate.

Declared prevalences amongst men from 18 to 23 called to a national service selection centre in 1996

Product	At any time	During the past month
Cannabis	40.0%	14.5%
Cocaine	2.5%	0.4%
Heroin	1.5%	0.3%
Ecstasy	5.1%	1.2%

Source: DCSSA, Drug Use Survey [*Enquête toxicophile*] 1996

2.3 Problem drug use

National and local prevalence

Estimation of the number of "problem" users of opiates

Consumption levels of such drugs as heroin and cocaine are difficult to detect through surveys of the general population. For some years, the research institute has sought to improve estimates of the numbers of these users, chiefly opiate users, by turning to indirect estimation methods.

The new estimates presented here are the result of work carried out at the European level in connection with the establishment of the EDMC's key indicators. In France, this exercise has made it possible to apply four different methods and thus to arrive at an estimated range.

The following table summarises the results of this study. The group targeted by the various methods is the group of "problem" users of opiates and cocaine. The notion of "problem" user refers to a level of consumption that can lead to the user turning to the health and social system and/or coming to the notice of the police or judicial authorities.

The four methods are described in detail in the technical report quoted as a reference. They are subject to variation depending on the working hypotheses and the sources of data used. No method can be considered, in itself, as ideal. The main interest of this study is in the application of the different methods and their cross-validation. Thus, a convergence in their results can confirm the reliability of such an estimate.

Estimates of the number of "problem" users of opiates and cocaine in France in 1999

Method	Prevalence
Demographic, multiplicative	146,000
Extrapolation of treatment data	180,000
Extrapolation of police data	150,000
Multivariant statistical analysis	178,000

Source: OFDT

The application of the European protocol to France gave, for 1999, a range of estimates for problem users of opiates and cocaine from 150,000 to 180,000.

The estimate made for the previous report was from 142,000 to 176,000 problem users of opiates in 1995. The comparison of the two estimates tends to indicate a stabilisation in the number of users, however this conclusion should be treated with great caution, in particular with two facts in mind:

- the coverage of the estimate has grown; it has been extended from the problem users of opiates to those of opiates or cocaine. However, the significance of this extension of cover is reduced by the fact that the consumptions of these two types of product are very much interlinked,
- the methods used have changed.

The current estimate is based, in part, on the results of a method known as "capture-recapture" that was applied to several French towns (Toulouse, Marseilles, Nice, Lille, Lens). These results make local estimates available of the prevalence of the use of opiates and cocaine in five large towns in France. This method makes it possible to calculate a confidence interval* for each estimate, the size of which shows very well how important it is to remember that these estimates should only be considered as giving a rough idea.

Estimates of the number of users of opiates or cocaine in 1999 in five French towns

Town	Number	Confidence interval (numbers)	Prevalence* (15-59 yrs.)‰	Confidence interval
Toulouse	2 802	2 577-3 027	6.50	6.0-7.0
Lille	5 296	4 444-6 148	10.00	8.4-11.7
Lens	1 557	1 387-1 727	7.00	6.2-7.7
Marseilles	5 758	4 663-6 853	10.60	8.4-12.6
Nice	4 541	3 255-5 826	15.30	11.2-19.6

Source: Prevalence survey 1999, ORSMIP-OFDT (Chevallier, 2001)

Risk behaviours

Intravenous injection

It is the practice of injection, independently of the substance concerned, that is the origin of the major part of the damage to health suffered by drug users (infectious illnesses, whether

viral or bacterial, increased risk of overdose, anaphylactic shock, abscesses etc.) (Emmanuelli, 2000). This is why it is important to monitor injection practices.

In the specialised treatment centres and health establishments, slightly more than 14% of those registered for care have used intravenous injection during the last 30 days and nearly 50% at some previous time. The situation is very different in social establishments, where more than 80% of users have never practised injection, which can be explained by the characteristics of the users who visit these establishments (mostly young cannabis users) [November survey].

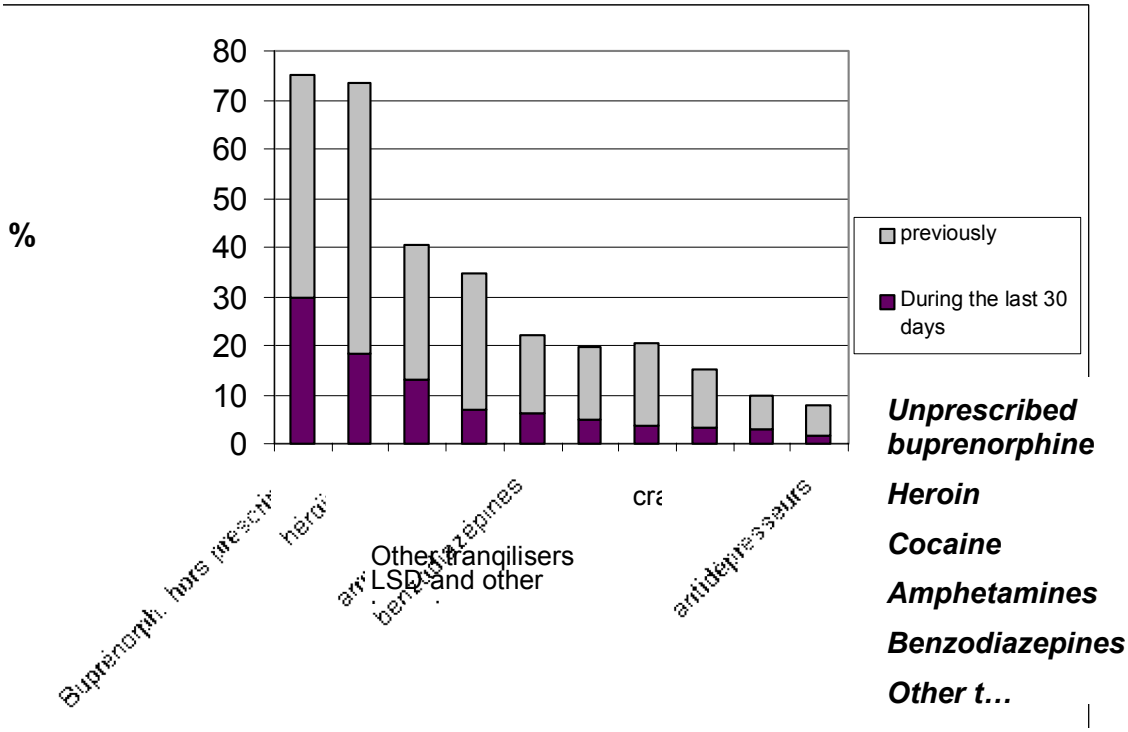
Amongst those turning to specialised treatment centres and health establishments, the proportion of users currently practising injection[10] had fallen compared to 1996 and 1997 (14.3% in 1999 compared with 17.4% in 1997 and 20.6% in 1996). There has been a reduction of the same order in the injecting users registered for care for the first time (13.4% in 1999 as against 16% in 1997[11]) [November survey].

The extent to which injection is used varies according to the substance leading to the registration for care and shows a particular link to abuse of and dependence on opiates. Those registered for care for the use of cocaine and amphetamines are also involved in this practice, even after exclusion from the result of those also dependent on opiates (mention of substitution treatment and/or opiates in a secondary product as reason for reception into care).

[10] As a percentage of those replying yes or no to the question on injection

[11] data not available for 1996

Percentage of those injecting by main substance leading to registration for care in November 1999 *(2305)*



Note: in order to monitor as precisely as possible the prevalence of the injection of substances other than opiates, the calculation is made from the number of receptions into care by main product with the exclusion, for non-opiates, of cases with opiate substitution treatment or opiates recorded as a secondary product.

Source: Survey on registration for care of drug addicts in November 1999, DREES/DGS

Amongst those who had recently consumed opiates or cocaine, the proportion of injecting users was much higher. According to the OPPIDUM survey, it reaches 50% amongst users of cocaine or unprescribed buprenorphine and 36% amongst heroin users. In the November survey, the practice of injection is also high amongst those having consumed these products during the past month and especially high in cases of an association between opiates and cocaine (cocaine + heroin, 50%; cocaine + Subutex®, 63%). Amongst heroin users, the proportion of those injecting has been falling sharply for some years (75% in 1995 as against 36% in 1999) [OPPIDUM]

In the two surveys quoted above, the risks taken in connection with injection (sharing and reusing a syringe) are not described and it is therefore difficult to know how they have changed recently. The repeated IREP surveys amongst drug users in care centres or encountered on the street (active or former injectors and non-injectors) have shown a sharp decline in the sharing of syringes between the end of the 1980s and 1996 (from 50% to less than 20% of those questioned) and a stable, high level of reuse. In another survey, carried out in 1998 amongst those frequenting the PES, the percentage of injecting users who had shared their syringes was about 20% while reuse was mentioned by about one user in two (Emmanuelli et al., 1999). However, the population of the survey consisted only of active injectors, mostly displaying rehabilitation difficulties and the only representatives to be found amongst the clients frequenting the PES, which can lead to an overestimated result.

3.1 Demand for drug treatment

Drug users monitored by the health and social institutions

Registrations with the health and social system in November

In November 1999, some 26,600 registrations were recorded by the health and social services that responded to the survey, corresponding to a rise of 5% compared with 1997. This overall average covers an increase of 12% in the registrations with specialised establishments and a fall of nearly 10% in the health establishments. This latter change, however, seems to be connected, at least in part, with a fall in the number of health establishments answering the survey.

Of the total of registrations with specialised centres during November, 34% of first registrations were counted in 1999, a slight fall in comparison with 1997 (36%).

Registrations during the year in specialised centres

In the course of 1999, more than 65,000 drug users were registered for care in specialised centres. The increase in the number of registrations for care recorded during the year (8%) is higher than in 1997 (3.7%) and follows a rise of about 10% between 1995 and 1996.

About 46% of registrations for care during the year were first registrations. This proportion is slightly lower than in 1997.

Changes in the manner of treatment

The distribution of users according to the nature of the care given has changed considerably following the introduction of substitution treatment. In the specialised centres, 32% of those registered for care are given substitution treatment as against 1.2% in 1993, whereas the proportion given withdrawal treatment has fallen from 30% to about 9%. A similar development, although less clear-cut, is to be observed in the hospitals, where the percentage of users received into care for substitution treatment has risen from 0.7% to 12% while withdrawal treatment has fallen from 39% to 27%.

Since 1997, the question as to the nature of the treatment has no longer been asked; it has been replaced by a question on substitution treatments. These are mentioned in 51% of all registrations in November 1999 (Subutex® 30%, methadone 19%) and 63% of registrations in specialised centres (Subutex® 35%, methadone 26%, others 2%). The proportion of those undergoing substitution treatment has continued to rise significantly in the specialised centres (+6 points) and more slowly in other establishments (+2 points).

Distribution of drug users received into care during November 1999 according to the category of establishment

	Number of establishments responding to the November survey	Number of drug users received in November
Total of specialised services	275	17,124
Total of health establishments, of which:	462	7,321
Regional hospital centre	52	1,691
Hospital centre, public hospital	239	2,700
Hospital centre specialising in psychiatry and private psychiatric hospital serving as a public hospital	104	2,640
Mental health clinic	67	290
Regional medico-psychological service*		
Total of social establishments	440	5,229
Total		29,674
Total without double entries		26,635 **

Source: DREES, November survey, 1999

* Hospital services providing care and treatment in prison establishments

** Double entries (persons being looked after in both a specialised centre and a health or social establishment) are deducted from the previous total

Any double entries that there may be within each category of establishment, however, are not eliminated. A user who had visited several specialised centres or several hospital services during November would have been counted several times.

Substances leading to the registration for care

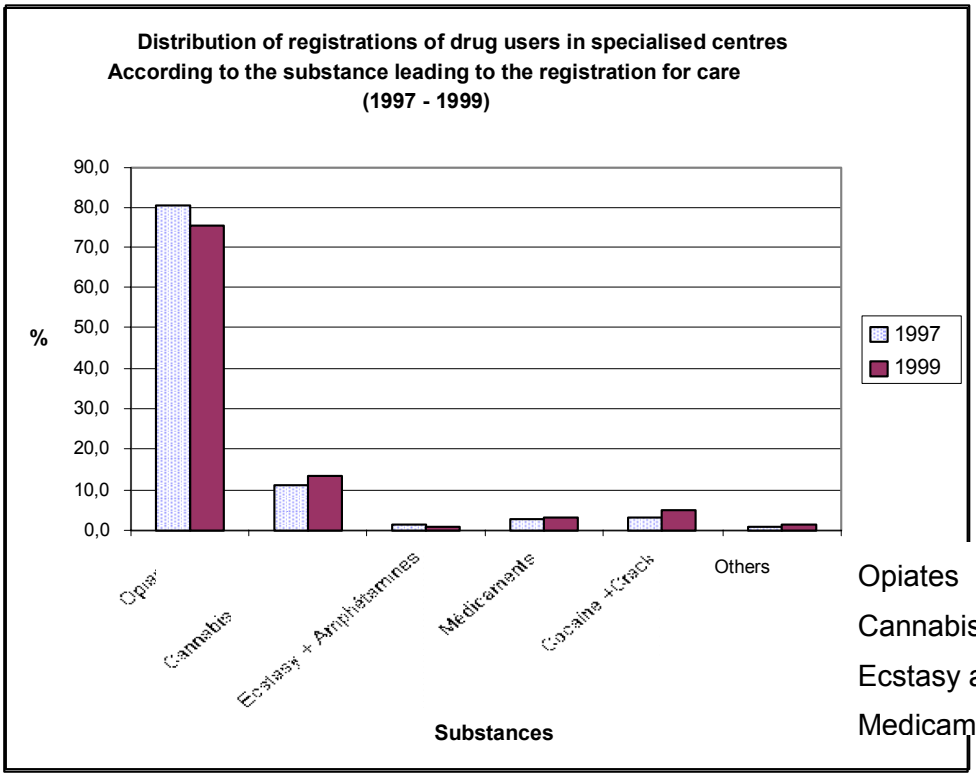
It is opiates that lead to reception into care in the specialised centres in almost 76% of cases in November 1999. Among them are drug users following a substitution treatment who have come into a specialised centre because of their dependence on opiates but whose consumption of illicit opiates is very small or nil. However the figures collected in a one-month survey tend to overestimate the numbers of such users. These patients, very often undergoing substitution treatment, visit care facilities more regularly than others and the probability of their being present during a given month is higher. If it were possible to record the number of different users visiting during the year, the proportion of opiates would no doubt be smaller. Furthermore, with the development in multiple consumption, numerous users are in difficulty with several substances amongst which, apart from opiates, cocaine, benzodiazepines and alcohol are frequently encountered. Dependence on opiates, however, remains a very frequent common denominator.

Cannabis is involved in almost 14% of cases registered for care, cocaine or crack in almost 5%.

A common factor for cocaine, alcohol and medicaments is that they are all much more frequently encountered as secondary rather than primary substances. Taking account of the preponderance of opiates in receptions into care, all the secondary substances are mostly associated with opiates but in differing degrees: more than 90% of cases for cocaine, 70% for medicaments and 50% for alcohol.

Developments between 1997 and 1999 were marked by a reduction in the share of opiates in favour of cannabis and cocaine. Amongst the opiates, the increase in the number of registrations in connection with the consumption of unprescribed Subutex® (4.3% in 1999 as against 1.5% in 1997). This development has to be seen in relation to the large numbers following substitution treatment with Subutex® and the ease of access to such treatment.

Distribution of registrations of drug users in specialised centres



Source : DREES

Medicaments: benzodiazepines, antidepressants, barbiturates and other hypnotics, other tranquillisers

Others: LSD and other hallucinogenics, glues and solvents, other substances

In the course of the 1990s, the proportion of opiates in the registrations for care fell back to the level reached at the beginning of the period, having risen during the first half of the decade; an opposing movement was seen for cannabis. For opiates, this progression is probably the consequence of the epidemic peak reached by heroin use at the end of the 1980s, which would have led to a rise in registrations for care with a few years' delay.

During the ten years under consideration, the only lasting changes in substances leading to registration for care that remain are the drop in the proportion of medicaments and the rise of cocaine and crack. This last increase is in line with the increase in survey arrests for cocaine use and the information collected through the mechanism for monitoring recent trends

(TREND mechanism) established by the OFDT. The fall in the proportion of medicaments is more surprising. One could put forward the hypothesis that information on this addiction to a licit product is more difficult to collect. Faced with the increase in registrations for care connected with opiates, the motivation to survey and record cases of addiction to medicaments may have been less strong. It is also conceivable that registration for care for difficulties connected with this type of product is carried out by other facilities. It should finally be considered that sales of tranquillisers have shown a downward trend since the beginning of the 90s, which is in line with the trend in registrations for care.

Development in the registrations of drug users in specialised centres by product leading to the registration for care (1989 – 1999)

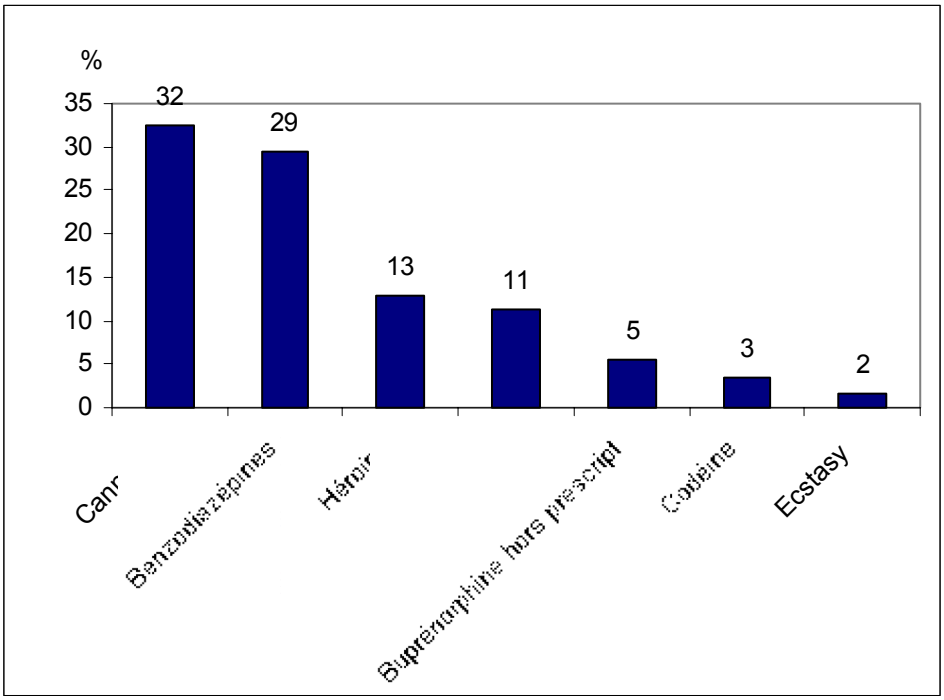
	1989	1991	1993	1995	1997	1999
Opiates	74.7	74.1	77.9	84.0	80.5	75.8
Cannabis and derivatives	12.7	14.3	10.8	8.4	11.2	13.7
Ecstasy & Amphetamines	0.9	1.2	0.9	0.8	1.2	1.0
Medicaments	6.7	5.3	6.0	3.4	2.9	3.1
Cocaine & Crack	1.7	1.5	3.1	2.2	3.2	4.9
Others:	3.3	3.6	1.2	1.3	1.0	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: OFDT, based on data from the DREES

Recently consumed products

The surveys on persons visiting care facilities also concentrate on the products consumed in the recent period before the visit (month or week). These products are not necessarily those leading to the registration for care. In the case of a user on substitution treatment, heroin can be the original reason for registration for care, even though it has not been used for some time. For this reason, heroin, although giving rise to the majority of registrations for care, is currently used only by a minority of users resorting to the care facilities. The proportion of current heroin users has diminished considerably since 1995, a development that is coincident with the growth in substitution treatments. On the other hand, the consumptions of cocaine, benzodiazepines and cannabis are more frequently encountered than before [18].

Frequency of drug use during the previous week amongst users seeking care, by product *{2304}*



Cannabis

Benzodiazepines

Heroin

Cocaine

Unprescribed buprenorphine

Notes on the chart: 32% of the 2,030 subjects included in the survey had consumed cannabis in the course of the previous week. Since a subject may have consumed several substances, the percentages cannot be added. Only the main substances concerned are shown in the chart.

Source: OPPIDUM 1999, CEIP

Age of the users

From the point of view of age, two groups can be distinguished amongst those making use of the health and social system (as well as amongst those arrested):

– **Users of opiates**, essentially heroin, whose average age is around 31 and increasing from year to year. The users of cocaine and crack who seek care are smaller in number and similar in age to the users of opiates. It may also be noted that those received into care in hospital for the use of medicaments (other than opiates) are younger in age.

– **Users of cannabis,** whose age is around 25 when seeking help. The average age of ecstasy users is comparable with that of cannabis users.

Age of users according to product leading to registration for care in specialised centres in 1999

Primary substance leading to the reception into care	Specialised centres	Health establishments (hospitals etc.)
Heroin and other opiates		
Heroin	31.4	30.9
Codeine derivatives	34.3	33.7
Morphine, opium and other opiates	33.4	35.7
Methadone without prescription	34.0	31.5
Buprenorphine without prescription	30.1	30.0
Cannabis	25.0	26.2
Psychotropic products		
Antidepressants	34.0	34.3
Barbiturates	30.9	33.6
Benzodiazepines	30.2	34.4
Other hypnotics and tranquillisers	30.2	38.6
Cocaine	30.1	30.5
Crack	32.2	32.7
Synthetic drugs		
Amphetamines	31.0	34.5
Ecstasy	24.3	23.2
LSD and other hallucinogenics	28.3	28.3
Glues and solvents	29.7	31.2
Other substances	32.8	32.2
Alcohol	33.8	
All those responding to survey	30.6	30.2
Those not responding	32.0	32.1
Overall	30.6	30.9

Sources: DREES, November survey, 1999

Users who sought help for the first time in the specialised centres in November 1999 were younger (28.5 yrs.) than those who had already contacted these institutions (nearly 32 yrs.).

Changes in the age of users registered for care in specialised or health establishments

	1987	1990	1991	1992	1993	1994	1995	1996	1997	1999
Spec. est.	25.9	27	27	27.4	27.8	28.2	28.9	29.4	29.8	30.6
Health est.	27.2	28.9	28.5	28.6	29.3	29.2	29.7	30.3	30.5	30.9

Source: DREES, November survey 1999

The tendency for an increase in the age of users seeking assistance in specialised centres and health establishments continued in 1999. This affects all types of users, whatever the product consumed, with the exception of cannabis users received into care in hospital who are becoming slightly younger. When seeking to explain the increase in the average age of the users of drugs other than cannabis turning to specialised and health establishments, it should first be noted that, between 1987 and 1999, their numbers rose for all age groups but the increase was greatest amongst the oldest. It is interesting to note that, between 1997 and 1999, the number of contacts by 20 to 24-year-olds fell and remained constant for the 25 to 29 age group. Any increases are amongst the very young and the over 30s.

The increase in numbers amongst the oldest users may, in part, be the consequence of the increasing age of users already having been received into care and who continue to register for treatment ("cohort" effect). However, there is also a rise in the age of those seeking help for the first time, which tends to show that entry into the care system is also being delayed: there is an increasing delay between beginning to use drugs and resorting to the care system; some of the users received into care came to drugs at a later age.

The sex of users

Traditionally, the user population in the care system is predominantly male. The proportion of males in 1999 was 77%, a figure that has been growing since the end of the 1980s when it was around 73%. In the specialised centres, the proportion of women amongst the first contacts is slightly lower (20% as against 23% in all registrations in specialised centres).

Registration for care of opiate users by general practitioners

- **Number of patients using heroin**

According to a survey carried out at the beginning of 2001 amongst a representative sample of general practitioners [20], almost 60% had agreed to treat at least one opiate dependent person during the previous year and 38% during the previous month (Coulomb *et al.* 2001). The average number of opiate users seen each month in an urban surgery was 1.9. Extrapolating this figure to all active general practitioners, we obtain 100,000 as the number of opiate users seen each month by GPs in urban surgeries at the beginning of 2001. This is only a rough estimate, with large margins of error related to assumptions made regarding the number of patients seen by GPs who refused to participate in the survey, the size of the sample and the retrospective collection of data by telephone (errors of memory). Further, if, for each GP, the patient population is different, a single patient could have visited several doctors in the course of the month and thus have been counted several times.

Doctors who have seen at least one heroin user during the previous twelve months very often prescribed substitution treatments, 79% of them with buprenorphine (Subutex®), 18% with methadone[12] [20].

- **Characteristics of doctors registering heroin users for care**

The doctors who never see an opiate user are more likely than others to be practising in towns of less than 20,000 inhabitants (true for 70% of them). 90% of them consider themselves badly trained or untrained in caring for drug users and quote lack of demand as the main reason for treating none. Conversely, doctors who see more than 10 users per year are mostly working in towns with more than 20,000 inhabitants and mostly consider themselves trained. Doctors who are part of a network, 10% of the sample, see a much greater number of heroin users than the others [20]. The data from the General Practice Barometer give similar indications [21].

- **Trends in the numbers of heroin using patients registered for care in urban medical practice.**

The survey of which the results are quoted above was also carried out in 1995 and 1998 so that comparisons can be made. Since 1995, the percentage of doctors who had seen at least one dependent heroin user during the previous year had not changed. On the other hand, the percentage who had seen ten users or more during the previous year increased markedly between 1995 and 1998 but remained stable between 1998 and 1999. The average number of heroin users seen during the previous year by doctors who agreed to respond to the survey increased from four in 1995 to seven in 1998 and nine in 2001, although this last increase (from 7 to 9) is not statistically significant. The changes between 1995 and 2001 reflect the rise in receptions into care of heroin users in urban practice, followed, no doubt, by stabilisation in recent years.

Between 1998 and 2001, the proportion of GPs who had seen at least one heroin user and prescribed buprenorphine only increased slightly (from 76% to 79%). On the other hand, the percentage of doctors who had prescribed methadone tripled from 6% to 18% [20]. The following section takes a closer look at the evaluation of the number of patients on substitution treatment.

3.2 Drug-related mortality

In the absence of a cohort study, it is not possible to have any overall knowledge of mortality amongst drug users[13]. The information currently available in France only makes it possible to measure the numbers and characteristics of certain deaths the cause of which is identified as being connected with drug use. These are deaths by overdose where these have been the subject of judicial proceedings, deaths from drug dependency and, finally, deaths from AIDS of injecting drug users.

a) Deaths directly or indirectly related to drugs, characteristics and trends, possible reasons for changes

Depending on the source of information, it is necessary to distinguish deaths directly connected with the use of illicit drugs from those more indirectly connected such as the death of drug users from AIDS.

[12] These two figures are not additive: a single practitioner can prescribe buprenorphine to some of his patients and methadone to others.

[13] A study of this kind is under consideration for 2002, based on a retrospective cohort of drug users questioned by police.

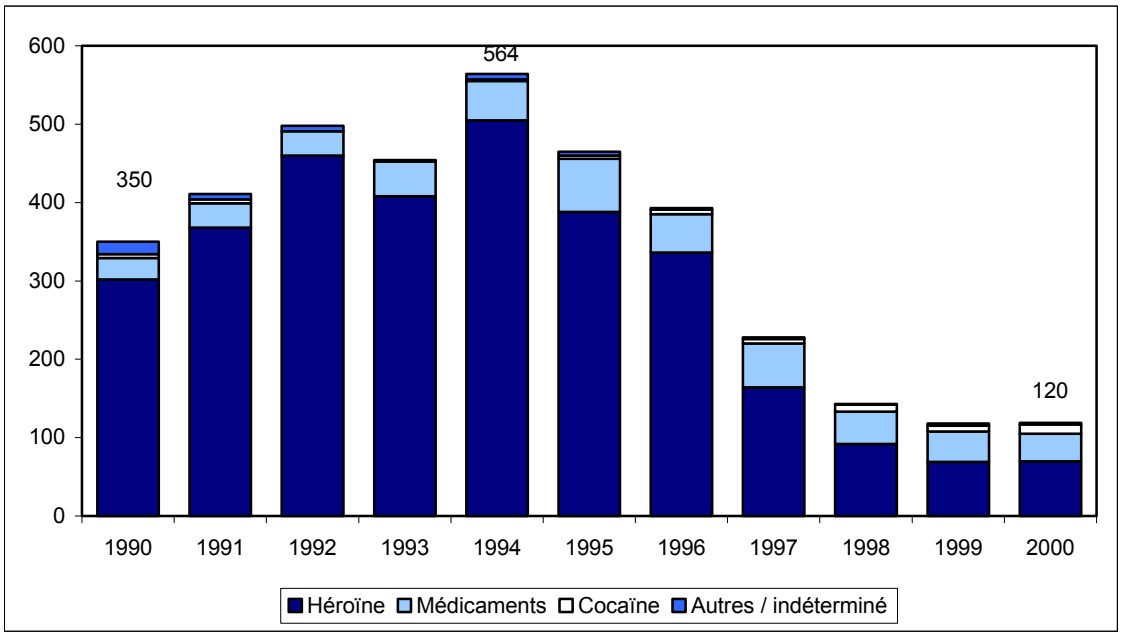
A proportion of the deaths from illicit drug use can be measured with the help of the national register of causes of death maintained by the National Institute of Health and Medical Research [*Institut national de la santé et de la recherche médicale*] (INSERM), which collects its information from death certificates. However, the data that are most quickly accessible come from the Central Office for the Repression of Drug-related Offences [*Office central pour la répression du trafic illicite de stupéfiants*] (OCRTIS) and record the overdoses that have been the subject of a police enquiry. Finally, data can be added from the information gathered by the DRAMES (Death Related to Abuse of Medicaments and Substances: *Décès en relation avec l'abus de médicaments et de substances*) monitoring system and fed to it by the CEIP, Centres for Evaluation of and Information on Drug Dependency [*Centres d'évaluation et d'information sur la pharmacodépendance*].

None of these sources can supply data on deaths where drug use is not the immediate cause such as suicides or road accidents.

Overdoses recorded by the police

Deaths by overdose recorded by the police have fallen sharply since 1995. Their number fell by a factor of almost five from the maximum recorded in 1994 (564 deaths) to the lowest level recorded in 2000 (120 deaths).

Deaths by overdose recorded by the police, from 1990 to 2000



Heroin/ Medicaments/ Cocaine/ Others

Source: FNAILS, OCRTIS

Even if it cannot be excluded that deaths by overdose have become less visible, the fall in mortality is confirmed by the data from INSERM (see below).

The trend can be largely explained by the drop in cases of heroin overdose. Although heroin still accounts for nearly 6 out of ten deaths recorded, deaths from this cause have fallen in both absolute and relative terms since 1995. The growth in substitution treatments and the fall in heroin use both contribute to this trend. The trend in the chart might be seen to suggest

that the number of deaths has now reached an irreducible minimum. What is certain is that there has been little drop in numbers since 1999, which perhaps coincides with the renewal in the taste for heroin reported by observers in the field.

At the same time as the fall in deaths from heroin overdose has fallen, those connected with cocaine, although limited to about ten, have assumed an increasing weight in the total of overdoses and, more important still, those attributed to medicaments now account for one death in three (the medicaments most often concerned are those habitually used by heroin addicts, whether as substitutes or not: Subutex®, methadone, Skenan®, Tranxene® etc.).

The results of toxicological examination often reveal the presence of several substances. This is the case for one third of the overdoses recorded in 2000.

A study of 123 deaths in 1998 and based on the statements of the toxicological experts has shown that, in 3 cases out of 4, narcotics are the cause of death and associated in half the cases with psychotropic products. The thirty other deaths can be attributed to buprenorphine (Subutex®) or methadone, associated with other substances in all cases.

Furthermore, the comparison of the characteristics of these deaths with those of the 143 overdose cases recorded by the OCRTIS in the same year showed the existence of a maximum of 15 cases with entries in both lists. This indicates that the number of overdoses is probably underestimated, whichever sources is considered.

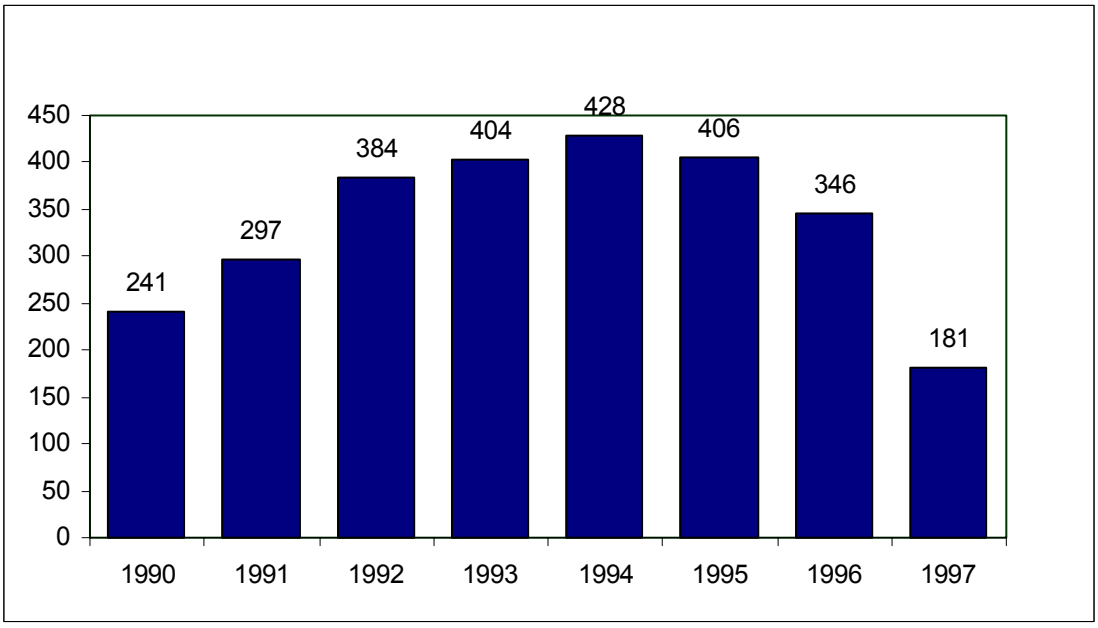
Other measures of deaths in connection with drug use

The deaths to be found in the INSERM causes of death file are not only overdoses since all deaths where drugs are implicated are likely to be recorded. This source does not act as a reliable indicator of overdoses in the strict sense, as certain deaths where the cause is not immediately identified are classified as "cause unknown", even if a later autopsy shows it to be a death by overdose.

It is therefore not possible to directly compare or to accumulate the numbers of deaths obtained from the OCRTIS and INSERM sources.

According to the international classification of diseases (9^{th} edition), deaths connected with drugs are grouped under three distinct causes: psychoses caused by drugs, dependence, and abuse of drugs without dependence. By convention, INSERM codes deaths connected with illicit drugs (overdoses) chiefly as drug dependency whereas death from abuse of drugs without dependence corresponds almost exclusively to deaths connected with tobacco and alcohol. No cases of death from psychoses are recorded.

Deaths from drug dependency as recorded in death certificates from 1990 to 1997



1997 is the last year for which information is currently available.

Source: National File of Causes of Death, INSERM-SC8

Cases of death from drug dependency have thus been in decline since 1994. This fall, steady at first, accelerated in 1997. At least half of these deaths are connected with the use of opiates. This trend corroborates that observed for overdoses recorded by the police without it being possible to verify whether the same deaths are concerned or not.

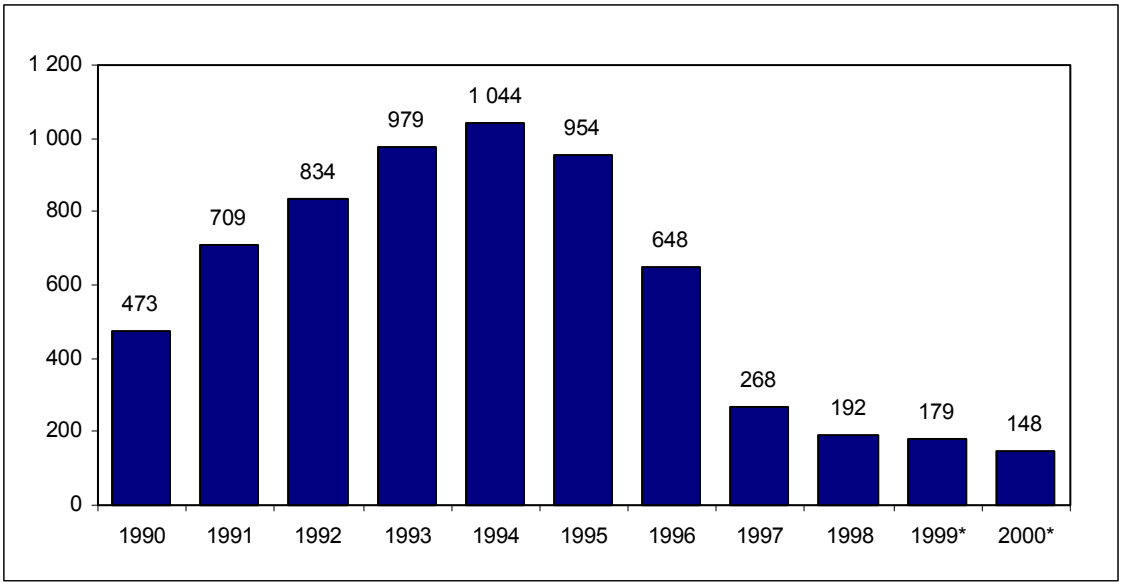
Deaths of injecting drug users from AIDS

The number of deaths from AIDS amongst drug users continued to fall in 2000. After the peak in 1994, these deaths have fallen by an average of 25% each year. Until 1999, a similar trend can be seen in the overall number of deaths from AIDS, irrespective of the way in which the infection was acquired; however, it is only the deaths amongst drug users that continue to fall in 2000.

The proportion of deaths from AIDS amongst injecting drug users fell in 2000, whereas it had risen throughout the last decade from about 20% in 1990 to 30% in 1999.

The new antiviral treatments and their greater accessibility explain in large measure the fall in the number of deaths from AIDS amongst drug users.

Deaths from AIDS amongst injecting drug users from 1990 to 2000



* *Corrected data*

Source: AIDS Monitoring System, InVS

b) Mortality and causes of death in drug-users, trends

« NO INFORMATION AVAILABLE »

3.3 Drug-related infectious diseases

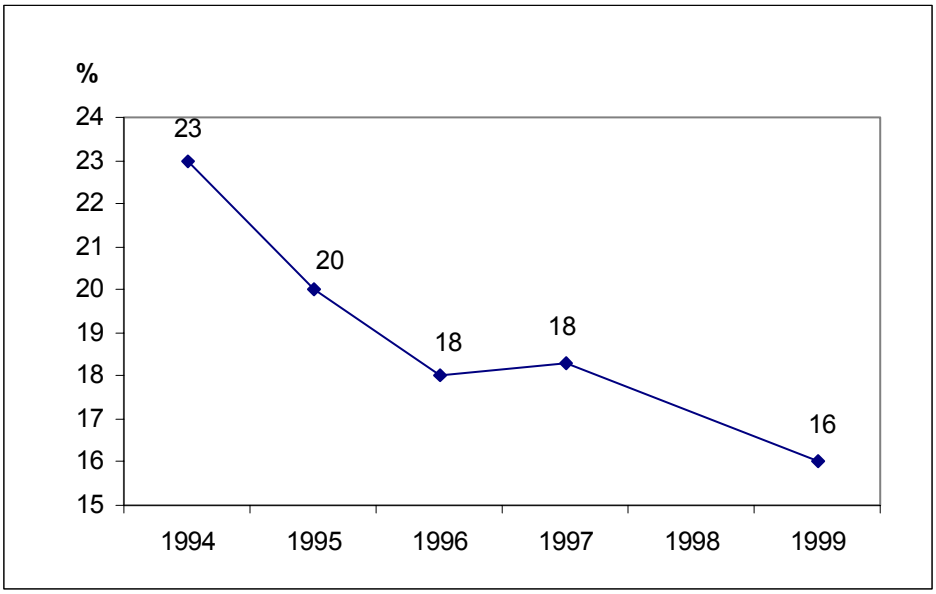
Prevalence of HIV infection

The prevalence of HIV infection in the population of injecting drug users differs widely from that in the population of other users. Amongst those seen in the Specialised Drug Addict Treatment Centres [*centres spécialisés de soins aux toxicomanes*] (CSST), the declared prevalence of HIV infection in November 1999 was rather less than 6% for non-injecting users and 16% for injecting users [17]. It should be noted that the serological status is unknown for 37% of the first group against 14% of the second. The prevalence of HIV infection amongst injecting users entering care for the first time is 13%.

According to the data from surveys carried out in the CSSTs in November, the prevalence of HIV infection amongst injecting users has tended to decrease since 1994[14] [17]. A survey repeated at longer intervals and carried out for the first time in 1996 (IREP, 1996) has shown that the decreasing trend goes back to the end of the '80s. The charts below show a fairly rapid fall-off between 1994 and 1996, which may be the consequence of a fall in the number of new infections from the end of the 1980s (Emmanuelli, 2000) and the large number of drug user deaths from overdose and AIDS at the beginning of the 1990s. In spite of the plateau seen in 1997, which could be linked to the decrease in deaths among HIV positive drug users, the downward trend seems to have continued until 1999. There also seems to be little doubt that the policy of prevention of risk of infection has had an impact on the prevalence of HIV infection, even if this is difficult to measure precisely. It should however be noted that the prevalence of HIV infection amongst injecting users accepted for treatment in the specialised centres for the first time remained stable from 1997 to 1999.

[14] Data on the prevalence amongst injecting users has only been available since then (1994).

Declared prevalence of HIV infection amongst injecting users visiting the specialised centres from 1994 to 1999 *{2306}*

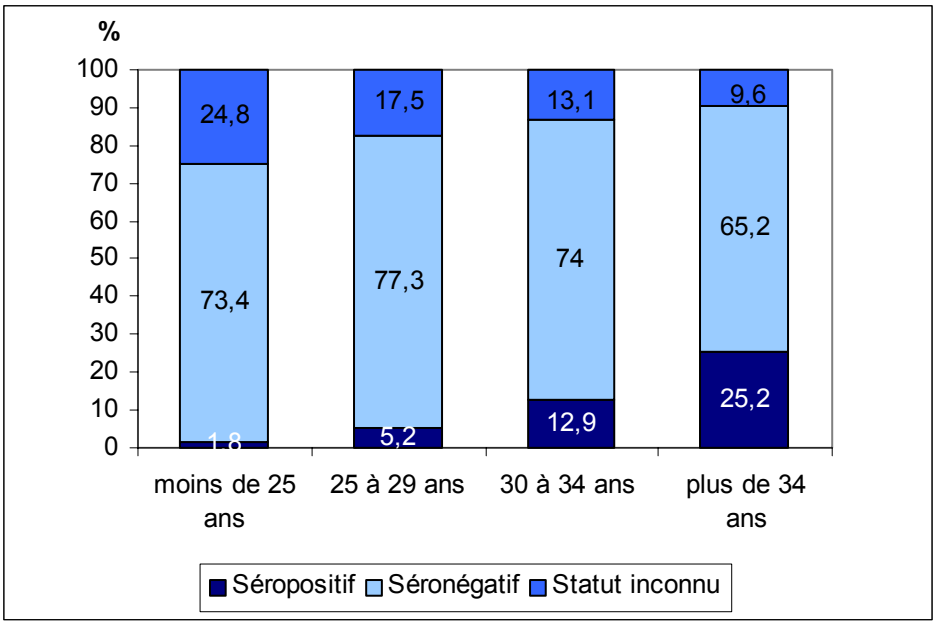


Source: Survey on reception into care of drug addicts in November, DREES/DGS

Another periodic survey was carried out by the European Centre for the Epidemiological Monitoring of AIDS [Centre européen pour la surveillance épidémiologique du Sida] (CESES) every six months between 1993 and 1998 amongst the users received into care with accommodation in the CSSTs. It should be emphasised that this population is included in the survey mentioned previously. These results also show a marked downward trend at the beginning of the period (second half of 1993 to second half of 1995) followed by a plateau (until the second half of 1996) and a renewed but very slight downward trend in prevalence until the first half of 1998 (Six *et al*., 1999). If the pattern of changes seems similar in the results of the two surveys, the prevalence in that carried out by the CESES is three or four points lower than that found in the DREES/DGS survey throughout the period. This difference could be explained by the age and geographical distributions of the populations of the two surveys and possibly by a selection effect connected with the type of facility. At that time (first half of 1998), the declared prevalence of HIV infection amongst users making use of the syringe exchange programs was 19% (Emmanuelli *et al*., 1999), a figure even higher than that found in the DREES/DGS survey. Here, too, there is little doubt that a population peculiar to a type of facility (dedicated specifically to injectors) is at the origin of the difference.

The prevalence of HIV infection is strongly linked to age, more or less doubling from one five-year bracket to the next but with an uncertainty in connection with the high percentage of younger people not yet tested. The prevalence grows with length of exposure to the virus, which is greater amongst the older drug users. The lower prevalence amongst the younger users could also be explained by the effect of the risk reduction policies (preventive message alongside increased access to sterile syringes and to substitution products).

Declared prevalence of HIV infection amongst injecting users seen in specialised centres by age group in 1999 *{2307}*



Source: Survey on registrations for care of addicts in November 1999, DREES/DGS

It should also be noted that amongst the injecting users seen in the specialised centres, women are more frequently HIV positive than men (18.5 against 15.1 amongst the men in November 1999).

For an analysis of regional differences, please refer to the geographical part at the end of this chapter.

New cases of AIDS

The number of new cases of AIDS amongst drug users is falling [14]. The fall was particularly pronounced in 1996 and 1997. Between 1997 and 2000, the downward movement continued but more slowly. A similar development has been recorded for AIDS amongst homosexuals. Up to 1999, the new diagnoses amongst heterosexuals also fell but less rapidly than amongst drug users and homosexuals amongst whom a peak of infection was reached in the middle of the 1980s. This fall in new cases of AIDS amongst homosexuals did not continue in 2000.

The effectiveness of treatment by the association of several anti-retroviral agents explains to a large extent the reduction in new cases of AIDS in all these transmission groups and especially amongst drug users.

Compared with declared cases amongst homosexuals, the proportion of cases where AIDS declares itself without the victim being aware that he is HIV positive is much smaller amongst drug users, which would seem to be explained by a higher detection level amongst the latter. Being better aware of their HIV status has enabled drug users to actively benefit, in the same way as homosexuals, from the new associations of anti-retroviral agents that became available in France in 1996.

New cases of declared AIDS amongst drug users from 1987 to 2000

1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*

640	905	1 079	1 218	1 342	1 493	1 376	1 317	962	423	346	285	244

** Corrected data*

Source: AIDS monitoring system, InVS

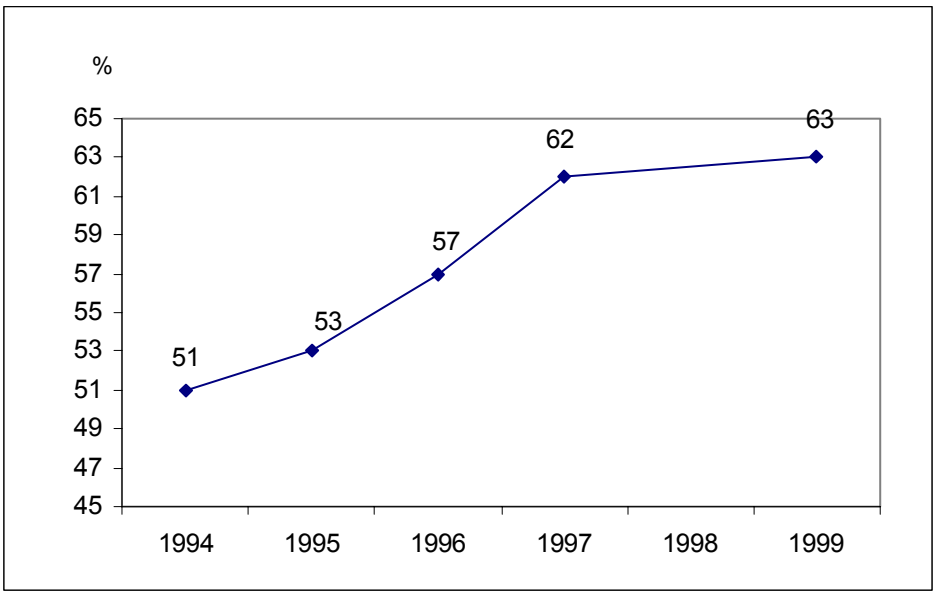
Hepatitis C

As in the case of HIV, the declared prevalence of HCV is closely linked to the practice of injection. Of those seen by the specialised centres in November 1999, 20% of non-injecting users were HCV positive as against 63% of injecting users. While bearing in mind that only slightly more than half of non-injecting users know their serological status, the high prevalence amongst the latter group raises a question mark. It is possible that some "non-injecting users" may have injected, even if only exceptionally. The risk of contracting the virus from a single injection are much higher for hepatitis C than for HIV (see below).

Tattooing is another route of infection that must be taken into account. Unprotected sexual relationships and the sharing of straws between nasal users have also been suggested but are still the subject of debate. Amongst injecting users, the serological status is better known with 81% known as against about 75% in 1997. Amongst first time registrations, the proportion of HCV positives is 54%, a figure that remained stable between 1997 and 1999.

Unlike HIV, the prevalence of HCV has risen since 1994. Nevertheless, the small change from 1997 to 1999 could indicate that a ceiling has been reached – a development that remains to be confirmed. The factors behind this upward trend have frequently been explained and will only be briefly recalled here: an increased prevalence of HCV, the higher infectiousness and resistance of this virus in the exterior environment. These make it highly probable that an injecting drug user will come into contact with the hepatitis C virus and, where this is the case, will be infected. The major persistence of certain risk practices (reuse of the syringe and the sharing of injection equipment other than the syringe) also contributes to this high level of prevalence.

Declared prevalence of HCV infection amongst injecting users visiting the specialised centres from 1994 to 1999 *{2308}*



Source : Survey on reception into care of addicts in November, DREES/DGS

Questions on HCV were introduced in the European Centre for the Epidemiological Monitoring of AIDS [Centre européen pour la surveillance épidémiologique du Sida] (CESES) survey in 1996. The data on prevalence amongst injecting users are very nearly identical to those of the chart shown above (63% in the first half of 1998), with an increase until the first half of 1997 followed by a tendency to stabilise.

For the same reasons as HIV, HCV infection is age-linked: Of injecting users under 25 visiting the specialised centres in November 1999 (N = 1,121), some 38% are HCV positive and 28% of unknown status while of those 35 and over (N = 3,132), 77% were HCV positive and 16% of unknown status.

Contrary to that which has been observed for HIV, women using injection do not seem significantly more affected by HCV than men.

For an analysis of regional differences, please refer to the geographical part at the end of this chapter.

Co-infection

Of all injecting users who know their serological status, 13.3% are infected with both HIV and HCV. In 1997 the proportion was 14.4%. Of those who are HIV positive, nearly 88% acknowledge that they are also HCV positive as against 83% in 1997.

3.4 Other drug-related morbidity

Other aspects of drug user morbidity are less well-known and either little or very inconsistently measured. Doctors questioned in the study made by EVAL in 2001 report cases of venereal disease in 7% of patients using opiates. 9% of them have been hospitalised in emergency, 1% have overdosed and 2 % have attempted suicide. 5% of users mentioned septicaemia in a rather old survey by the IREP (1996), venous infections are cited in 14% of cases in the ARES92 study (1998) and precursors of infection in 23% of cases in the GT69 study (1996).

Dental problems are the most frequently mentioned preoccupation of users encountered in the street in the IREP survey (52% of cases).

Overdose, attempted suicide and psychiatric problems are major elements in the morbidity of the most dependent drug users, aspects that we are not in a position to measure in a precise and consistent manner.

On the question of driving a car, several studies, both in France and abroad, have made it possible to estimate the incidence of drug use amongst drivers involved in traffic accidents. The figures obtained range from 6 % to 16 % (Mura *et al*., 1999, p. 200 ff.). The second figure comes from a French study dating from 1998. For this study, the presence of narcotics was investigated in the blood samples taken from 164 persons for alcohol testing as required for drivers involved in accidents causing serious injury or death (Mura *et al*., 1999).

In the majority of studies carried out up to now, the absence of a control group made it impossible to determine any increase in the risk of a road accident that might be caused by the use of cannabis. Recently a study was carried out of 800 drivers injured in a road accident and hospitalised in various towns and 800 control subjects admitted in emergency for other reasons. All the subjects in this study were investigated for the use of alcohol, various psychotropic medicaments and illicit drugs. The results are still to be published at the

time of going to press. Further, according to the legislation in force since 1 June 2001[15], drivers involved in a fatal road accident are to be systematically tested for cannabis, opiates, cocaine and amphetamines. The data are to be collected in order to study the role played by cannabis and other illicit substances in road accidents. The results of this study are expected to be available at the end of 2004.

4. Social and Legal Correlates and Consequences

4.1 Social problems

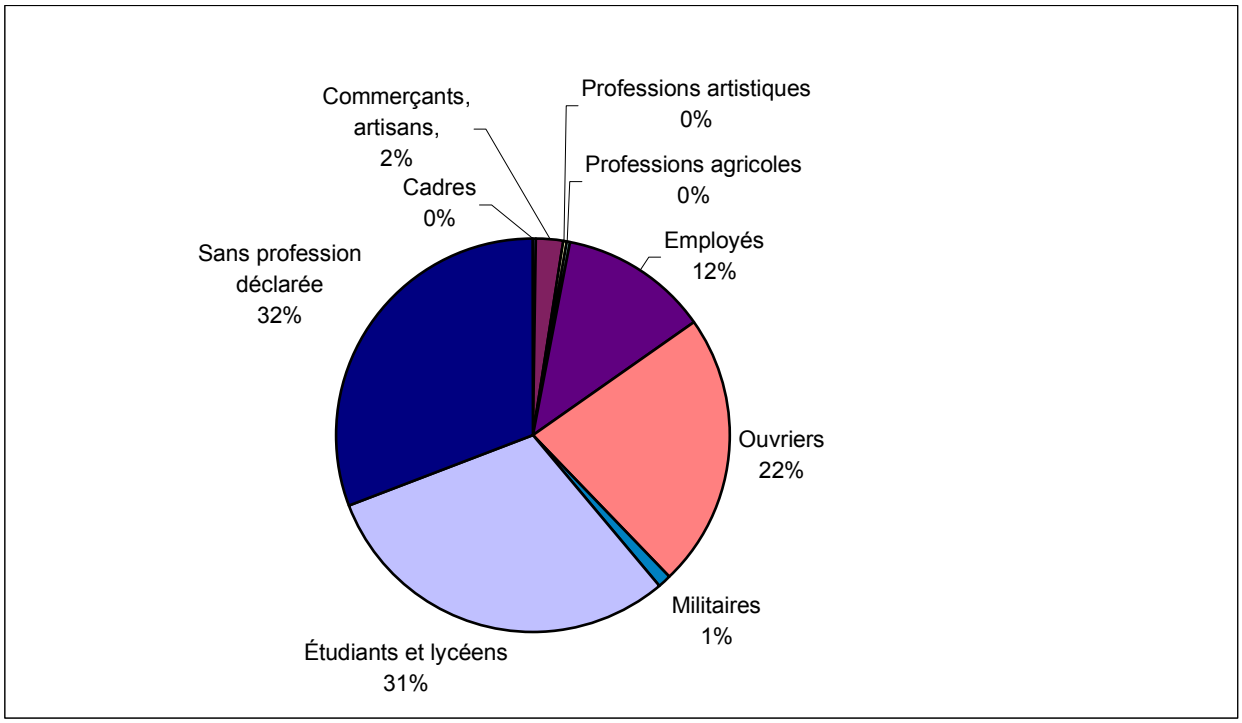
a) Social exclusion (e.g. housing, unemployment, minorities and education)

Of the users registered for care in the health and social system in November 1999, 32% are recorded as unemployed and 27% as inactive giving a total of 60% without activity (neither in paid employment nor students). Of users questioned by police in 2000, 32% were "without declared occupation". The difference to be observed here is largely to be explained by the very high proportion of pupils and students amongst the users questioned (31%), the proportion being much smaller amongst users registered for care in November 1999 (7%).

Applying the same definition as in the November survey, we find a proportion of 63% "inactive", made up of 32% "without declared occupation" and 31% students.

The active/inactive share is thus fairly similar from the two sources, students, however, being much more numerous amongst those arrested.

Distribution of arrests for use and use with resale of narcotics in 2000 by socio-professional category



Source: FNAILS 2000, OCRTIS

[15] The law No. 99-505 of 18 June 1999 regarding road safety requires the systematic testing for narcotics of drivers involved in a fatal road accident. The decree regarding the testing to detect narcotics to be carried out on drivers involved in a fatal road accident should be enforced from 1 October 2001.

The distribution by socio-professional category of those cautioned for the use of cannabis or ecstasy is close to that described earlier in the whole of the population. On the other hand, those cautioned for the use or use with resale of heroin or cocaine are more often without declared occupation (half) and much less often students in higher education or upper school (of the order of 5-6% in 2000).

In the total of cautions, the trend that has been noticed since the beginning of the 1990s is a reduction in the number of persons who declare themselves without occupation in favour of an increase in students and labourers. The other socio-professional categories remain stable or are barely represented.

b) Public nuisance, community problems

The establishment of risk reduction facilities is often badly accepted in the neighbourhood, where people are reluctant to see a gathering of drug addicts who are in difficulty or marginalised in a single place. The **proximity teams** are a pilot scheme; they play a mediation role and are in touch with the inhabitants, tradesmen, pharmacists etc. in the area. Furthermore, these teams are given the task of improving the care of the users. They mediate between the neighbours, the town hall and the police, justice and health services. The street work is principally carried out by specialist educators working in several areas of the district. They are required to seek out drug users in order to give them information and strengthen links with the health and social system. Co-ordinators organise the front-line street workers to respond to problems drawn to their attention. In total, four proximity teams have been set up in the towns of Paris (in the 10th, 13th and 18th arrondissements) and Montpellier (one team only). A similar trial, financed by the town, has also been started in Marseilles.

4.2 Drug offences and drug-related crime

According to the laws on narcotics use in force in France, any person who consumes and/or traffics in these substances is liable to penalties including imprisonment and can therefore be arrested, which may or may not be followed by conviction and possibly imprisonment. This section seeks to determine the number and characteristics of persons concerned at each of these stages (arrests then convictions/imprisonments), distinguishing in each case the users and traffickers involved.

a) Arrests for use/possession/traffic

Arrests for use

During the year 2000, about 94 300 arrests for use or use with resale of narcotics were made in France. They represent 95% of all arrests for infringement of drug law (ILS).The remaining 5% are cases of trafficking.

Arrests for use and use with resale of narcotics in 2000 by product, sex, nationality and age

	Total of arrests		Women	Foreigners	Average age
	Numbers	% in column	% in line	% in line	in years
Cannabis	82 349	87.3	6.8	6.6	21.8
Heroin	5 833	6.2	13.3	11.4	28.3
Cocaine	2 323	2.5	18.1	12.0	29.6
Crack	869	0.9	14.0	23.2	31.3
Ecstasy	1 921	2.0	13.4	4.9	23.3
Others*	1 044	1.1	10.6	13.5	-
Total	94 339	100.0	7.7	7.2	22.3

** Medicaments, LSD, hallucinogenic mushrooms, opium, morphine etc.*

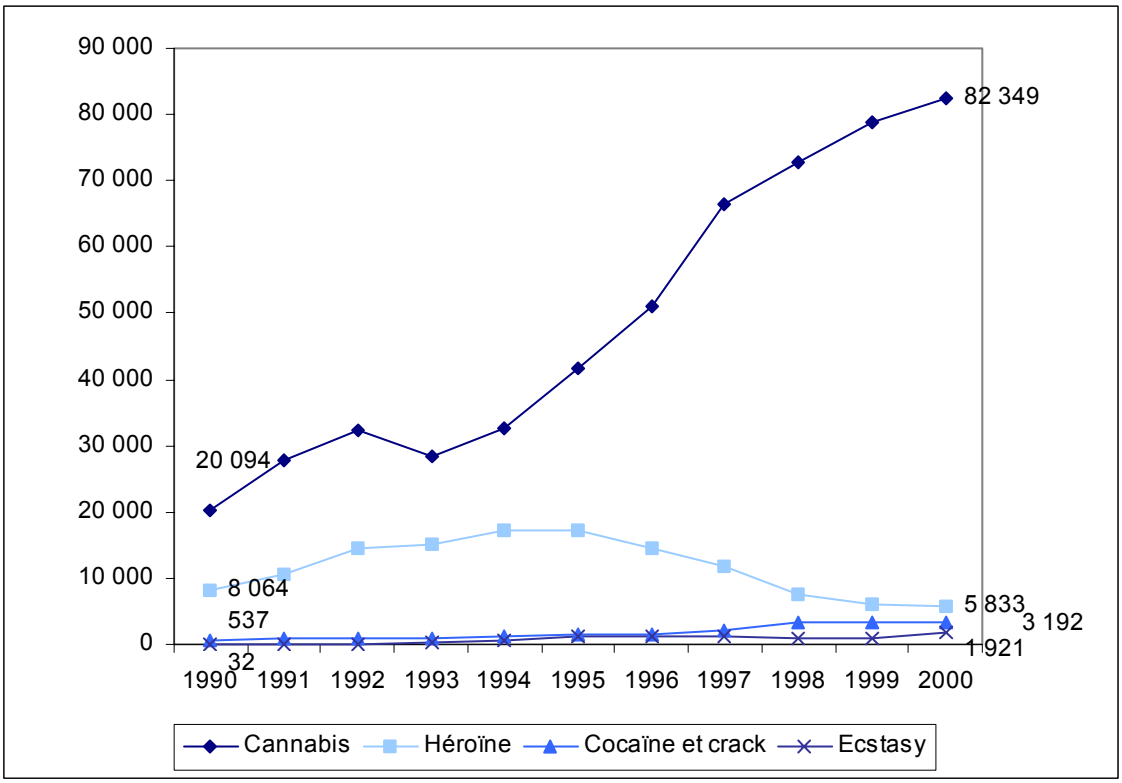
Source : FNAILS 2000, OCRTIS

In nine out of ten arrests for use, cannabis is the substance in question. Far behind in second position comes heroin with 6% of cases followed by cocaine and ecstasy. The involvement of this last substance in arrests has increased sharply compared to 1999.

Development from 1990 to 2000

In the course of the last decade, the arrest statistics have shown four major trends: an explosion in arrests in connection with cannabis, a sharp fall in those for heroin use in the second half of the 1990s, the growth in arrests for cocaine and crack use and the appearance and rise of those for ecstasy use.

Arrests for narcotics use from 1990 to 2000 by product



Source: FNAILS, OCRTIS

Arrests for cannabis use have quadrupled since 1990 at which time this was the substance in question in every second arrest as against nine out of ten in 2000. These arrests are now one of the major sources of court appearances, almost on the same level as voluntary assault and battery. This large number is no doubt the consequence of the extremely widespread use of cannabis as is shown by surveys amongst the general population on the use of psychoactive substances. The unfortunate absence of any mention of the substance in question in the statistics of convictions and imprisonments makes it impossible to know the penal response to these arrests (for cannabis use). Faced with such a large number of arrests, which make a far from negligible demand on public resources, it would nevertheless seem to be essential to have a minimum of statistical information available in order to measure the consequences, at least at the judicial level.

The sharp fall in arrests for heroin use since 1996 is the second notable development during the decade. These have fallen from more than 17,000 in 1995 to less than 6,000 in 2000. It should be noticed that the rate of decline grew less in 1999 and in 2000, which may indicate that a plateau has been reached. The years of the sharp fall are those of the introduction and rise in substitution treatments with buprenorphine. The estimated number of people undergoing such treatment continued to grow in 1999 and 2000 but more slowly. The two developments (arrests for heroin and substitution treatment) are very probably connected.

The third notable feature of the decade is the rise in arrests in connection with the use of cocaine and crack.

At the beginning of the 1990s, the main increase was in arrests in connection with crack, probably associated with a spread in the distribution of this product at the end of the 1980s and the beginning of the 1990s. In the second part of the decade, it is cocaine that tends to play the leading part in the rise in arrest figures. The graph above clearly shows the symmetry between the curve of arrests for use of cocaine and that for heroin since 1995. The sharp fall in arrests in connection with heroin is matched by a rapid rise in those connected with cocaine. This is followed by a simultaneous slowing in the downward trend for heroin and the upward trend for cocaine. One of the hypotheses that might explain the apparent connection between the two curves is that it is, in part, the same population that is involved. A heroin user who also used cocaine only previously appeared amongst the arrests as a heroin user. If the same person were later arrested while following a course of substitution treatment and at same time occasionally using cocaine, they would only be listed as a cocaine user. A similar "change of label" effect appears to be making itself evident in the demands for treatment. The growth in arrests for use / use with resale of ecstasy is also one of the strong trends observed during the last decade, as is shown by the graph above. This increase occurred in two stages with a first rise from 1990 to 1995 following the introduction of this product in France and then, after four years of stagnation, a doubling in the number of arrests from 1999 to 2000. According to the analyses from the TREND facility for the observation of recent trends, the availability of ecstasy rose sharply in the traditional places of resale between 1999 and 2000 while remaining stable in the "party scene" (techno parties). This change could partly explain the rise in arrests, the police and the gendarmerie being on more familiar ground with street sales than with trading during *rave parties*.

In 2000 these various changes led to a less intense concentration on heroin and a more even distribution across the various substances. This can be explained by the growth in substitution treatments and by the diversification of substances consumed. The offer side of

the market has also adapted to these changes with more sellers now trading in a number of substances.

As in the case of users, the sentencing statistics for traffickers do not make it possible to follow a case or a person through from one end of the penal process to the other. The substance information is only available in data relating to arrests.

Arrests for narcotics trafficking

In the course of the year 2000, the police, gendarmerie and customs have arrested 6,500 traffickers, representing 6.5% of arrests for infringement of drug law [*infractions à la législation sur les stupéfiants*] (ILS).

More than eight out of ten traffickers arrested were involved in local dealing or resale and two out of ten in larger scale import or export traffic. The distribution by product amongst all arrests for trafficking is as follows:

Arrests for narcotics trafficking in 2000 by product, and type of dealing

	Total of arrests for trafficking		International trafficking (= 1 245)	Local dealing and resale (= 5 286)
	Numbers	%	%	%
Cannabis	3 625	55.5	37.1	59.8
Heroin	1 228	18.8	17.6	19.1
Cocaine	1 088	16.7	34.0	12.6
Crack	200	3.1	0.7	3.6
Ecstasy	312	4.8	8.9	3.8
Others*	78	1.2	1.7	1.1
Total	6 531	100.0	100.0	100.0

** Medicaments, amphetamines, LSD, khat, etc.*

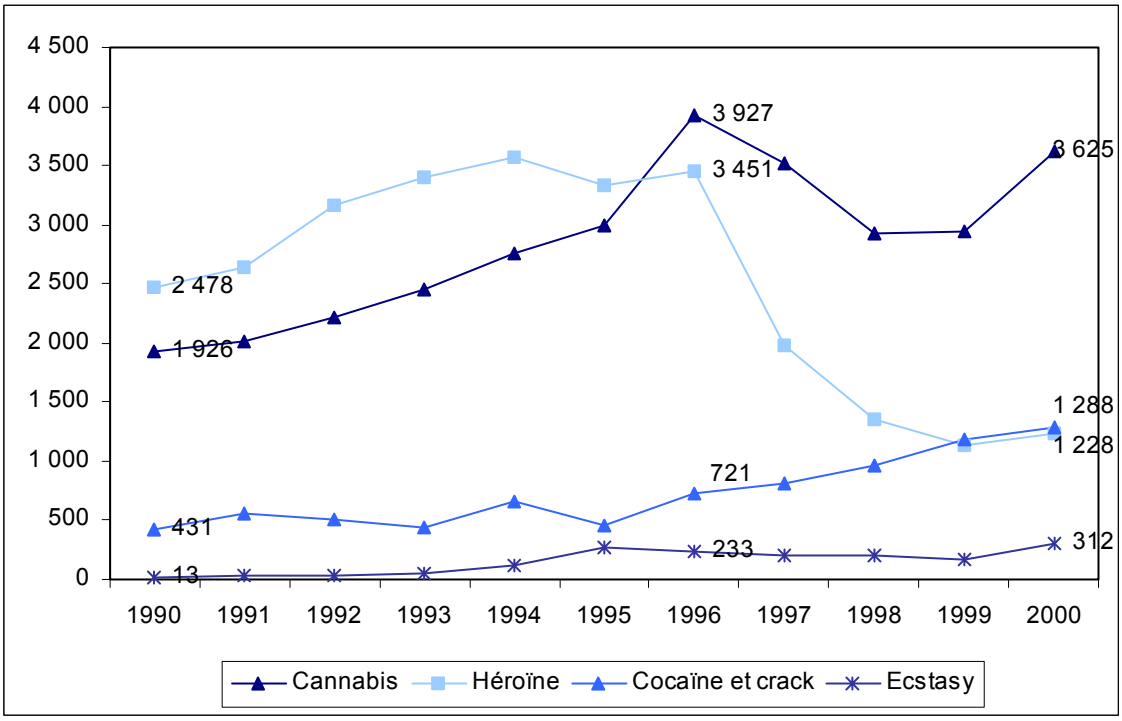
Source: FNAILS 2000, OCRTIS

The traffickers arrested show a greater diversification by product than do the users. Cannabis, at rather more than half of cases, is less dominant (it accounts for 87% of arrests amongst users). With nearly one in five arrests each, heroin and cocaine are the substances most frequently involved in this type of arrest after cannabis.

If we consider only the arrests of small traffickers (local dealing and resale), we see that cannabis is slightly more prevalent (60% of cases). However the difference is mainly due to the fact that international traffic deals include a strong cocaine component.

During the second half of the decade, arrests for trafficking were on the increase or stable. While the arrests of cocaine traffickers continued to increase, those for trafficking in cannabis or heroin fell between 1996 and 1999. The constant fall-off in cases of heroin trafficking is comparable with that in the arrests of users of this product. In 2000, the number of arrests for trafficking rose irrespective of the product, interrupting, in the cases of cannabis and heroin, the previous downward trend.

Arrests for narcotics trafficking from 1990 to 2000 by product



Source: FNAILS, OCRTIS

b) Convictions and court sentences for drug offences / Imprisonment for drug law offences

Convictions for use

The sentencing statistics taken from the national police records [*Casier judiciaire national*] give information on the sentences passed on users brought before the court. One conviction can cover several offences, which is often the case with convictions for infringement of drug law. The conviction can be characterised by considering only the principal offence, the method used in the Statistical Justice Yearbook [*Annuaire statistique de la justice*] or by also considering all the other offences taken into account. The second approach expands on the first.

Numbers of convictions as principal offence

During 1999, slightly over 6,700 convictions for illicit narcotics use as principal offence were passed. This figure has been relatively stable for some years (apart from the drop recorded in 1995 following the presidential amnesty). After cases of possession or procurement (see below), infringement of drug law (ILS) is the offence featuring most frequently in the convictions passed.

The number of convictions for use shows a progression parallel to the total of convictions for ILS and represents no more than one third of this total.

Convictions for illicit narcotics use (as principal offence), from 1992 to 1999

	1992	1993	1994	1995	1996	1997	1998	1999*
Number of convictions for use	7 374	8 157	6 201	4 670	6 751	6 640	6 622	6 742
% in the total of convictions for ILS	33,7	25,8	28,3	22,6	28,3	27,6	27,8	28,8

** Provisional data*

Source: CJN, SDSED - Ministry of Justice (data published in: Ministry of Justice, 2001)

The relative stability of the number of convictions for use is in contrast with the rapid growth in arrests for use. It is as if the "funnel" that is the system of justice were calibrated for a given number of convictions, regardless of the number of arrests. As the growth in arrests only concerns cannabis users, these figures could show that these are rarely sentenced. If this is the case, it might seem astonishing that the sharp drop in arrests for heroin use from 1996 to 1998, only slightly compensated by the growth in arrests for the use of cocaine and ecstasy, did not lead to a fall in the number of convictions.

Numbers of convictions as secondary offence

The offence of using narcotics occurs more frequently than is shown by the counting of principal offences. Indeed, in 1999, an offence for use appears in almost 15,000 sentences and mostly in association with other offences (78% of convictions mention use).

Convictions for use and associated offences from 1991 to 1999

	1991	1996	1997	1998	1999*
Number of convictions for use (at least one use offence)	11 505	15 493	15 685	15 026	14 864
Total (%)	100.0	100.0	100.0	100.0	100.0
Use alone (%)	36.9	19.5	21.5	23.1	22.1
Use and offence other than ILS (%)	19.1	15.4	14.3	14.1	15.1
Use and other ILS (%)	44.0	65.1	64.2	62.8	62.8

** Provisional data. ILS: infringement of drug law*

Source: CJN, SDSED - Ministry of Justice

Most frequently, the use of illicit substances is associated with another infringement of drug law. Where another type of offence is connected with narcotics use, this is theft in almost half the cases.

The most frequent combinations of offences are use and transport (probably as a runner), use and possession or use and supply (user-resellers in these last two cases).

The situation changed little between 1998 and 1999. On the other hand, changes are apparent compared to the data for 1991, in particular:

- the increase in convictions for at least one count of use,
- this increase is particularly marked for convictions where use is associated with another ILS, which have risen from 44% to 63%,
- the association of use with offences other than ILS is falling.

These trends probably reflect, more than anything, changes in the practices of judges, who, in determining the severity of a given offence, have a tendency to take a greater number of infringements into account than used to be the case and, in particular, that of use where the offence involves narcotics.

In fact, since 1994 the revision of the nomenclature of the sentencing statistics has split certain categories in order to ensure a better agreement between the facts and their description. To qualify the same matter, the judges can now use not one but several infringements. "*This overqualification no doubt lies behind the fall to one half of the convictions for a single infringement between 1991 and 1995*" (Burricand *et al.*, 1999).

Nature of the sentences passed

Convictions for narcotics use and nature of sentences passed in 1999

	Total (number)	% imprisoned	% fined	% other penalties [1]	Total	% imprisoned without remission [2]
Use as principal offence	6 742	58.4 %	26.9 %	14.6 %	100 %	(37.6 %)
Use as sole offence	3 282	46.0 %	37.3 %	16.8 %	100 %	(38.2 %)
Use associated with other offences (total)	11 582	78.7 %	11.6 %	9.7 %	100 %	(45.3 %)
Details:						
use and trafficking	1 119	94.8 %	3.4 %	1.8 %	100 %	(54.9 %)
use and transport	3 518	85.0 %	7.6 %	7.4 %	100 %	(45.3 %)
use and supply	2 017	84.1 %	6.0 %	9.9 %	100 %	(40.3 %)
use and possession/acquisition	2 660	56.5 %	27.6 %	15.9 %	100 %	(31.9 %)
use and other offences	2 247	82.4 %	8.2 %	9.4 %	100 %	(55.3 %)

[1] *Alternate sentence, care/training order, suspension of sentence*

[2] *Interpretation: 38.2% of imprisonments for use as sole offence are without remission*

Source: CJN, SDSED - Ministry of Justice

Convictions for use alone and for use as principal offence attract fairly similar sentences: half or more are imprisonment (of which two out of five are without remission) and about one third are fines.

Similar sentences are imposed in cases of use with possession/acquisition, implying that judges may use this double qualification but punish the simple offence of use.

In all the other cases the nature of the sentence would seem to show that it is not the use but the other offence that is considered in sentencing. These offences mostly attract a sentence of imprisonment (of which almost half are without remission). Other sentences are rarely imposed. In the case of imprisonment without remission, the length of sentence varies from 18.6 months for use and trafficking to 6.4 months for use and other offences (compared with 2.1 months for use alone).

Comparison with sentences imposed for trafficking (discussed below) indicates that use does not appear to be treated as a mitigating circumstance where it occurs with trafficking. It is possible that, in some cases, the association of an offence of use with one of trafficking

arises rather out of systematic multi-qualification than from any certainty or suspicion that the person arrested is a user.

Imprisonment for use and prisoners held for use

Those convicted of the narcotics use can be subject to a sentence of imprisonment, without or with remission (partial or full). A count of imprisonments following conviction for use alone is difficult. The data from prisons only mention a single offence, that at the head of the list of convictions. This is generally to most serious offence but can sometimes be otherwise. All those cases where use is associated with a more serious offence will therefore not appear in the intake statistics under use unless, for some reason, the use appears at the head of the convictions.

Number of imprisonments in 2000 and trends

During 2000, nearly 400 persons were imprisoned for narcotics use in mainland France (34 in overseas departments). They constituted less than 1% of prison intake in that year and a little over 4% of imprisonments for infringements of drug law (ILS). These last correspond mostly to cases of trafficking (see below).

Imprisonments for the use of narcotics have been falling since 1993 in both absolute and relative terms:

Imprisonments for narcotics use (as principal conviction) from 1993 to 2000

	1993	1994	1995	1996	1997	1998	1999	2000
Number of imprisonments for use	1 213	1 034	892	870	700	468	471	395
% of all imprisonments for ILS	10.2	8.6	7.1	7.3	6.6	5.1	5.2	4.4
% of all imprisonments	1.5	1.2	1.1	1.1	0.9	0.7	0.7	0.6

Coverage: mainland France

Source: FND, DAP/ SDSED - Ministry of Justice

The intake numbers convicted of narcotics use has fallen to one third during the 1990s. The rate of fall was steady and continuous.

Prison population at a given time

At the beginning of 2000, the prison administration counted less than 300 imprisoned for narcotics use (as principal conviction), making 3.4% of those imprisoned for ILS and 0.6% of the total prison population.

An ad hoc survey made in a single day in the French prisons provided a more refined analysis in terms of principal conviction and showed that on 1 November 2000, 197 were imprisoned for narcotics use alone, slightly more than in 1994. These prisoners are a very small proportion of the prison population.

Prisoners held for narcotics use on a single day in 1994 and 2000

	1 April 1994	1 November 2000
For use alone	168	197
In % of the prison population	0,3	0,4
For use and possession	-	2 692
In % of the prison population	-	5,5

Coverage: mainland and overseas

Source: "Hand" counts in the prisons, PMJ1 - DAP- Ministry of Justice

The number of people held in prison for use and possession is much higher: 2,700 on 1 November 2000, of which almost half are awaiting sentence.

Convictions for trafficking

Whereas police statistics refer to only three categories of trafficking (international, local and resale), the nomenclature in the judicial statistics is more detailed and uses the infringements of drug law as listed in the penal code.

Unlike arrests, convictions for trafficking are more numerous than those for narcotics use: 16,700 and 6,700 convictions respectively as principal offence.

Convictions for trafficking in narcotics concern, more particularly, four types of infringement: possession and procurement, trade or employment or transport, import or export, offer or supply of narcotics. Also counted in 1999 were 68 convictions for aiding and abetting in the use of narcotics, 10 cases of failure to justify income (infringement currently called "living on the earnings from drugs[16]") and 55 other ILS.

Convictions for trafficking in narcotics (as principal offence) and nature of sentence in 1999 by type of infraction

	Total (number)	% imprisoned	% fined	% other penalties (1)	Total	% imprisoned without remission (2)
Possession/procurement	8 945	78.9 %	12.0 %	9.1 %	100.0 %	(49.2 %)
Offer and supply	2 363	86.6 %	5.3 %	8.0 %	100.0 %	(55.5 %)
Trade/employment/trans-port	3 403	87.5 %	7.1 %	5.4 %	100.0 %	(54.7 %)
Import/export trafficking	1 839	96.3 %	2.6 %	1.1 %	100.0 %	(73.0 %)

"Other penalties": alternate sentence, care/training order, suspension of sentence

(2) Interpretation: 49,2 % of imprisonments for possession/acquisition as principal offence are without remission.

Source: CJN, SDSED - Ministry of Justice

The higher we go on the scale of trafficking, the more a sentence of imprisonment is favoured. In the same way, the proportion and length of imprisonment also increase.

Trafficking offences are more likely to be mentioned as principal offence than are cases of use. Nevertheless, multiple qualification of cases is frequent. In 1999, for the offences in the table above, the judges noted 3.6 individual offences to qualify the case. Nearly 23,600 convictions for at least one trafficking offence (in the broad sense, i.e. apart from use) have thus been counted. The most frequent associations are use and transport (15% of

[16] being unable to justify resources corresponding to one's standard of life if one has a standing relationship with a narcotics dealer or user (See chapter " Legal framework")

convictions), use and possession/procurement (11%), possession with trade and supply with neither import-export nor use (15%).

Convictions for trafficking in narcotics (as principal offence) from 1992 to 1999

** Provisional data*

Source: CJN, SDSED - Ministry of Justice

After a period of relative stagnation, the rise in convictions for trafficking in narcotics observed in 1995 was mainly due to cases of trading, employment or transport of narcotics (+22% in 1995), offer or supply (+12%) and import-export (+10%). This continued for two years but since 1997-1998, all these convictions have been declining.

On the other hand, we note the increase, in both absolute and relative terms, in ILS by minors: 451 cases in 1995 (or 2.2% of convictions for ILS) as against 1,594 in 1999 (or 6.8%) (Ministry of Justice, 2001, p. 231).

Imprisonments for trafficking and prisoners held for trafficking

The prison statistics, in their turn, use a nomenclature differing from those above. The amount of detail is less because they only distinguish cases of trafficking, supply, use and other ILS. Furthermore, the figures are only categorised by principal offence.

At this stage in the penal process, it is only logical that the offences most severely punished by the penal code should be more highly represented amongst the imprisonments. « Thus, during 2000, those imprisoned for trafficking in narcotics represented 62% of all imprisonments for ILS and 8% of total intake (compared with 4 and 0.6 % respectively for use).

Imprisonments for trafficking in narcotics (as principal offence) from 1993 to 1999, by type of infringement

	1993	1994	1995	1996	1997	1998	1999	2000
Trafficking	7 845	7 726	7 991	7 842	6 869	5 720	5 867	5 538
Supply	686	1 140	1 053	987	910	863	491	616
Other ILS	2 091	2 158	2 653	2 244	2 115	2 074	2 296	2 345
Total ILS	11 835	12 058	12 589	11 943	10 594	9 125	9 125	8 894
Total offences	82 201	84 684	81 398	78 778	75 098	71 768	72 172	66 862

Coverage: mainland France

Source: FND, DAP/ SDSED - Ministry of Justice

As with the total of imprisonments for ILS, those for trafficking and, to a lesser degree, for supply of narcotics have been falling since 1993. At the same time, the category of other ILS represents an increasing number of imprisonments (18% of all ILS in 1993, 26% in 2000).

Note that the recorded fall in the number of imprisonments for ILS is of the same order as the fall in imprisonments for all offences (on average, -4% and -3% respectively each year). Of all ILS it is those relating to use that have fallen the most.

The number of those convicted (not on remand) for ILS in prison on a particular day is also falling in both absolute and relative terms. On 1 January 2001, the prison administration

counted 4,085 convicted for ILS or 14% of the population of condemned prisoners. On 1 January 1995, the 6,118 held for ILS represented 21% of convicted prisoners.

c) Drug-related crime (theft, violence etc.)

« NO INFORMATION AVAILABLE »

4.3 Social and economic costs of drug consumption

Assessment of the social cost of drugs

Social costs

Beyond the costs to the public purse alone, a study published in 2000 by the OFDT[17] sought to measure the overall social costs connected with illicit drugs, alcohol and tobacco. This study is based on the social costs according to the "cost of disease" method defined by international experts.

Illicit drugs cost society 13,350 million francs, a per capita expenditure of 111 francs and 0.16% of GNP. Loss of productivity accounts for nearly 46% of the social cost of illicit drugs. The total amount for this fraction is 6,099 million francs, made up of 5,246 million francs in connection with imprisonments for ILS and 852 million for premature mortality.The cost of implementing the law takes second position (29.3%) and represents 3,911 million francs arising from the fact that these drugs are illegal. Then come health care costs (11.4%) or 1,524 million francs made up of hospitalisation costs without surgical interventions (924 million francs) and urban medical practice (600 million francs). In fourth position (7.1%) come the costs of prevention and research, amounting to 948 million francs and, finally, the losses of taxes and social security contributions (6.5% or 866 million francs).

5. Drug Markets

5.1 Availability and supply

Drug availability – trends and reasons

A general examination of the principal psychoactive substances brings to light the following trends:

- The availability of heroin appears to be falling. Arrests have been falling continuously since 1996. Between 1995 (the last year before the extension of the substitution programmes) and 2000, these fell by 64%. Furthermore, observers in the field find that the product is less accessible. This would seem to be due to a disruption of local trafficking, which has fallen victim to the wide accessibility of substitution products, making street dealing less profitable.
- After some years of a sharp rise in arrests for use alone, +8.42% in 1999 and 49.53% in 1998, a drop in arrests of 7.60% was recorded in 2000. In volume, the cocaine seized has fallen by 64% compared to 1999. Observers in the field, in both the street scene and the party scene, report an increase in the availability and accessibility of this product compared to 1999.
- Seizures of ecstasy increased in 2000 by 22.75%; those of amphetamines fell by 1.41%. It seems that, in the techno scene, the availability of speed is falling slightly

[17] Kopp, P., Fenoglio, Ph. .The social cost of licit drugs (tobacco and alcohol) and illicit drugs in France. OFDT, study No. 22, September 2000, 277 p

whereas it is increasing in urban areas. The same goes for ecstasy, the use of which is spreading beyond the party context.

- Anesthetics such as GHB and ketamine seem to have been less available in 2000 than in previous years. If these products are used, this remains confined to a small group on the fringe of the frequenters of free-parties and teknivals.
- Hallucinogenics, and LSD in particular, are more and more available. LSD, which appeared on the techno-party scene at the beginning of the 90s, appears to be spreading increasingly in urban areas outside the party scene itself.

Sources of supply and trafficking patterns within the country

In 2000, records show an increase in seizures of narcotic substances of 13.87% and an increase in arrests for use and trafficking of 5.17%. Particularly notable is the increase in arrests for trafficking in and use of ecstasy (+114.75% and +101.41% respectively).

***Cannabis**:*

In 2000, 4,865 kg of marihuana were seized in France, an increase of 43.86% over the previous year. 14.6% of marihuana seized comes from Belgium (476 kg), 12.82% from the Netherlands (431 kg) and 11.9% from France (373 kg). Since 1996, in which year the seizures were essentially of Asian and South-American origin (90%), the amount coming from Europe has increased continuously until it is now the major source of supply.

France, with 45% of seizures intended for sale within the country, is the major destination area, ahead of Great Britain and Belgium.

With regard to cannabis resin, seizures amounted to 48,710 kg, a fall of 24% compared with the previous year. Morocco and Spain are the main countries of origin of the cannabis resin seized. France and Great Britain are the prime destinations with 29.84% and 31.86% respectively of the total seized.

Heroin:

Seizures of heroin rose by 118, 35% compared to 1999 (444kg as against 203 kg).

The Netherlands, for the tenth year running, was the leading supply country with nearly 46.63% of heroin seized and of which the origin could be identified. Then come Belgium, Bosnia and Slovenia. 33.53% of the heroin seized was intended for the French market.

Cocaine:

2000 saw a sharp fall in the amounts seized compared to 1999 (1,310 kg as against 3,687 kg). South-America remains the principal region of origin of the cocaine seized (42.93%). The principal outward transit countries for cocaine intended for France are, in order of importance, the South-American countries, the Caribbean area and Central America. As for inward transit through European countries, Spain has lost its first place to the Netherlands, which, in 2000, became the leading gateway to France for cocaine.

Ecstasy:

Seizures of ecstasy have increased by 22.75% compared to 1999. This is largely transit traffic destined for Great Britain and Spain in Europe and Canada and the United States in North America.

Ecstasy reaches France in proportions of about 44.6% from the Netherlands and 40% from Belgium. The latter appears essentially to be a transit country for drugs manufactured in the Netherlands.

Amphetamines:

In 2000, the enforcement agencies seized 229 kg of amphetamines, 1.41% less than in 1999. Like ecstasy, the majority of amphetamines seized come from the Netherlands via Belgium and are in transit, mainly to Great Britain.

5.2 Seizures

a) a) Trends in quantities and numbers of seizures (Trends in numbers of seizures and quantities seized)

The quantities of the various substances seized are difficult to compare realistically. First of all, the values of a given quantity vary widely between the substances. Marihuana/cannabis, with a very low price per gram, is often trafficked in large quantities, sometimes several tonnes; heroin circulates in much smaller batches. Thus, several tonnes of marihuana/cannabis can be seized in a single operation, which is never the case for heroin. Further, France being a transit country, a part of the seizures is not destined for the domestic market. Thus it is the changes in seizures that are of most interest.

Recent changes in seizures

Quantities of drugs seized in 1998, 1999 and 2000, by product

	1998	1999	2000
Cannabis/Marihuana (all forms) (kg)	55 698	67 480	53 579
Heroin (kg)	343	203	444
Cocaine (kg)	1 050	3 687	1 311
Crack (kg)	25	10	22
Amphetamines (kg)	165	232	230
Hallucinogenic mushrooms (kg)	4.8	5.6	11
Ecstasy (doses)	1 142 226	1 860 402	2 283 620
LSD (doses)	18 680	9 991	20 691

Sources: FNAILS, OCRTIS

After a record year in 1999, the quantities of cannabis seized returned to the level of 1997 and 1998. A similar progression is to be seen for cocaine.

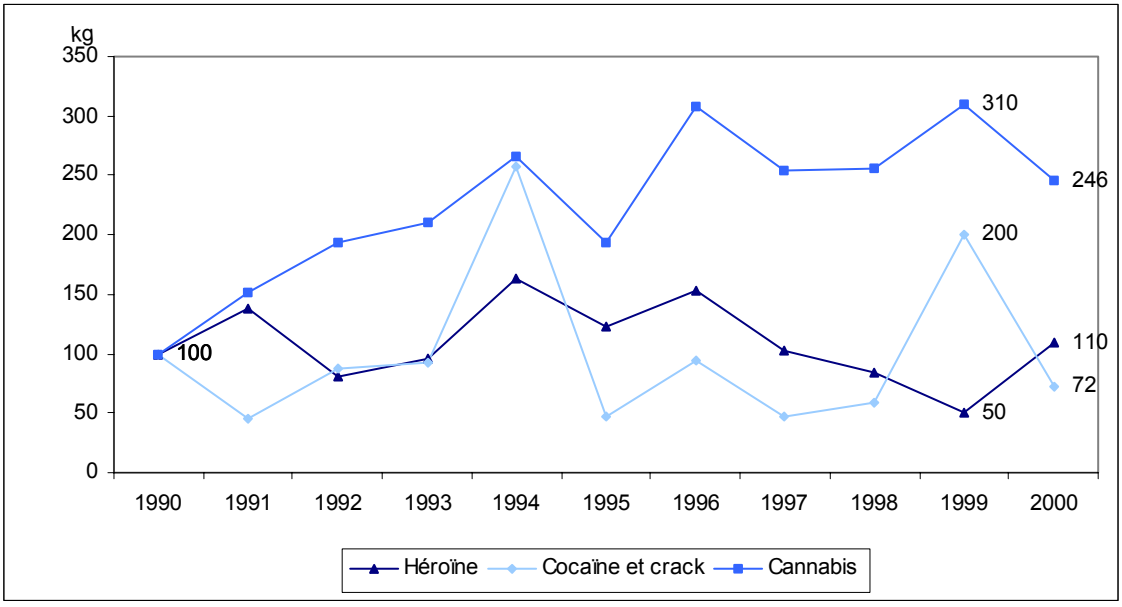
For the first time since 1996, the quantities of heroin seized rose sharply in 2000. It should be noted, however, that the drop in 1999 and the rise in 2000 were accompanied by small changes in the number of large operations (seizures of 5 kg or more). The number of these seizures changed from 11 in 1998 (194 kg in total) to 5 in 1999 (53 kg) and rose to 15 in 2000 (273 kg). The large influence of these few major cases, representing more than 60% of the quantities of heroin seized in 2000, suggests that the figures should be interpreted with caution. In addition, the variation observed is in large part the result of an increase in the quantities seized en route for Great Britain and Spain (about 270 kg for these two countries). France was the destination of less than one third of the heroin seized in 2000.

After remaining limited for a long time, the quantities of ecstasy seized have risen sharply since 1998. This trend is also linked to an increase in the quantities of ecstasy destined for Great Britain. France is the destination of only a small share of the ecstasy seized (less than 10% in 2000), although this share is increasing.

Changes in seizures between 1990 and 2000

The last decade was marked by a considerable increase in seizures of cannabis, with a continuous and rapid growth up to 1994 (an increase in the quantities seized by a factor of 2.5) followed by fluctuations around the 1994 level until 2000.

Quantities of cannabis, heroin, cocaine and crack seized from 1990 to 2000 (normalised to a base of 100 in 1990)



Source: FNAILS, OCRTIS

This trend throughout the decade can only be traced for heroin and cocaine amongst the other drugs; these having reached a level in 2000 that is comparable to that for 1990.

The quantities of heroin seized, which were tending upwards between the end of the 1980s and the mid-1990s, while showing sharp fluctuations, fell sharply between 1997 and 1999, only to turn upward again in 2000.

As for the quantities of cocaine seized, these fluctuate below the 1990 level, apart from 1994 and 1999, when exceptionally large seizures were made.

Looking beyond the annual variations, about one third of the cannabis seized was for resale in France, as against half the heroin and one fifth of the cocaine.

5.3 Price, purity

Products seized:

The analyses made of the products seized give some indication of the composition of the various products now in circulation. However such analyses are not made systematically. The results cannot be considered representative of the entire product in circulation or even of the entire product seized.

The study of the results of laboratory analyses of the samples from seizures by the police and customs show no improvement in the purity of heroin. Between 1999 and 2000, there has, in fact, been a slight but statistically insignificant fall in the content of base heroin and heroinhydrochloride. The percentages of samples showing the highest (50% to 100%) and medium (20% to 100%) fell by 13%. For the lowest purity category (0% to 20%), a rise of 6% was observed.

The proportion of base and hydrochloride in the cocaine seized by police and customs showed a statistically significant fall between 1998 and 2000. Between 1999 and 2000, the proportion of samples from seizures with the highest level of purity (50% to 100%) fell by 16%.

The forensic laboratory at Lyon received too few samples of ecstasy or amphetamines to be able to supply results for these products.

Products recorded in the SINTES - OFDT database:

The SINTES database is the result of combining four databases. It contains the physical and chemical description of the samples of synthetic products seized by the enforcement agencies and analysed in the forensic laboratories of the police, customs and IRCGN (national gendarmerie) or collected in various environments (party scenes, private parties, night clubs) by prevention and care personnel and analysed by two hospital toxicology laboratories (the Fernand-Widal hospital, Paris and Salvator, Marseilles).

In 2000, an analysis of the data collected in this facility shows that:

- molecules of the amphetamine family are present in more than two thirds of samples collected in 2000 of which 64% are MDMA; the average dose in pills containing MDMA is 75 mg; almost one fifth of samples show an MDMA content higher than 100 mg; medicinal substances are still frequently encountered (11%); furthermore, several stimulants were identified for the first time in the SINTES database: cathinone, 2-CT7, 4-MTA and PMA.
- the absence of any active ingredient is not rare; indeed, in more than one sample in eight, none was found.

Products from "collections in the field" (TREND Monitoring system – OFDT)

Street prices in euros in 2000 for nine illegal substances:

(the prices below are the result of converting francs to euros - hence the decimals)

Cannabis resin (1 g): 4.5 euros

Marihuana (1 g): 6.1 euros

Brown heroin (1 g): 60 euros

White heroin (1 g): 97 euros

Cocaine (1 g): 81.5 euros

Crack: 7.6 euros

Amphetamines (1 g): 15.2 euros

Ecstasy (1 tablet): 15.2 euros

LSD (1 dose): 7 euros.

6. Trends per drug

Cannabis (& marihuana)

Consumption

- The consumption of cannabis has spread considerably in the last few years, especially amongst the young.
- In 2000, one French person in five had already tried cannabis. Amongst young people at the end of adolescence, this goes for a majority.
- Amongst the young, consumption is mostly occasional but increases in amount and regularity with age. Thus, of boys of 19 who have tried cannabis (60%), more than one in three is a regular or heavy user.
- Cannabis is used by all social groups. It remains strongly linked to age and, to a lesser extent, sex: heavy consumption amongst adolescents and young adults then falling to become marginal after the age of 50, higher consumption amongst men than amongst women. However, the difference between the sexes is less marked amongst the younger generations of consumers.
- Cannabis use is very often associated with that of tobacco and alcohol. Cannabis is very common on the party scene, accompanying the taking of stimulating agents and hallucinogenics where these are to be found.

Health and social consequences

- Registrations for health or social care in connection with the use of cannabis increased markedly from 1997 to 1999.
- Cannabis use is the reason for registration for care for drug use in 15% of cases.
- The profile of those cared for by the social and health system for use of cannabis is very different from that of opiate users as seen through the same monitoring system: they are younger (25 on average), more frequently registered for the first time (60%) and more often referred by the courts (25%).
- In the absence of data on the implication of cannabis for the incidence of road accidents or of cancer, no serious consequences (morbidity and fatality) of cannabis use are recorded.

Criminal consequences

- Arrests for the use and use with resale of cannabis increased considerably during the 1990s. It is by far the substance most frequently involved in the arrests of users (79,000 out of 90,000).
- The cannabis users arrested are the youngest group amongst all users arrested (22 on average). Minors arrested for use, although very much in the minority, are becoming increasingly numerous and increasingly young, a tendency that is the inverse of the increase in age observed amongst other users arrested.

Offer and trafficking

- The number of seizures of cannabis and the quantities seized are on the increase. A high proportion of these, made in France, concern haschich from Morocco.
- Cannabis is very accessible with moderate prices and high availability. The nature of the product consumed is highly variable, especially in the proportion of active component (THC).

Analysis of samples from seizures shows a more than negligible proportion of high concentration cannabis (THC > 8%), in 4 cases out of ten in resin.

Synthetic drugs

Consumption

- Ecstasy use made its appearance in France at the beginning of the 1990s and since then has been rising. Experimentation with it remains relatively limited, current use even more so. It seems to be limited to young adults and the party scene.

- Experimentation levels amongst the adult population are low (0.7% of women and 2.2% of men from 18 to 44 years of age). Amongst young people, the experimentation level varies between 1% and 7% according to age and sex.

- Amphetamine use goes further back but, like ecstasy, experimentation and current use levels remain low.

- Experimentation levels amongst the adult population are low (1.2% of women and 2.3% of men from 18 to 44 years of age). Amongst young people, the experimentation level varies between 1% and 4 % according to age and sex.

- The numbers of women admitting to having experimented with ecstasy and amphetamines are smaller. For both sexes, the prevalences increase with age.

- The use of ecstasy is frequently associated with the use of other licit and illicit drugs, principally alcohol, tobacco and cannabis. This is especially the case on party locations where these products are associated with other stimulating agents and hallucinogenic substances.

Health and social consequences

- Ecstasy and amphetamines are the reasons for a very small number of registrations for care, which seems to have stabilised during recent years.

- Those registered for care in connection with ecstasy have a very similar profile to the users of cannabis. They, too, are young. On the other hand, they are more likely to be multiple consumers.

- Those registered for care for the use of amphetamines have different average characteristics from ecstasy users. They are significantly older and are more likely to inject.

- At present, we are aware of no serious consequences to health of the use of ecstasy or amphetamines apart from their implication in a few exceptional cases of death that have occurred since 1999, there being no data on their possible implication in road accidents. Available scientific studies also indicate psychiatric problems and a potential for long-term neurotoxic effects in connection with the use of ecstasy.

Criminal consequences

- Arrests for use and use with resale of ecstasy rose very sharply during the last decade, with the exception of 1998 and 1999. They remain very much in the minority in comparison with total arrests for use and use with resale of narcotics (1,900 as against 94,300). Arrests in connection with amphetamines remain relatively stable and marginal (about one hundred).

- The users of ecstasy arrested resemble those of cannabis rather than those of heroin or cocaine. They are young, mostly between 18 and 25 years of age.

Offer and trafficking

- After rising sharply in the first half of the 1990s, seizures of ecstasy seem to have stabilised.

- Ecstasy and amphetamines are very accessible in the party scene. In recent years, the price of these products has tended to fall.

The generic term, ecstasy, in fact covers a wide range of products. The pills sold under this name do not always contain the active substance expected (MDMA) but often contain several substances whose interaction is little known, especially medicaments diverted from their normal use. When MDMA is present, the dosage is very variable.

Heroin/opiates

Consumption

- Experimentation with heroin and other opiates remains rare in both the adult and adolescent populations. This is still truer of current use.

- Amongst adults from 18 to 44, 0.4% of women and 1.7% of men had tried heroin. Amongst youngsters from 14 to 18 and still at school, 0.8% of girls 1.4% of boys admitted to having already taken heroin.

- At all ages, the consumers were predominantly male.

- Occasional consumption of heroin is frequently associated with the use of other licit and illicit drugs, principally alcohol, tobacco and cannabis. This is especially the case on party locations where heroin has recently been associated with stimulating agents and hallucinogenic substances.

- The problem consumption of heroin is even more limited although socially more visible (it is estimated that there are 150,000 to 180,000 problem users of opiates or cocaine, mostly opiate users).

Health and social consequences

- The large majority of registrations for care for the use of illicit drugs are in connection with the abuse of or dependence on opiates. Between 1997 and 1999, the number of registrations for care in connection with opiates remained more or less stable while their share in the total of registrations fell, principally because of the increase in registration in connection with cannabis and cocaine.

- The population of opiate users registered for care continues to grow older. Its average age increases by roughly one year every two years: in November 1999, the average age was 31 with only a small minority (13%) under 25. These users were mainly men (3 out of 4), mostly without paid occupation (more than 60%) although the number in paid employment has increased in recent years. The majority of these people had already been in contact with care facilities in connection with their use of opiates.

- A secondary product was recorded for 57% of registrations in connection with opiate use, cocaine being the most frequent (18% of cases), followed by cannabis, alcohol and medicaments (7 to 10 % of cases each).

- The great majority of opiate users registered for care had already used intravenous injection (73%). The use of this method of administration is, nevertheless, in decline.

- The establishment of substitution treatments and the rapid rise in their use in the mid-90s have profoundly altered the care afforded to opiate users. Many of them now follow substitution treatments. At the beginning of 2001, it was estimated that 84,000 opiate users were undergoing substitution treatment, buprenorphine (74,000) being more frequently prescribed than methadone (11,000).

- In connection with the policies of risk reduction and substitution treatment, the number of overdoses attributable to heroin has been declining sharply since 1994. Heroin remains, nonetheless, the product most frequently implicated in deaths by overdose (70 out of 119 in 2000).

- The declared prevalence of HIV infection is falling sharply amongst opiate users who have recently or previously practised injection (15% in 1999). The number of deaths from AIDS amongst drug users continues the downward movement started in 1994, thanks to the prolongation of life-expectancy afforded by the new antiviral treatments (1,037 in 1994, 180 in 2000).

- The declared prevalence of HCV, on the other hand, is rising (65% in 1999).

Penal consequences

- Heroin is the second most frequently involved substance in arrests for use or use with resale of narcotics (5,800 cases in 2000), far behind cannabis (82,300 arrests) and ahead of cocaine (some 3,200 arrests).

- Since 1996, arrests of heroin users have fallen continuously in number. As a proportion of all arrests, they have also fallen (6.2% of arrests in 2000). The most recent data seems to suggest that the trend is now levelling out to a stable number of arrests.

Offer and traffic

- In the course of the 1990s, the quantities of heroin seized fluctuated considerably. Having fallen noticeably for three successive years since 1996, a sharp rise occurred in 2000 (440 kg). The number of arrests for heroin trafficking followed the same pattern, however the rise in 2000 was less marked (1,200 arrests).

- Heroin is currently less accessible in urban areas than it has ever been in recent years. An inverse trend is observed on the party scene. Both the purity and the price levels of heroin seem currently to be falling slightly.

Cocaine/crack

Consumption

- The consumption of stimulating agents in general and cocaine in particular seems to have been rising in recent years, a trend that is significantly more evident amongst certain populations (those frequenting festival events, users dependent on opiates).

- Experimentation with cocaine nevertheless remains relatively limited and current use still more so. In 2000, 1.4% of the French population between the ages of 18 and 75 had tried cocaine.

- Within the adult population, the highest levels of experimentation are to be encountered amongst 18 to 44-year-olds and, more particularly, amongst 35 to 44-year-olds (1.6% of women and 4% of men). Amongst the youth, experimentation levels vary with age and sex between 1% and 3%.

- Women who admit to having tried cocaine remain less numerous and, whatever the sex, experimentation is most common amongst young adults.

- The consumption of cocaine is frequently associated with the use of other licit and illicit drugs, principally alcohol, tobacco and cannabis. This is especially the case in the party context where cocaine is associated both with other stimulating agents and hallucinogenic substances.

Health and social consequences

- Registrations for health or social care in connection with the use of cocaine or crack rose noticeably between 1997 and 1999. The majority of those concerned in this rise were already under observation, dependent on opiates and often undergoing substitution treatment.

- The use of these two products is the primary reason for registration for care in less than 5% of cases and a secondary reason in 15% of cases.
- Cocaine is particularly involved in multiple drug consumption leading to registration for health or social care, its consumption being very often linked to that of opiates.

- This observation explains why the profile of cocaine users seen in the health and social system is close to that of opiate users as seen through the same system.

- Cases of death attributable to cocaine appear to be rare.

Penal consequences

- Arrests for use and use with resale of cocaine or crack increased considerably during the last decade, especially from 1997 onwards. The numbers remain very small compared to those for use and use with resale of cannabis (3,200 as against 82,300) but have now reached one half of those relating to heroin (5,800).

- The average age of cocaine and crack users arrested is rising: 29 and 31 years on average in 1999.

Offer and traffic

- The number of seizures of cocaine and the quantities seized are increasing but vary considerably from year to year as they depend on the realisation of major special operations.

- Cocaine is becoming more readily accessible. Its price fell markedly during the 1990s and seems now to be stabilising.

- The offer of crack appears to be relatively localised and at present affects Paris, the West Indies and Guiana.

Multiple use

See part 4, chapter 11

7. Discussion

7.1 Consistency between indicators

To help in drawing conclusions as to the present state of affairs with regard to drug consumption and its consequences we have many indicators extracted from sources belonging to three major categories:

- surveys of the general population (or a subset of the population), which, on the basis of individual statements, provide information on the extent and frequency of the consumption of the various drugs and on views and opinions on the matter,

- national files and registers which supply data on the consequences to health of drug consumption (mortality and morbidity),

- administrative statistics that chiefly reflect the activities of the public apparatus set up to deal with the matter in the health and social field and that of the application of the law and give an indirect indication of the scale and nature of consumption and of the offer of drugs.

The information drawn from these indicators can be consolidated or complemented by qualitative data based on observations in the field. This is the case of some of the data supplied by the project monitoring emergent trends (TREND) that was set up 2 years ago. Each source of data reflects only a part of the matter from a particular point of view. It is by setting them against one another that general trends can be recognised. Thus it was by using an approach based on a cross-analysis of the different indicators that it was possible to recognise the trends referred to above. The general agreement between the available indicators provides strong support for certain conclusions such as:

- the fall in the importance of heroin in cases of problematic consumption of illicit drugs,

- the correlation of the above with a rise in the importance of cocaine,

- the fall in the frequency of certain problematic consequences of drug use,

- the tendency of cannabis consumption to become commonplace and the rapid rise of synthetic drugs.

7.2 Implications for policy and interventions

A periodically updated assessment of the national situation with regard to drugs is of general interest to decision-makers. The trends described in this report can also have numerous implications for public policy. It is not our mission to enter into a discussion in this area. Indeed, the French public authorities have decided to set up the OFDT as an autonomous public body, dedicated to the observation of all aspects of drug consumption. It remains the responsibility of the authorities to decide on the implications for public policy of the tendencies discussed above.

7.3 Methodological indications and data quality

With regard to the scale of drug consumption, one of the main gaps in the French information system has, in large part, been filled by setting up a permanent system for observing consumption, perceptions and opinions on drugs amongst the general population. Nevertheless, this system has its limitations. On the one hand, there are those inherent in this type of survey, the most important being that those questioned must be prepared to admit to any consumption. The rise in declared consumption of licit drugs sheds an edifying light in this regard. On the other hand, there are the biases introduced by certain characteristic details of the method used, in particular, the method of completing the questionnaire (see remarks in the earlier chapters).

One of the principal methodological problems that faces us for the coming years is with regard to telephone surveys (biased declarations and coverage in the face of the development of "red lists" and the mobile telephone).

The available indicators on the health consequences of drug consumption are still too fragile. We remain without a global approach to the mortality of drug users. While the three available indicators show the same trend, they are insufficient for a complete statement on the trend of drug user mortality. In the same way, the downward trend in the prevalence of HIV amongst drug users needs to be backed up by data that is not based on declarations.

Finally, taking into account the limitations inherent in their extraction from the data, it is, generally speaking, unwise to attach too much importance to small fluctuations in any one indicator. Only significantly large changes in indicators, with confirmation from other data of the same nature, can be interpreted as trends.

Principal sources used in part II:

Health Barometer 2000, first results: The Health Barometer 2000 was a telephone survey of the general population on the basis of a random sample. It was carried out by the French Committee for Health Education in partnership with the National Salaried Workers' Insurance Fund, the Ministry of Employment and Solidarity, the French Observatory of Drugs and Drug Addiction [Observatoire français des drogues et des toxicomanies] (OFDT), The French National Federation of Complementary Health Insurances, the Senior Committee on Public Health, the Interministerial Mission for the Fight Against Drugs and Drug Adiction and the National Federaion of Regional Health Research Institutes.

This survey covers a number of topics with regard to the behaviour and opinions in France in respect of health. The sample of 13,685 individuals from 12 to 75 years of age is representative of the national population.

Adult Health Barometer 95/96, CFES: This telephone survey, carried out in 1995, is based on a sample of 1,993 individuals representing the population of 18 to 75-year-olds living in France. This was of a very similar composition to the total population (age, sex, region of residence and type of dwelling). The Health Barometer provides information on behaviour, knowledge and attitudes with regard to health.

Survey of addictive behaviour in selection centres in 1995 and 1996, DCSSA

This survey, carried out in 1995 and 1996 and covering 10,870 and 2,698 individuals respectively, is based on an interview with a doctor regarding the use of psychoactive substances together with a urine test that can provide confirmation of the veracity of the statements recorded. The representative nature of the sample was guaranteed by the fact that 95% of young men of French nationality underwent the selection tests.

The wind down of obligatory military service means that this survey has not been carried out since 1997.

Survey of Health and Behaviour on Call-Up and Preparation for Defence Day [*Enquête sur la santé et les comportements lors de la journée d'appel et de préparation à la défense*] (ESCAPAD), OFDT, 2000

The OFDT has established an annual survey that takes place on the occasion of the Call-Up and Preparation for Defence Day [*Journée d'appel et de préparation à la défense*] (JAPD) throughout mainland France. Once a year, on the Wednesday and Saturday of a given week, all the young French presenting themselves for these days in the 250 centres throughout the country spend some twenty minutes filling in a questionnaire on health, way of life and consumption of psychoactive substances.

On the first occasion that this survey was carried out, in May 2000, of 14,553 who attended, only 92 returned a blank form and, after checking age, sex and the coherence of the answers to the main questions on the consumption of psychoactive substances, 13,952 questionnaires were used. The JAPD is centred on young people of 17 with the possibility of a later, catch-up attendance, mainly for 18 and 19-year-olds. Since the JAPD for girls started later than for boys, the 2000 sample includes girls of 17 and boys of 17 to 19. For 2001, this survey has been extended to the overseas departments.

"ESPAD" European Survey on Alcohol and Other Drugs, INSERM, OFDT, 1999

In 1997, the OFDT established a permanent system for the monitoring of practices, attitudes and opinions with regard to drugs on the basis of national surveys of the general population. The participation in the 1999 European schools survey project, "ESPAD", falls within this framework. The realisation of the survey was entrusted to the INSERM "adolescent health" team, M. Choquet and S. Ledoux, who have participated in the "ESPAD" project since 1993 in partnership with the OFDT and the Ministry of National Education.

ERROP (Survey on Representations, Opinions and Perceptions of psychoactive substances), OFDT, 2000.

It is a telephone survey devised by the OFDT. The data were collected from 30 March to 10 April 1999 by the BVA demographic institute, from 2,002 persons aged from 15 to 75. This sample by quotas (according to sex, age, profession of the head of the household, region of residence and size of agglomeration) is representative of the French population. Those questioned were asked about their knowledge of psychoactive substances, about their perception of the danger of such substances, about their own consumption experience, about users in their entourage, about their opinions regarding heroin users and about public policies currently implemented or that might be envisaged. This enquiry will be repeated in 2002.

"Trends in registrations for addict care, survey of general medical practitioners in 1998 and comparison with 92, 95 and 98, November 1998", EVAL, OFDT report.

SIAMOIS system: The System for Information on Accessibility of Equipment of an Officinal (dispensary) nature for Injection and Substitution, initiated by the General Health Authority [*Direction générale de la santé*] and developed by the Health Watch Institute [*Institut de veille sanitaire*] was devised in 1996 to monitor the trends in access to the sterile injection equipment available from pharmacies and to substitution medicaments. These data are transmitted by the Group for the Implementation and Elaboration of Statistical Studies for the Pharmaceutical Industry. By considering these data for the 20 to 39 age group of the population, which includes 80% of drug users, indicators are obtained that allow comparisons to be made on a regional and departmental level. These indicators can be lined up against new AIDS cases, deaths by overdose and arrests for infringement of drug law in the same age group.

National Catalogue [*Fichier National*] of Authors of Infringement of Drug Law (FNAILS), OCRTIS.

OCRTIS receives figures supplied by the police and the gendarmerie. A large proportion of proceedings for ILS instituted by the police is also sent to OCRTIS. The procedures are used to redefine certain data supplied by the police, which explains a certain disagreement between the two sets of statistics. The National Gendarmerie and the police services in Paris and its inner suburbs supply data directly to the FNAILS without any possibility of carrying out the same redefinition as for the other data. The proportion of trafficking probably tends to be overestimated in the latter sources. Like the statistics drawn up by the CID, the FNAILS does nor generally take account of customs offences not recorded in a formal statement. The substance mentioned is the main substance used by the user arrested. Up to 1993, there were major differences in the figures for arrests for use and use with resale supplied by OCRTIS and those of the CID. This difference was gradually eliminated between 1988 and 1993, which may have led to a catch-up effect and artificially increased the growth in the number of arrests. Since 1993, the difference between the two sets of statistics has been very small.

National Register of Prisoners [*fichier national des détenus*], SCERI.

This register yields information on the annual flow of imprisonments, i.e. the number of persons entering prison establishments between the 1 January and 31 December each year. Only the first offence listed in the committal order is taken into account. In the same way as for convictions, this offence is not necessarily the most serious. It could also be the first to have been established.

The National Register of Prisoners can also yield information on the number of persons in prison on a given date. This number results from the prison intake and discharges from prison in any year and the previous years.

November Addiction Survey, DREES

A record is kept of drug addicts resorting to the health and social system (drug addiction specialised centres, hospitals, non-specialised social centres) during the month of November, irrespective of whether the registration for care occurred in November or earlier.

The drug addicts registered for care are regular users of illicit substances or licit substances diverted from their normal use. A single drug addict may make several visits to a single establishment, to different establishments, sometimes even simultaneously.

INSERM unit SC8 (national register of causes of death)

Since 1968, the INSERM unit SC8 has recorded all causes of death on French territory. These are identified according to the information entered on the death certificate and according to the CIM-8 code (from 1968 to 1978) and the CIM-9 code (up to 1997). Three causal factors are mentioned on the death certificate: precipitating factor, main cause and morbid condition contributing to the fatal outcome. Three CIM-9 codes indicate drug addiction: drug dependency, abuse of drugs and psychoses caused by drugs.

Health Watch Institute (death from AIDS).

Death from AIDS is notifiable. The Health Watch Institute keeps a record of deaths from AIDS (by year of decease) and of the cause of HIV infection. There is a certain delay in the notification of such deaths, the data are corrected for this. There is also a shortfall in notifications of about 20%.

OCRTIS (deaths by overdose that have been the subject of judicial proceedings).

In cases of suspicious death (crime, accident, suicide, sudden death, overdose, often of a young person) judicial proceedings are started. As soon as proceedings are opened and if overdose is the suspected cause of death, the OCRTIS is sent a telex and the case is entered on the computerised register. The record of the proceedings is later sent to the OCRTIS. This database is by name.

PART 3: DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

8.1. Major strategies and activities

8.2 Approaches and New Developments

The national strategy defined in the current government plan has been described in detail in chapter 1.2. The reader is asked to refer to this part of the report in which the main lines of interministerial policy are explained. We repeat here as a reminder:

The plan to fight against drugs and prevent dependence (1999-2000-2001) takes certain observations as its starting point:

- the methods of consumption of psychoactive products are changing,
- users are increasingly adopting multiple consumption behaviours (consumption of several substances, e.g. ecstasy and alcohol),
- care facilities are unequally distributed across the national territory,
- there is no common approach to drugs and drug addiction,
- the social and professional support at the time of reception into care remains inadequate.
-

Starting from these points, the plan defines some broad lines of policy. Certain general priorities become clear, in particular:

- the development of a monitoring system for the use of licit and illicit psychoactive substances with an emphasis on work in the social sciences (studies and research) and the organisation of the available information to inform public policy,
- the distribution of reliable, scientifically validated data to the general public in order to give the answers required regarding the drug situation,
- the extension of preventive measures to address all aspects of drug consumption behaviour (rather than concentrating on the substances alone, as at present),
- the development of a common approach with regard to psychoactive products amongst all professionals and others active in the field of prevention in order that public policies and new approaches that are adopted can be understood and shared by all those involved in their implementation,
- the extension of the risk and damage reduction policy to cover all aspects of use behaviour,
- the establishment of a system of early medical and social care response (before users of psychoactive substances become dependent) in order to provide users with a support adapted to their needs,
- the integration of a public health attitude into the public security system, starting from an adaptation of criminal policy, whether with regard to users held for questioning or those placed in detention,
- the strengthening of the action taken against trafficking, making more means available to act against both local and international traffic, money laundering (law of 1996 on living on the earnings from drugs) or the sources of chemical precursors,

- the development of French activity in the international arena with a global approach aiming at a balance between reduction of supply, reduction of demand and reduction of risk; this will involve a redefinition of geographical priorities and favour the development of actions for demand and risk reduction.

9. Intervention Areas

9.1 Primary prevention

The major development in the prevention field is its extension to cover a range of psychoactive substances, both licit and illicit, favouring a behavioural approach and taking account of use, harmful use (abuse) and dependence.

A number of sectors are affected by the drug problem, which, in itself, is an explanation for the multiplicity of agencies active in the prevention field. The fact that no law – not even that of 1970 – directly addresses the question of prevention has left the ministers free to organise public action through numerous ministerial directives and implementing provisions and has probably contributed to the major share of private initiatives in this domain.

If the political will to take global preventive action[18] has only recently been officially expressed, in practice, professionals involved in prevention have long been persuaded of the need for an overall perspective on consumption. However, the definition of global prevention and, above all, its integration with specific prevention[19] – between the globalising behaviourist approach and the establishment of coherence between actions on specific topics to achieve an overall effect – is not easily done. Furthermore, the many factors at the origin of consuming behaviours lead directly to a wider reflection on social phenomena at the heart of political preoccupations: at risk behaviours, exclusion and delinquency. Thus it is that a major part of dependence prevention is rooted in the generalist programmes of horizontal arrangements (urban contracts and their derived manifestations, PRAPS and PRS). This integration creates a masking effect that complicates any attempt at an appraisal of global prevention.

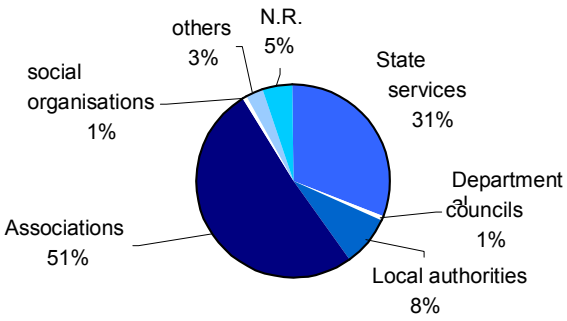
Major participants

According to the activity reports of the Drugs and Dependence project managers, the great majority (70%) of actions take place in schools. Far behind come cultural associations and the work environment with 5% of initiatives each. Although the three-year plan emphasises the need to develop risk reduction measures for the party scene, very few actions cover this domain at the present time.
In 1999, half (52%) of preventive actions were launched by the association sector, the second large promoter being the state with about one third of the actions implemented [APPRE]. About six times out of ten this is through the national education system, preventive actions being concentrated in the schools. In 2000, about 497,400 pupils of public colleges and upper schools (nearly a quarter of the total in France) benefited from a preventive action in direct or indirect connection with psychoactive substances (OFDT, 2001).

[18] Prevention of consuming and dependent behaviour with regard to all psychoactive substances.

[19] Prevention related specifically to one or more psychoactive substances.

Organisations initiating preventive actions in 1999.



Source: APPRE, 2000, OFDT

Approaches

It is estimated that a little over three quarters of preventive actions implemented in 1999 target psychoactive substances as a whole [APPRE]. Of these, about one action in five follows the principle of a reflection on personal behaviour and aptitudes without concentrating on any particular substance. Actions dealing with the theme of a "product" (about 20%) address, in the great majority, alcohol (about 80%), followed by tobacco (20%) and cannabis (10%).

Distribution of product specific actions by target product

	(in %)
Alcohol	82
Tobacco	20
Cannabis	11
Medicaments	6
Cocaine and its derivatives	5
Synthetic drugs	4
Heroin and its derivatives	2
Doping products	1

Source: APPRE, 2000, OFDT

The preventive strategy is based on vulnerability factors in one action out of ten, on protective factors in one quarter and of both these aspects in about three quarters.

Funding

In the field of prevention, the State services are the main source of funds both in terms of the allocated budget (about 60%) and in the number of fundings granted (43% of the various sole or joint fundings) [APPRE]. Then come the local authorities (principally the departmental councils followed by the municipal councils) who provide 20% of the funding allocated to prevention and represent 28% of the budgetary sources [APPRE]. Each year, the MILDT delegates a budgetary envelope to the Drugs and Dependence project managers – in the framework of their departmental prevention programmes – and to the ministries concerned by the question on the basis of the propositions that they present. In 2000, the interministerial credits allocated for prevention to the Drugs and Dependence project managers amounted to 47 MF. The total of decentralised credits allocated in this field could not be calculated.

However, the analysis made of the activity reports from the 70 departments suggests a distribution of sources of funding of the order of 60% and 40% respectively between the interministerial credits and the decentralised credits allocated to prevention.

Sources of funding for preventive actions

State: - MILDT - Other state sources	61%
Departmental councils	13 %
Municipalities (Communes)	8 %
Regional councils	1 %
Others	6 %
Associations	4 %
Private funds, sponsors	4 %
European Commission	2 %

Source: APPRE, 2000, OFDT

Partnerships

It is notable that prevention involves a high level of partnership. Indeed, two thirds of actions involve at least two partners (20% involve at least 5) with the state and its services in first place, whether for funding (61% of actions), the implementation of actions (25%) or as an expert advisor (32%).

The associations intervene as often as the state services (25% of actions) in the implementation of actions. In fact, the "prevention specialists" and "drug abuse professionals" – the majority of whom are association members – are the main "professional bodies" working in preventive actions (30% to 40% of actions) [APPRE]. General practitioners and nurses (mostly school personnel), psychologists, teachers, instructors and gendarmes all take part in preventive actions in similar proportions (20% of actions) [APPRE].

The social services are the fourth key actor. Although their participation in funding is relatively infrequent (5% of cases), they are more frequently mentioned as participating in the implementation of actions (12%).

9.1.1 Children and Family

There is no change to report in comparison with previous years.

This domain is not the object of any centralised action by state bodies. Local initiatives passed down through the associations are not recorded at present and are therefore difficult to delimit.

With regard to early childhood, the problem of drug addiction is only touched on very indirectly through health education and often nutritional education projects, which touch on the subject of orality and the dependencies that flow from it.

9.1.2 School programmes

In schools, prevention is organised according to the local initiatives of the administrative and educational teams and according to the priorities defined at the academic, departmental and school levels. Apart from the organisational system, represented by the Health and Citizenship Education Committees, there is no prevention system model that can be imposed

on all establishments. However, the national training programmes must, henceforth, be included in the departmental prevention programmes.

National education actions in schools

National and decentralised management of the pupils' health promotion policy

The question of the prevention of dependence is a part of the pupils' health promotion policy defined by the Ministry of National Education and co-ordinated and evaluated by the Schools Teaching Directorate [*Direction de l'enseignement scolaire*] (DESCO). This latter body directs the network of technical advisors (doctors and nurses), rectors and academic inspectors, making them aware of the broad lines of ministerial policy. It also defines the national protocol on the organisation of care and emergencies in schools and local public education establishments.

The technical, academic or departmental advisors are associated in the implementation of the regional or departmental systems contributing to the health of and prevention amongst school populations: access to prevention and care programme, dependence prevention programme etc.

Health and Citizenship Education Committees

The Health and Citizenship Education Committees [*Comités d'éducation à la santé et à la citoyenneté*] or CESC, started in 1990 as Social Environment Committees, are intended to co-ordinate prevention and training for life in society in public primary and secondary establishments of general or vocational education. Since 1995, these bodies are co-funded by the MILDT and the Ministry of National Education. Their constitutional text[20] confirms the adoption of a globalising approach to care provision for the difficulties encountered by young people, implying the prevention of any kind of dependence. This approach is also in line with the principal of a global approach to prevention in the MILDT three-year plan. This circular also lays down the principals of the generalisation of CESC throughout the country. Set up around the head of the establishment, these committees include the educational community and the organised forces of social life and the area (associations, institutional organisations etc.) in order to create a link between the school and its environment. Concretely, the CESC should determine operational objectives for the establishment projects that can be identified in time and place and are adapted to the locally identified reality of health problems. The transition between primary school and college is prepared by teachers from both establishments. In this framework, occasional meetings are organised to define protocols for the prevention of problems of violence and drug abuse amongst pre-adolescents (pupils at the end of primary school). A summary of the various actions undertaken is returned to the appropriate rectorates.

During the school year 1999-2000, the number of CESC in public secondary establishments increased by 35% compared with the previous year. In June 2000, 4,530 were counted, distributed across 65% of secondary schools, 60% of vocational schools and 55% of colleges. Given the 543 CESC that operated a circuit system in that year, six out of ten public establishments (4,687) had the benefit of such an arrangement, as against five out of ten in the previous year. Of these, 843 are located in a priority educational area (against 549 the previous year) and 135 of those classed as "sensitive establishments" giving coverages of 84% and 77% respectively. Furthermore, in 2000, 510 primary schools, 23 private establishments (primary and secondary) and 34 regional agricultural teaching establishments have a CESC.

[20] Circular No. 98-108 of 01/07/98

The experimental programme "Pupils Active for Prevention"

From 1997 to 1999, the Ministry of National Education ran an experimental programme in the field of the prevention of at-risk behaviour entitled: "Pupils Active for Prevention". This experimental phase led to the publication of a leaflet providing information and recommendations for teams that might wish to follow this example. The goal of this programme is to involve the pupils who are changing school in the joint management of preventive actions and to train them accordingly. These pupils are trained to act as preventive organisers and messengers who can adopt the position of a supporting peer and establish a listening and intermediary relationship. They work under the guidance of reference adults who ensure that they do not attempt to take the place of professionals by taking on the serious problems of their schoolmates.

According to the conclusions of the evaluation made in 1999 (Ballion, 2000), which can be consulted at www.eduscol.education.fr, this programme is at best implemented in establishments engaged in a global health and citizenship education policy and committed to the involvement of the pupils in school life.

The collection, "Reference Points"

In November 1999, the Secondary Schools and Colleges Directorate (Ministry of National Education), in collaboration with the MILDT, edited a new collection of "Reference Points for the Prevention of At-Risk Behaviour in Schools" and "Reference Points for the Prevention of At-Risk Behaviour in Elementary Schools". A total of 800,000 copies was distributed in 2000.

National Police actions in schools

The actions of the National Police in schools are listed below.

*Mission for the Fight Against Drugs [*la Mission de Lutte Anti-Drogue*] (MILAD):*

The Mission for the Fight Against Drugs (MILAD), charged with the policy co-ordination of the national police services in the fight against the use of and trafficking in narcotics, also organises the national prevention system. Its actions are directed towards the initiation of a local prevention movement in which the local police can be involved. It is also required to unify the political discourse of the Ministry of the Interior in accordance with the three-year plan.

The MILAD Roving Campaign

The MILAD runs and manages a roving information and drug addiction prevention campaign directed particularly at schools. It uses a high-visibility group of vehicles, including a 38 tonne lorry, able to accommodate 30 to 40 visitors and staffed by MILAD officers and local anti-drug training officers. In 2000, 34,000 pupils were encountered in schools. Discussions with the teaching staff were held in advance.

Anti-Drug Training Officers

The Central Public Safety Directorate (463 police stations) maintains the largest number of specialist policemen, the Anti-Drug Training Officers [*policiers formateurs antidrogue*] (270 PFAD). The original task of the PFAD was to ensure the continued training of their colleagues. However, since 1998, their action has been redirected by MILAD to concentrate on schools, in particular, in the framework of the Health and Citizenship Education Committees. Within this framework, they give information on permitted and illicit substances, the consumption behaviours connected with these products, the consequences for the individual and society, the provisions of the law with regard to trafficking and use and the

various facilities for the provision of care. In 2000, the PFAD implemented about 5,000 preventive actions and met with nearly 177,000 pupils.

Part Time Anti-Drug Trainers of the Gendarmerie Nationale

The Part Time Anti-Drug Trainers [*Formateurs relais antidrogues*] (FRAD), created in 1990, are officer grades of the CID who, in addition to their normal duties, pursue a preventive mission. The approach aims to awaken public responsibility and demystify drugs, pointing out the social consequences of trafficking and the part played by traffickers and dealers. Their action is primarily aimed at young people in secondary schools and colleges but also includes their parents, the social services and military personnel. In addition to illicit drugs, the FRAD discuss licit psychoactive substances, mainly alcohol and medicaments. In 2000, 450 FRAD were counted, in general, four or five per department. They made some 20,000 presentations to nearly 480,000 persons including 310,000 still in education (college to university). The FRAD are associated with the steering committees of many CESC (about half the total).
However, the primary function of the FRAD is to train investigative gendarmes in prevention and enforcement and especially in the methods of communication and in the path from use to trafficking and the methods of use and how better to detect them. The organisation of a network and the operation of its communication channels are also under discussion.

9.1.3 Youth programmes outside schools

Actions under the supervision of the Ministry for Youth and Sport

National and decentralised management

The prevention of dependency actions run by the Ministry for Youth and Sport are co-ordinated by the Youth and Adult Education Directorate. They are implemented by the following operational institutions:

- the directorates for youth and sport in the regions (DRJS) and the departments (DDJS) where a 'resource person' is in charge of questions of prevention of dependency,
- the departmental youth councils (19 in 1999, 27 in 2000) in which young people can put their proposals to the public authorities as to the actions to be implemented in all those domains that concern them (training, employment, health etc.),
- the national training establishments,
- the branches of the youth information network (1500 public information centres covering all aspects of daily life).

80% of the budget delegated by the MILDT is passed for decentralised spending to the departmental directorates who are closely associated with the elaboration of the departmental prevention programmes and carry out their actions within this framework.

- The departmental directorates carry out their actions within the framework of the departmental prevention programmes defined in concert with the state services concerned, the local communities and the associations. These departmental programmes are co-ordinated by the project managers nominated by the Prefects.

In recent years, the decentralised services have been extended the particular invitation to support the implementation of preventive actions in **summer camps and in leisure centres without accommodation**.

They have also been asked to ensure the involvement of the **Departmental Youth Councils [*Conseils Départementaux de la Jeunesse*]** in the definition and implementation of actions (19 councils in 1999, 27 councils in 2000).

The departmental youth councils are intended as a framework within which young people can make known their needs and put their proposals to the public authorities in all those domains that concern them (training, employment, health etc.),

Twenty percent of the interministerial (MILDT) credits are used for the implementation of actions on a national scale, especially in the field of training.

National Police actions outside schools

Since 1995, during the summer break, the MILAD mobile unit (cf. preventive actions in schools) visits tourist spots. There the police meet not only with young people but also their parents, who generally express a strong demand for information. For these campaigns, the MILAD works in association with various partners: in 1999, the Ministry for Youth and Sport on the topic of doping, in 2000, the National Association for the Prevention of Alcoholism [*Association nationale de prévention de l'alcoolisme*] (ANPA). In the course of this last campaign, the team met with about 20,000 people during the months of July and August. In order to meet demand, coming, in particular, from the Ministry of National Education, a second mobile unit will come into service at the end of 2001.

9.1.4 Community programmes

Actions of the Ministry for Youth and Sport

Training of part-time workers. In order to provide a knowledge update and ensure that the guidelines of the three-year plan are taken into account, a course of training (8 sessions) was devised in collaboration with the CRIPS[21], Ile de France. This was attended by more than one hundred managers of decentralised services, establishments and branches of the youth information network. These interdisciplinary courses were open to youth professionals, sports doctors, anti-doping doctors, establishment nurses, youth information librarians etc.

Following on-the-spot preparatory work, two additional sessions, especially adapted to local needs and circumstances, were offered in Martinique and Guadeloupe. The priority target group was that of urban area field workers.

"Prevention à la carte"

The Ministry for Youth and Sport also supported the development of the "prevention à la carte" service, set up and managed by the AREMEDIA association. This service is based on an interactive program (accessed through an IT terminal), which provides a personal risk assessment. It supplies diagnostic and practical information. This system is anonymous and makes it possible to collect quantitative and qualitative data that can be used in epidemiological studies and the development of appropriate preventive strategies. In a pilot project, this service has been installed in some fifteen youth information centres since the beginning of 2001.

Ministerial actions initiated by the Ministry of Regional, Town and Integration Planning and the General Health Authority

[21] Regional Information and Prevention Centre for AIDS [*Centre régional d'information et de prévention du sida*].

Counselling Centres , neighbourhood reception and monitoring centres

The 1999-2001 three-year plan recommends the extension of the Counselling Centres, reception, monitoring and discussion centres and, above all, improving their accessibility, i.e. their geographical distribution and their operation (extending opening hours, for example).

The *Counselling centres* are financed by the Addictive Practices Office of the General Health Authority (SD6B). However, numerous reception and counselling centres are financed within other frameworks, in particular, that of urban policy. They base their activity on a principle of global prevention of drug addiction and marginalisation, where drug problems are understood within the logic of urban social development. Locally, the counselling centre teams work in close partnership with the municipalities in order to negotiate the establishment of a presence as close as possible to the point of need and the mobilisation of part-time neighbourhood workers.

The youth counselling centres have the special objective of attracting a young public from 18 to 25 years of age, away from the institutions, and, in particular, those from deprived social and family circumstances who are at risk of marginalisation and delinquency. They aim to provide a response to emergency situations in connection with family or social emotional distress and to help young people gain access to social service. The *Counselling centres « parents »* welcome families and encourage discussions in order to prevent or halt the breakdown of parent-child relations and, where necessary, establish a contact with the care system.

Within the framework of the law and the implementing provisions of 1998 and 1999 on social exclusion, 12.5 MF of additional funding were released, bringing the total to 43.8 MF for the strengthening of the existing structures and the creation of new counselling centres in departments that did not yet have them. In 1995 there were 26 youth counselling centres, 62 at the end of 1997 and 75 at the end of 1999. In 1999, there were 16 "parents" counselling centres.

The flexibility of the constituting text has led to a diversity of approach and working method. An evaluation (Jacob et al., 1999), completed in October 1999, identifies four main classes of strategy in the 40 *Counselling Centres* that took part in the study: a "community" approach (involving the public in the identification of needs and reinforcing local solidarity), a "psychoclinic" approach (an individual approach centred on "the problems of the subject"), a "social and educational" approach (support, access to rights, work on personal competence) and a "mediation" approach.

Youth counselling centres, set up during the same period as the *Counselling Centres*, work on the problem of social emergency (deviation and exclusion) amongst young people and also find themselves involved in handling dependency problems. The General Health Authority [*Direction générale de la santé*] (DGS) and the General Department of Social Services are currently working on the possibilities of creating a single structure from these various types of counselling centre.

9.1.5 Telephone help lines

Drugs alcohol tobacco info service, national telephone help line

The national social telephone service, Drugs alcohol tobacco info service or DATIS (formerly Drugs info service) has been running in France since 1990. It can now be accessed using a short number: 113. Financed by the MILDT, the service is constituted

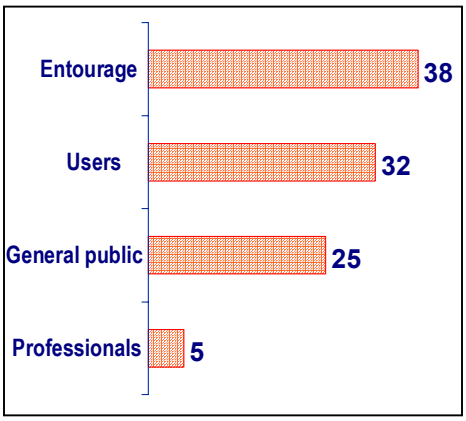
as a public interest group. DATIS is open to the general public and to professionals, accessible 24h/day, free of charge, anonymous and confidential. The role of the service is to facilitate requests for help, access to information and to care by providing:

- attention, support and advice for use related problems,
- information on substances, their effects, the risk connected with their use, the law and the care system,
- referral to the competent bodies in the domains of prevention, care, rehabilitation and risk reduction.

Since December 1999, DATIS has run two areas on the Internet reference site on drugs and dependency (www.drogues.gouv.fr): *"Your Questions / Our Answers"*, a question and answer forum and *"Useful Addresses"*, a national directory of specialised services. The service is spread across six sites: a national centre in Paris (24 hour service) and five regional centres (Lille, Strasbourg, Lyon, Marseilles and Toulouse).

In 2000, the service received nearly 60,000 requests for help and information. A high proportion of calls (40%) are requests for information, most often relating to substances (DATIS, 1999). The service also answers requests for support (20%) and advice (18%). Almost 15% of calls lead to referrals to care services.

38% of calls are from the entourage; these are callers motivated by suspected or real use on the part of someone in their immediate circle. **Users (32%)** are those who mention their own use in the course of the call. **The general public (25%)** is the category of those who call to request information without the request being motivated by any real or suspected use. Finally **the professionals (5%)** call for reasons connected with their professional responsibilities.



A very high proportion (37%) of callers are between 15 and 20 years of age. It is also noticeable that the age groups below 25 represent two thirds of callers (64%). This proportion underlines the role of the service with regard to a population of young adults and adolescents, users or not, who ask the service about substances, risks etc.

The distribution of the callers by sex continues to show **a high proportion of women**: **56.5%** as against 43.5% for men.

The five substances most frequently mentioned by the callers are: cannabis (57 %), heroin (20 %), alcohol (12 %), cocaine (7 %) and medicaments (8 %) (DIS, 1999). The main change in 2000: cocaine overtook medicaments in the order of callers' preoccupations. Most frequently, alcohol and tobacco are said to be combined with other substances.

Alcohol and tobacco are most frequently said to be combined with other substances. More precisely, when a single substance is associated with alcohol, it is very often cannabis

(56%), which is followed by heroin and tranquillizing agents. When alcohol (61%) and tobacco (75%) are mentioned, the great majority of calls come from users.

Other telephone help lines

DATIS exists alongside other telephone help services that became active in the field of licit psychoactive substances before DATIS extended its field of competence (such as Doping Line [*Écoute dopage*] and Tobacco Infos Service [*Tabac infos service*]). There are also services that include the problem of "psychoactive substances" in their field of action (such as Youth Health Line [*Fil santé jeunes*] 0 800 235 236 or AIDS Info Service [*Sida info service*], 0 800 840 800). Also to be noted are local initiatives, the decentralised services, for example, or associations such as Narcotics Anonymous [*Narcotiques anonymes*].

Telephone help services have also been developed to handle specific fields such as doping or tobacco.

9.1.6 Mass media campaigns

The communication programme of the MILDT elaborated for the years 1999/2000/2001.

In its three-year plan, the MILDT announced a voluntary policy to raise the level of knowledge in the whole of the population (general public and professionals) with regard to use, harmful use, and dependence in connection with all psychoactive substances. It was therefore proposed to develop the transmission of clear and credible messages on these topics based on scientifically confirmed knowledge.

The MILDT's communication plan, implemented in partnership with the French Centre for Health Education [*Comité français pour l'éducation à la santé*] (CFES), was established for a period of three years from 1999. It was also co-ordinated with the actions undertaken by the National Salaried Workers' Health Insurance Fund [*Caisse nationale d'assurance maladie des travailleurs salariés*] (CNAMTS) on the questions of alcohol and tobacco. Concretely, this strategy led to:

- the creation of an information Web-site, drogues.gouv.fr, in partnership with the CFES, DATIS, the OFDT and Toxibase; this went on-line at the end of 1999,
- the First Interministerial Meetings [*Premières rencontres interministérielles*] colloquium of 10 December 1999, bringing together institutional and professional representatives and dealing, in particular, with the required preconditions for the transmission of knowledge,
- the launch of a collection of four information booklets, "Drugs: know more about them [*Drogues : Savoir plus*]", intended for professionals, of which 70,000 copies were distributed,
- the distribution, at the beginning of 2000, of a book of information for the general public "Drugs: know more about them, take less risks [*Drogues : savoir plus, risquer moins*]"; this was sold by newspaper stands (a million copies) and distributed (three million copies), free of charge, in pharmacies, some doctor's surgeries, various associations and state services (e.g. 360,000 copies distributed to teaching, training and health personnel in secondary schools and colleges, in documentation centres and in libraries). The national distribution was supported by a television publicity campaign transmitted on all the national channels (April-May and October-November 2000) on the theme: "There is no such thing as a society without drugs". The campaign distinguished three behaviours: use, harmful use and dependence. All psychoactive substances are covered, including licit substances (alcohol, tobacco,

psychotropic medicaments). The book is now on sale in libraries. Up to the first half of 2001, a total of some 4 million copies had been distributed or sold,

- the launch, at the end of 2000, of 5 series of brochures (flyers) on alcohol, cannabis, ecstasy, tobacco and cocaine, aimed at a youth audience and created in partnership with associations of users and risk reduction. Two other documents are in edition: one on drugs and driving, the other on amphetamines.

For 1999 and 2000, the budget for this action amounted to 26 million francs. The work undertaken in 2001 seeks to consolidate this approach of bringing public knowledge up to date. The MILDT also proposes to initiate more precisely targeted communication strategies. Two publicity campaigns in this direction are to be developed: one re-affirming the educative role of adults, the other dealing with at-risk behaviour, especially on the party/festival scene.

9.1.7 Internet

The public information service Web-site on drugs, , is run by the MILDT in association with four partners: The French Centre for Health Education [*Comité français d'éducation à la santé*] (CFES), the French Observatory of Drugs and Drug Addiction [*Observatoire français des drogues et des toxicomanies*] (OFDT), the Drugs, Alcohol, Tobacco Info Service (DATIS) and Toxibase. Each provides the information for the sections for which they have editorial responsibility.

The site is part of the strategy of improving the general level of knowledge being followed by the MILDT. It also gives access to scientifically validated and regularly updated knowledge (in the domains of epidemiology, neurobiology and sociology) on all psychoactive substances, licit or illicit, for researchers, decision makers, professionals, specialists and the general public.

The audience is just as much the body of researchers, decision-makers, professionals and specialists in the fight against drugs and prevention of dependence as it is the general public.

For professionals, it includes a legislative database (MILDT documentation), a documentary database (Toxibase association) and a large number of study reports (OFDT).

Cross-headings offer a large number of services and a great deal of practical information: a directory of useful addresses, a lexicon drawn up in partnership with Larousse and a selection of sites on the Internet. A forum, "Your Questions, Our Answers", run by DIS, allows visitors to obtain answers to their questions in full confidence and anonymously. Several sections complete the site: a daily press revue, a diary of events and the latest publications, communiqués and press folders edited by the MILDT. Free subscriptions are available.

The site, www.drogues.gouv.fr, is run under the guidance of a steering committee that approves technical and editorial choices. Under the chairmanship of the Interministerial Mission for the Fight Against Drugs and Drug Addiction [*Mission interministérielle de lutte contre la drogue et la toxicomanie*] (MILDT), it also includes representatives of the site partners and external partners.

Since its launch in December 1999, the site has recorded a steadily increasing number of hits.

The number of hits rose from 19,700 (**9,188 visitors**) in January 2000 to a peak of 65,220 (**20,130 visitors**) in March 2001.

Traditionally, the number of hits falls during the summer period: in July and August 2000 and 2001, about **35,000 hits** were recorded, corresponding to about **13,000 visitors**.

9.2 Reduction of drug related harm

The system of risk reduction

The risk and damage control policy for consumption behaviours in general is clearly a priority guideline for 1999. In the **circular of 13 March 2000**, the objective of the public authorities is to support the actions taken to reduce the risks for drug users. They are insufficient in number and do not appear to be well distributed across the country. New credits have been proposed by the authorities, either to contribute to the strengthening of existing "low threshold" programmes (syringe exchange programmes, *Sleep'in* shops) or to promote the establishment of new programmes or new structures, especially in urban areas not yet covered or, again, the installation of syringe dispensers in public places.

9.2.1 Outreach work

Proximity teams have the objective of improving the care offered to users by playing a mediating role between the neighbourhood (inhabitants, traders and pharmacists), the town hall and the police, justice and health services. The street work is principally carried out by specialist educators working in several areas of the district. They are required to seek out drug users in order to give them information and strengthen links with the health and social system. Co-ordinators organise the front-line street workers to respond to problems drawn to their attention. In total, four proximity teams have been set up in the towns of Paris (in the 10th, 13th and 18th arrondissements) and Montpellier (one team only). A similar trial, financed by the town, has also been started in Marseilles.

Drug Addiction unit of the 18th arrondissement of Paris:

Since October 1999, an experimental operation for fighting against drug addiction has been running in the18th arrondissement of Paris. It has two objectives: to develop mediation between the neighbourhood and the users and/or the institutions and to improve the care provision for users.

The work at street level is essentially developed around social mediation with seven specialist "front-line" street workers operating in three different districts of the arrondissement. They attend and respond to the legitimate preoccupations of the local population. They are required to seek out drug users in order to give them information and strengthen links with the health and social system. Three co-ordinators organise the front-line street workers to respond to problems drawn to their attention.

An evaluation was planned. The service provider (ACT Consultants) engaged to carry this out was selected after a consultative phase of two months. The work started in July 2000 and a preliminary report was submitted in November 2000. Work is expected to be completed in May-June 2001 (results end 2001). The evaluation should give an appreciation of the effectiveness of the programme in realising its initial objectives and as seen by the users and the neighbourhood (from interviews and an opinion poll). One of the final objectives of this evaluation will be to define the main recommendations for improvements in the operation and, if appropriate, to extend this type of operation to other agglomerations.

9.2.2 Low threshold services

The primary objective of these "low threshold" or "low requirement level" programmes or services is to limit the injection of drugs and to make care more accessible. The principal

underlying these low threshold programmes is that many injecting users cannot or do not wish to, for a certain time, stop their consumption. It is therefore necessary to find a means of helping them reduce the risk of infection to themselves and to others. This also provides a means of making contact with them, of supporting them, taking account of their position in the drug-taker's cycle, and of offering them the possibility of entering into addiction care.

The public targeted by these low threshold services is:

- on the one hand, a population that is difficult to reach, having little or no contact with the care services or with urban substitution programmes,

- on the other hand, a population that is unable, for the time being, to accept demands that are too high.

The **syringe exchange programmes** distribute syringes singly or in prevention packs (Kit + ® or Kap®). The practice of exchanging syringes started at the end of the 1980s on the initiative of humanitarian associations such as Médecins du Monde. Since then, the number of such operations has grown continually; there were less than ten syringe exchange programmes in 1993, 16 programmes were funded in 1994, 61 in 1996, 86 at the end of 1997 and the number reached nearly one hundred in 2001. These programmes can be operated from fixed bases (associations, pharmacies) or mobile units (buses or street teams). In 2001, 15 programmes are operating from pharmacies, 40 from mobile units and 41 from fixed specialised bases (in boutiques, for example). The distribution of injection equipment and condoms serves as a support for building links, favours the reduction of at-risk behaviour and offers the possibility of referral to social or care services.

The "contact centres" or **boutiques**, created at the end of 1993, are front-line reception centres for the drug users in the most insecure situations. These services offer, apart from the syringe exchange programme, material assistance (shower, help with food, washing machine etc.), nursing care, an open ear and social and/or legal services. This activity can take various forms: supply of syringes, distribution of tokens to exchange in a pharmacy. Two boutiques, under the appellation 'front-line reception centre', were set up in 1993. Their number grew rapidly, reaching 34 at the end of 1999 and 42 in 2001. They are staffed by multidisciplinary teams of four or five, financed by the state and are generally located in towns with populations over 100,000.

The "***sleep'in***" provide emergency night lodging to dependent drug users in very insecure circumstances. During their time in these facilities, users can have access to health and social consultations. The first *sleep'in* officially opened its doors in 1995. In 2001, there are two *sleep'in* with 30 places (Paris and Marseilles). Two more *sleep'in* are being set up in Paris and Lille.

The **methadone bus** is an "adapted demand threshold [*seuil à exigence adaptée*]" service, facilitating the access to methadone as a part of the substitution programme and also taking social problems into account. It is a mobile, itinerant facility that aims to stimulate demand (goes to the user) in order to facilitate access to the therapeutic and social systems for a highly marginalised group having little or no contact with the care services. The bus must also act as an intermediary between the user and the usual social and health services. At present, two methadone buses are operating: the first experiment, undertaken in Paris, dates from 1998. On average, patients stay in the bus for three months. In 2000, some 100 to 120 drug users visited the bus each day. In the same year, a new bus went into service in Marseilles.

Still in 2000, the risk reduction scheme – building on the participation of users (knowledge of needs, contact with users, peer training) – has been reinforced by the opening of six new

boutiques, four syringe exchange programmes and a methadone bus. Support for associations and the active role plaid by users or ex-users in the front-line teams are of vital importance. These frontline workers are able to build links to those drug users who are most resistant to institutions. They are reception or prevention agents, intermediaries who know their town or area and its inhabitants particularly well. They also know the workings of the market, the places and methods used by consumers, their living habits, the communication codes, the social links and the balances of power between drug users. They contribute inside knowledge to the team of social and health professionals (specialist workers, social workers, doctors and nurses) working in and around the service centres.

9.2.3 Prevention of infectious diseases

The measures for the prevention of infectious diseases are based on actions aiming to facilitate access to injection equipment and to spread preventive information amongst a high-risk population. Since 1987, syringes have been on sale in pharmacies without prescription. The availability in dispensaries is complemented by the syringe exchange programmes and the automatic vending machines. As well as single syringes, prevention packs are available.

Risk reduction measures largely take the form of a fabric of associations outside the specialised system, often benefiting from the financial support of the state or the local authorities. All these measures are financed mainly by the state with additional participation by the health insurance system from the national fund for medical prevention, education and information in the framework of the local implementation of national schemes.
The following complementary measures are taken in the field:

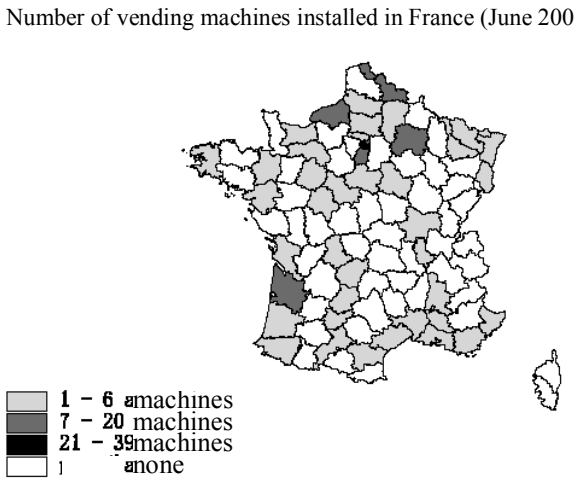
- the unrestricted sale of syringes from dispensaries,
- vending machines supplying prevention packs,
- the syringe exchange programmes run by associations,
- contact points or boutiques for drug users.

The Kit + ® and Kap® are prevention packs distributed through the associations to injecting drug users. These **"street model" packs** are distributed free of charge by the associations supported by public credits for their action to prevent AIDS or reduce risks amongst drug users. They contain two syringes, two alcohol soaked swabs, two doses of sterile water for injection, one condom, two heating/dilution recipients, two dry swabs, two sterile filters, an official reminder of the legality of selling syringes in the prevention context, the "green" (free) numbers of the Aids Info Service [*Sida info service*] and the Drugs Info Service [*Drogues info service*], advice on the use of the contents and an information leaflet on the local outlets for general assistance.

Since 1999, the **pharmaceutical Stéribox2®**, with identical contents to the Kit + ®, has been on sale on the official circuit. Its distribution benefits from a state subsidy (2 F per pack), allowing it to be put on sale at the recommended price of 7 F. The Stéribox2® is also intended for injecting drug users. This pack, which replaces the Stéribox® (on sale since 1994), adds two small recipients and two sterile wads to the contents of the old model. The Stéribox2® makes it possible to avoid not only the risk of HIV and hepatitis infection connected with sharing syringes but also the formation of abscesses. In 1999, the number of Stéribox® sold annually in France per 1,000 inhabitants from 20 to 39 years of age reached 168, an increase of 6% over 1998. From 1996 to 1999, the sales of Stéribox® increased steadily to reach 2.8 million in 1999.

The prevention packs are also made available through **vending machines** in public places. A total of 277 were installed in France in 2001. They are accessible 24 h/day and include:

- vending machines supplying prevention packs (Kit + ® or Kap® in a cardboard box),
- electronic or mechanical collectors delivering a token for a syringe,
- simple collectors (syringe waste-bins) and mechanical distributors delivering a token for a syringe,
- electronic exchangers delivering a Kit + ® or Kap® for a syringe,
- Totem® prevention posts (modular street furniture that can include a mechanical collector, a mechanical pack dispenser, a condom dispenser and an information panel).



Distribution of vending machines in France in June 2001 (410c)

Source: DGS/SD6A

The installation of vending machines on the public highway is encouraged by the public authorities. The responsibility for taking the decision lies with the town halls. The investment required in these installations can be borne 100% by the state; the running costs are borne by the municipalities.

Number and types of risk reduction measures in 2001

Number of syringe exchange programmes in operation:	
in pharmacies	15
in mobile facilities	40
in fixed specialised facilities	41
Number of "contact points" or boutiques	42
Number of "*sleep'in*"	2
Number of methadone buses	2
Number of proximity teams	4

Source: DGS/SD6A

9.3 Treatments

9.3.1 Treatments and health care at national level

These measures include the facilities funded by the General Health Authority (DGS) to fight against the use of drugs. With the ultimate objective of improving care provisions, the

authorities concerned wish to bring together the facilities and the teams working in the fields of drug abuse, drinking and smoking.

Specialised care centres for the users of illicit drugs: CSST

Since the decree of 29 June 1992, all facilities specialising in the care of users of illicit drugs and financed by the state come under the generic designation of specialised addict care centres [*centres spécialisés de soins aux toxicomanes*] (CSST) with or without accommodation.
Their mission is to provide, together since the decree of 1992, medico-social care and social assistance and support including assistance with rehabilitation. In more detail, these centres must provide:

- reception, guidance and information to drug addicts and their families,
- withdrawal treatment and withdrawal support where this is carried out in hospital,
- support for the family environment.

To ensure the success of these missions, the care centres must draw up a therapeutic project for a period of five years, which fixes the therapeutic and social-educational objectives and lay down the methods to be used in realising and evaluating these objectives.

The policy paper of 5 November 1998 from the Directorate-General for Health sets out the developments to be taken into account in a revision of CSST projects. This policy line should lead the centres to:

- establish a partner relationship with the health and social professionals of the regular services, especially with the general practitioners,
- remove the barriers between the specialised facility and the psychiatric sector in order to take better account of the psychiatric co-morbidities,
- take account of multiple consumption and new fashions (consumption in association with alcohol, consumption of ecstasy).

The CSST can be managed by associations or by public health establishments.

In 2001, there are 263 CSST of which two thirds are managed by the association sector. They are established in 90 French departments.

Three main types of centre can be distinguished:

- outpatient care centres of which there are 201,
- care centres with communal accommodation of which there are 46,
- care centres in prisons of which there are 16.

Numbers and types of specialised addiction facilities in 2001

outpatient specialised centres	201
24 h. reception units attached to the centres	85
specialised care centres with communal accommodation (e.g. post-cures)	46
	(569 funded places)
Specialised centres in prisons	16
The CSST offering outpatient care or with accommodation can maintain:	
networks of treatment stop-over apartments	86
	(about 422 places)
transitional or emergency accommodation facilities (communal or individual)	18
	(about 134 places)
networks of host families	20
	(about 116 places)

Source: DGS/SD6B

The **outpatient care centres** receive and give guidance to all those having a dependence-related problem and provide medical consultations, nursing care, psychological follow-up and social and educational support appropriate to each situation. They can offer support to the families and immediate circle of those affected by drug use. They also supervise outpatient withdrawal and provide support for withdrawal in hospital and substitution treatment.

The outpatient centres are asked to give particular attention to the following:

- the promotion of risk reduction and access to care,
- the improvement of their social function,
- the increased availability of care for drug users in prisons.

Two thirds of outpatient care centres are run by associations, the remainder being under hospital management. Their numbers increased from 183 in 1998 to 201 in 2001. These centres run 24-hour outpatient reception units. These are units run by the specialised centres but in a different geographical location. Their numbers rose from 56 in 1998 to 85 in 2001.
This extension of the system was possible thanks to work done to reorganise provisions and carried out by the departmental directorates of health and social affairs with the support of the Directorate-General for Health. Thus, the revision of the therapeutic projects, some of which were not approved as they stood, made redeployments possible at departmental, regional and national levels.

In the **centres with communal accommodation** (also called residential therapeutic centres), drug users are afforded medico-psychological and socio-educational care by a multidisciplinary team (doctors, psychiatrists, nurses, psychologists, educators and social workers). The objectives are the restoration of the personal equilibrium and the rehabilitation of the residents. Almost all the centres with accommodation are run by associations.

In 2001, there are 46 such centres. Four centres lost their approvals between 1999 and 2000. The reception capacity of these centres was therefore reduced by 19% from 697 places in 1998 to 569 in 2001. At the same time the available accommodation was diversified.

These centres also organise collective activities outside the centre and support for external procedures. The social care also includes a heavy involvement of the families or immediate circles of residents.

Originally, a stay in these centres followed withdrawal treatment during which the patient undertook not to take any more substances, not even medicaments. This approach was modified by the introduction of substitution treatment and an intensification of problems of a social nature. In accordance with the decree of June 1992 and the policy paper of November 1998, the therapeutic centres were called on to review their therapeutic project and refocus their activity: relaxation of their conditions of reception and residence, collaboration with the local medical team for patient care, better attention to the social and professional needs of the patients.
The specialised addict care centres offering outpatient care or with accommodation can maintain networks of treatment stop-over apartments, transitional or emergency accommodation facilities or networks of host families.

The aim of the **therapeutic apartment networks**, of which there are 86 in 2001, is to allow drug users to recover their autonomy. At present, they must be reserved for those with serious health or social difficulties. These facilities must also make their contribution to the emergency and transitional accommodation capacity, a type of care allowing the user to "take a break", to stabilise a withdrawal or substitution treatment or to wait for permanent accommodation. This type of accommodation also receives drug users coming out of prison or subject to an alternative to prison. The therapeutic apartment networks make approximately 422 accommodation places available.

The **transitional or emergency accommodation** facilities offer short stays of one to four weeks according to the health and social needs of the individual. Socio-educational and/or medical support is also available. This type of accommodation is especially reserved for those suffering from severe desocialisation and those coming out of prison or subject to an alternative to prison. In 2001, 147 places are available in the 18 existing facilities.

The **host family networks** were started at the end of the 1970s. A stay with a host family is appropriate to various situations that can occur at different times in an addicted person's career. In 2001, there are 20 host family networks. In 1999, they represented a resource of 215 families who had welcomed 348 drug users. The types of beneficiaries (single, with a child, withdrawn, on substitution or subject to a court order) and the length of stay (from a weekend to 9 months) vary. The reception in a family is directed towards a recovery of autonomy and can be a step towards the rehabilitation of addicts for employment. It allows them to regain contact with a "normal" pace of life, confronting them with tasks to be performed, timetables and individual attitudes in a non-institutional environment. At the same time, the addict remains in the therapeutic care of the CSST to which the host family is attached.
According the figures from the General Health Authority, the total capacity of all types of accommodation in 2001 is about 1,250 places.

The **care centres in prisons**, formerly known as *antennes toxicomanie* (addiction offices), are 16 in number. The CSST in prison are affected directly by the new policies laid down by the General Health Authority, the Directorate for Hospitalisation and Organisation of Treatment, the Directorate of the Prison Administration and the MILDT in the interministerial note of 2001 regarding the improvement of health and social care for detainees exhibiting dependence on licit or illicit substances or with an abusive consumption. This letter provides for the establishment of new protocols for the reception into care of dependent persons in each penal establishment. The procedure selected is based on the mobilisation all participating parties in each penal establishment, including the CSST[10]. Further, a certain number of external CSST are signatory to a service agreement within the framework of the

[10] For further information, refer to the chapter on recent changes in health policy.

programme of departmental agreements on objectives. This programme organises, from the health point of view, the care of imprisoned users, the preparation for their release and subsequent follow-up.

9.3.2 Substitution and maintenance programmes

The interministerial plan of 1999 renews its support for the development of the substitution policy for those dependent on opiates. The new provisions, which seek to reduce the disparities in the duration and manner of prescription, the follow-up and the delivery for methadone and buprenorphine, have led the authorities concerned to re-examine the respective applicable protocols in order to define more appropriate policies. The regulatory changes affecting the two available treatments, methadone and buprenorphine, are presented below.

Regulatory framework for substitution treatment in France in 2000

	Buprenorphine	Methadone
Came into force	Early 1996	1994
Criteria for inclusion	Assessed as dependent on opiates by a medical practitioner	Assessed as dependent on opiates by a medical practitioner + urine test (for opiates other than methadone)
Prescription	Start of treatment and follow up in an urban medical practice CSST First prescription and continuation of treatment in course possible in prison.	Start of treatment in a CSST and follow up possible in an urban medical practice First prescription possible in prison environment if CSST internal or external. Continuation of treatment in prison environment. Initiation of treatment in hospital under consideration.
Maximum duration of prescription	28 days	14 days
Posology	Recommended maximum of 16 mg/day but no limit	Recommended maximum of 100 mg/day but no limit
Delivery	Delivery in pharmacy in all cases Delivery in batches for maximum periods of 7 days with the possibility of a single delivery for a maximum period of 28 days at the request of the doctor.	Administered under supervision in a Specialised Care Centre for Drug Addicts or issue of the medicament for up to 14 days. Maximum delivery in pharmacy, 7 days' supply.
Urine tests	Not anticipated	1 or 2 per week in the first 3 months then twice a month. As considered necessary by the doctor if supervised in urban practice. Always carried out in a Specialised Care Centre for Drug Addicts.
Payment for treatment	Common regulations if followed-up by the city services	Gratuity then common rules if taken over by the city services

Source: DGS

Since the **order of 20 September 1999**, regarding the application of the regulations controlling narcotics to certain medicaments based on buprenorphine, the maximum issue of buprenorphine has been for maximum periods of 7 days with the possibility of a single issue for a maximum period of 28 days at the request of the doctor and for special reasons relating to the patient's situation.

The **decree of 8 February 2000**, regarding the fractionated delivery of medicaments based on methadone, fixes the maximum duration of prescription for this medicament at 7 to 14 days, but the maximum issue in pharmacy at 7 days.

A project is currently being drawn up that envisages the extension of the Authorisation to Place on the Market [*autorisation de mise sur le marché*] (AMM) to allow the first prescription to be issued by doctors practising in health establishments.

9.4 After-care and re-integration

Housing

In France, the post-cure and re-socialisation programmes are mostly integrated in the general system of specialised care (see chapter 9.3.1 of Part III).

Two ***Sleep-in*** offer emergency overnight accommodation to dependent drug users whose situation is highly insecure; during their time in these facilities, users have access to medical and social consultations.

Measure in connection with the departmental agreements on objectives:

Accommodation for those subject to a court order or leaving prison and combined with appropriate medical and social support is a priority in the departmental agreements on objectives.

9.5 Interventions in the Criminal Justice System

The circular of 17 June 1999 "*regarding judicial responses to addicts"* recalls that, in addition to its illicit nature, the use of drugs is also an at-risk behaviour requiring a medical and social, for minors even an educative, response. (cf. 1.2). For this reason, the text proposes that the courts should more frequently have recourse to measures alternative to legal proceedings and imprisonment. Two strong lines emerge from this text:

- improved development and co-ordination of the as yet diffuse actions encouraging those concerned to turn to the medico-social sector,
- ensure that at all stages of the procedure, from arrest to execution of sentence, access is open to the medical care systems by means of a wide range of appropriate responses: in particular, alternatives to proceedings, encouragement to seek treatment, social education under court supervision and the alternatives to incarceration. This approach suggests that the imprisonment of those who are only users should only come into question for those who are a danger to themselves or others.

The public prosecution officials (prosecutors and their deputies) decide on the course of action with regard to offences detected by the police and the gendarmerie, the action of whose CID they direct. The most serious cases give rise to the opening of a judicial enquiry, the investigation being then led by the examining magistrate before the court or, in some cases of trafficking by organised gangs, the court of assizes is called on to pronounce on guilt and sentence. The sentences are executed by the Prison Administration, whether in prison or outside (mostly for probationary sentences); minors are supervised by officers of the court of juvenile protection.

At the Ministry of Justice, the Office for Fighting Against Organised Crime, Trafficking in Narcotics and Money Laundering is responsible for directing and co-ordinating public action.

For some years, liaison officers have been in position in French embassies in Europe and the United States. Together with their foreign counterparts in Paris, they facilitate international legal co-operation, especially in the field of fighting against narcotics.

In procedures involving the users of narcotics, the prosecutors' departments are in close contact with the appropriate health and social authorities, in particular by the use of mandatory treatments as an alternative to court proceedings. Where proceedings are taken, the sentences pronounced by the court aim most frequently to allow treatment where this is found to be necessary, to ensure social rehabilitation and to diminish the risks of recidivism. The execution of sentences is followed up and arranged by the judges for the implementation of sentences in collaboration with the rehabilitation and probation services of the Prison Administration.

When the user is a minor, it is the judge in the juvenile court who decides on the educational assistance or penal measures that are to be applied. The officers of the Judicial Juvenile Protection take control of these compulsory care measures for minors who are consumers of psychoactive substances.

With the exception of some deputies, there are, amongst the justice services, no structures specialising in the fight against infringements of drug law. In full-time equivalent, the number of magistrates who devote their activity to the fight against infringements of the legislation on stupefacients was estimated at 200 in 1995, to which can be added 400 court civil servants. 3,400 employees and care officers of the Prison Administration devote their time to this activity.
The departmental agreements on health and justice objectives define the priorities of judicial policy with regard to the users of illicit drugs at a local level.

The provision of medical and social guidance and advice in connection with the courts and the follow-up of treatment orders imposed

Addiction offices are being established in the courts in order to facilitate diagnosis and guidance on the situation of drug users. In the absence of any agreement, it is the section in charge of treatment orders that is responsible for medical and social guidance and referral arising from the justice system. If there is a voluntary service recognised by the Departmental Management for Health and Social Action [*Direction départementale d'action sanitaire et sociale*] (DDASS), this can be designated as a permanent point of reference.

The record of treatment orders drawn up in 1997 by the Ministry of Employment and Solidarity shows a continued improvement in relations between the state prosecutors and the DDASS, with the development of co-operative methods that operate formally (agreements on objectives and guidelines for treatment orders) or informally (regular consultative meetings).

In 1997, the follow-up was provided in 37 departments by general practitioners with whom the DDASS had signed a supply contract, in 26 departments by a treatment order section set up within the DDASS or in premises close to the court and in 16 departments by a CSST under a service agreement with the DDASS.

The average period for a treatment order had converged on about 5 months in 1997 but could vary from a single appointment to follow-up for an entire year.

Alternatives to court proceedings

The DDASS take responsibility for the implementation of the presentation for treatment orders made by the courts and for the diversification of the forms of treatment available to those with a drug use problem who are subject to court supervision.

Closure with referral

The prosecution departments have the option of closing a procedure on condition that the arrested user attends a medical and social guidance interview. Unlike the treatment order, this measure is intended to be applied to users whose dependence has not been established.

Encouragement to seek treatment

A user under threat of court proceedings can voluntarily engage in a treatment or rehabilitation procedure before appearing before the magistrates' court. According to this principal of encouragement to seek treatment, the accused must be able to obtain appropriate guidance from the judicial system. Even if no court order is made, the court will take this voluntary initiative into account in pronouncing sentence.

Alternatives to imprisonment

These measures are applied to those found guilty of the offences of which they are accused, they are followed up by the Prisons Rehabilitation and Probation Service [*Service pénitentiaire d'insertion et de probation*] or SPIP. The SPIP, under the control of the Judge responsible for the Application of Sentences [*Juge d'application des peines*] (JAP), identifies the local social, medical or other facilities, which can be used in meeting the obligations imposed.

Suspended sentence with probation and obligatory treatment

A prosecuted user can be given a suspended sentence with probation requiring the user to accept obligatory treatment under the supervision of the *Juge d'application des peines* (JAP). The sentence is entered on his criminal record.

The *Juge d'application des peines* can also decide to adjourn sentencing to the end of a period of probation. The decision on sentencing is then suspended for a defined period during which the user is required to undergo medical treatment. At the end of the period, the user's compliance is taken into account in pronouncing sentence.

Community service [*travaux d'intérêt général*] or TIG

The *Juge d'application des peines* can propose that the user before the court should volunteer for community service. This is unpaid work, carried out for a local authority, and can range from 40 to 240 hours.

Departmental agreements on objectives [*conventions départementales d'objectifs*] (CDO)

Please refer to the section "*Status of the implementation of departmental conventions on objectives"* under *"Penal policy implementation"* of chapter 1.2.

Rehabilitation facilities of the type, "Prison Leavers' Units"

The rehabilitation of drug users leaving prison was also one of the points in the government programme of 1990.

Since 1997, the arrangements for the control of addictive behaviour in prisons have been backed up by the Prison Leavers' Units [*Unités pour sortants*] (UPS), facilities for preparing prisoners due for release and presenting a dependency problem for their release into public life. Started in 1992 with the "intermediate prison leavers' quarters" of the Fresnes prison, seven further UPS have since been set up in prisons in Lille, Lyon, Strasbourg, Marseilles, Metz, Nice and in the Fresnes women's prison. Concretely, the UPS are special detention units in which detainees presenting dependency problems are placed, usually for the month preceding their release. They benefit from group activities (sports, theatre etc.), pre-employment training and help with administrative procedures (lodging etc.). These units make use of group dynamics to bring the "trainees" to work on their self-esteem and their relationships with the group and with others. The UPS are managed and staffed by a CSST within the prison.

About 100 to 200 benefit from training in these units each year. This variation is explained by variations in the numbers of participants and the frequency of courses: on the seven sites, some four to five courses are organised each year with four to six prisoners per course.

In response to organisational difficulties brought to light by the evaluation of the process undertaken in 1999, in particular in the "recruitment" of the prisoners benefiting from these courses, at the end of 2001, the central supervisory administrations are to redefine the framework for the implementation of these UPS facilities to make it more flexible.

Other local arrangements for the co-ordination of judicial, medical and social responses.

In order to provide responses to addiction that meet users' needs as closely as possible, the judicial authorities must collaborate closely with other workers and networks in the field, both institutions and associations. This especially involves a close participation of the legal and police services in the local partnerships dealing with the combat against drugs and addiction. It requires, as a precondition, internal co-ordination between the magistrates, the representatives of the prison administration and the legal youth protection service, especially within the urban justice units.

Apart from the departmental conventions on objectives, the representatives of justice participate in the **select committees on the fight against drugs and drug addiction**. These bodies perform a co-ordinating function with the departmental councils for the prevention of delinquency acting in a consultative capacity (Prime Minister's circular of 09 July 1996 regarding the combat against drugs and addiction at the departmental level).

The **local security contracts** draw up an inventory of the local arrangements for prevention, enforcement and care. They should seek to reduce barriers between these individual arrangements, laying down the principles of communication between them and defining individual projects, such as the creation of suitable community service places, in collaboration with the local elected representatives.

9.6 Specific targets and objectives

With regard to alternatives to court proceedings and imprisonment, see the previous section.

No other information available.

10. Quality Assurance

The attention to quality is one of the new features in the MILDT three-year plan for fighting drugs and the prevention of dependence for the 1999-2001 period. The new policy lines of the plan favour a "quality" approach whose main characteristic is its horizontal nature. In other words, with regard to the demand reduction activities in the various sectors (whether in the area of prevention/training, of care provision or of enforcement), the plan defines a horizontal action which manifests itself in the forms described below:

- promotion of an evaluation of public policies in order to contribute to its permanent development at the institutional level,

- structuring and development of research in order to better support the feedback between scientific and decision making communities (the authorities).

- promotion of training to enable professionals to improve their knowledge and optimise their responses.

10.1 Quality assurance procedures

In order to embed a quality approach in French anti-drug policies, it is essential to set up mechanisms for informing the public not only of the results of actions carried out that are financed from public funds but also of the relevance of objectives defined in order to resolve problems that have been recognised or to respond to the needs of a deprived section of the population.

A pluralist approach to the conception and implementation of policy and the evaluation of the results

It is indeed the case that the plan and the institutional system on which it is based, translate this political will of the decision-makers to place the programming, implementation and evaluation of the national strategy within the framework of a pluralist approach. It is clear that taking account of the various viewpoints of the players involved and the discussions that can result would favour transparency and credibility in decision making and the consequent actions - in short, a quality approach.

Communications to legitimise public actions

It is also necessary to ensure that a communication and information policy is maintained to make the grounds for and legitimacy of this public action clear. In this respect, the plan defines guidelines that seek to make valid information available to the whole population in order to improve its capacity to make appropriate responses. This information should deal with behaviour patterns, substances and the policies applied. It should also serve as a reminder of the legal framework. These objectives are as follows:

- to pursue a voluntary communications and information policy, which should be long-term,
- to engage in more precisely targeted actions directed at the young, professionals, elected representatives and opinion-makers and, in particular, suitable for the special needs of the overseas departments,
- to open an Internet site giving access to data and knowledge relating to drugs and dependence; it should be equally accessible to the general public and to professionals and scientists.

- to set up a national network of drug and dependence information and resource centres,
- to reorganise the Drugs Info Service (its name will be changed) to respond to calls with regard to all psychoactive substances; it will be accessible from the overseas departments and will also provide an electronic mail service.

The MILDT is giving very special attention to the quality approach to its policies. However, this approach cannot be properly supported until appropriate mechanisms have been developed and suitable machinery made available to decision-makers and professionals. Indeed, one thing implemented by the MILDT was to provide itself with appropriate mechanisms for the best response to its needs for scientific expertise and, in the end, provide an aid to political decision-making.

Within this framework, the political entity - the MILDT - has set up a directly attached, permanent scientific committee. This committee of experts and institutional representatives participates closely in the selection of candidate projects amongst the responses to calls for tenders organised by the Interministerial Mission. It also has recourse to working groups or consultative commissions when it wishes to start a particular enquiry, go into greater depth on a particular matter or validate a procedure. By way of example, we shall mention the commission for the validation of preventive tools made up of both institutional representatives from the various ministries concerned and of recognised experts in the field of prevention.

Finally, the MILDT bases its actions on the expertise available from the collegiate scientific committee of the OFDT. This body is made up of representatives of the major data collecting organisations as well as individually nominated personalities. These personalities are recognised experts in the fields considered by the group. The collegiate scientific committee is consulted on projects entering into the work programme of the OFDT and gives its opinions on these projects, their progress and their results.

With regard to the principles to be followed within the framework of a quality approach, five main criteria have been laid down for the preparation of studies and reports. They serve to shed light on the decisions of the authorities and follow the criteria of the Scientific Evaluation Council:

- the usefulness and relevance of the information produced,
- the reliability of the information collected in order to avoid bias in the conclusions drawn and lessons to be learned,
- objectivity with regard to the personal preferences or the position of the commissioning persons,
- the possibility to generalise on the basis of the conclusions,
- the transparency of the process with regard to the conditions under which it is carried out, its position with respect to similar work and its current limits.

10.2 Evaluation (Treatment and prevention evaluation)

The evaluation of public policies is one of the priorities defined in the guidelines of the interministerial plan. In this respect, two actions were taken:

- on the one hand, the establishment of a global evaluation framework for the actions in the plan,
- on the other, the development of a centre of expertise.

In order to do this, the MILDT mandated the French Observatory of Drugs and Drug Addiction [*l'Observatoire français des drogues et des toxicomanies*] (OFDT) to contribute actively to the realisation of these two tasks.

Establishment of a global evaluation framework

In the interests of methodological rigor, considerable effort was devoted to preparing the evaluation of the plan. As a first step, the MILDT prepared an evaluation contract, which was awarded to the OFDT and approved in interministerial committee (by the 17 ministerial departments concerned).

This contract served to set down:

- the ends to be served and contributions expected from the evaluation (in other words, the use that the authorities were expected to make of the results of the evaluation of the plan),
- the field to be covered by the evaluation with regard to the conception, implementation and first results of the plan,
- the evaluation criteria required by the commissioning bodies, namely: relevance (reconciliation of the requirements not covered and the stated objectives), coherence (complementarity) and effectiveness (efficacy of the implementation); so far as possible, efficacy (achievement of objectives relative to the results obtained) would also be appreciated.

As a second step, an evaluation reference document was drawn up by the OFDT and approved in interministerial committee. Its preparation formed a part of a participatory action with those responsible for drawing up the plan. This structural tool made it possible to identify specific objectives susceptible of evaluation, that is to say, realistic, measurable and limited in time. With regard to these specific objectives, the list of actions, of arrangements or programmes covered by the field of evaluation were levelled by identifying what is innovative (new measures) and what is a continuation or modification of earlier measures.

In particular, the reference document served to define the most important lines of evaluation of which two are sectoral in nature (training and alternative care facilities) and two are operational (Departmental Conventions on Objectives and the Departmental Prevention Programmes). Within this general working framework it may also be possible to integrate valuations of particular arrangements.

Method for carrying out an evaluation project

Within the framework of its missions, the OFDT developed a partnership with the various ministries and/or professional bodies concerned in order to define the specifications relating to the evaluation projects. This work, prior to starting the evaluations, made it possible to define the requirements more precisely; they are three:

- to take stock of the knowledge and available information available in the field under evaluation,
- to define evaluation questions,
- to define recommended methodological guidelines for the realisation of the investigations.

Furthermore, the institute organised a call for projects and the selection of external providers for the realisation of these evaluations. These were selected by competition between public and private organisations short-listed after a limited consultation. The heads of studies ensured that the quality approach was maintained through their running of the steering committees. Throughout the process and especially during the study approval procedure, they also drew on the competencies and qualifications of the collegiate scientific committee of the OFDT and, in particular, of the evaluation commission.

The quality approach adopted was constructed around the various documents that the evaluation teams were required to present to the steering committees: the study protocol and the information gathering tools, the intermediate report(s) and the draft of the final report.
The study methods and tools were examined in steering committee to ensure that they were the most suitable for the field under study.
The submission of an intermediate report at key stages in the evaluation made it possible to take account of the working conditions encountered by the evaluator and:

- reframe the expectations of the commissioning bodies,
- readjust the study protocol (experience can show that certain lines of enquiry are not very feasible) or
- establish or consolidate the best possible working conditions for the evaluation team.

The draft final report was drawn up when the results and conclusions could be produced. It was subject to the approval of at least two experts from the collegiate scientific committee who were specialists in the study area or the methodology used. If the subject demanded it, the OFDT could call on external reporters.
This procedure made it possible to evaluate the scientific quality of the work, its conformity with specifications and the distribution of the document. A certain number of corrections could be required of the authors following this proofreadingIn the event of disagreement amongst the various reporters on these points of judgement, the Evaluation Commission had a deciding voice.
The programme of evaluations planned for 2001:
- evaluation of the departmental conventions on justice and health objectives,
- evaluation of the section, "interministerial training",
- evaluation of the experiences in global care and the bringing together of the care facilities specialising in addictive behaviours (CSST/CCAA),
- evaluation of the departmental prevention programmes.

The order definition work was undertaken for the evaluation of the departmental conventions on justice and health objectives and the evaluation of the section, "interministerial training". With regard to the evaluation of the experiences in global care and the bringing together of the care facilities specialising in addictive behaviours (CSST/CCAA), the partnership developed with the General Health authority, as principal commissioning body, consisted of the joint definition of a descriptive grid, addressed to the DDASS to draw up the status of the projects and actions designed to bring the existing structures closer together in each French department. Finally, with regard to the evaluation of the departmental prevention programmes, the preparatory stage of drawing up the project specification was not started in 2000. This evaluation project could draw on the information and results from the APPRE programme (1999 and 2000) and from the annual activity reports of the "Drugs and Dependence" project managers.

10.3 Research

The three-year plan to fight against drugs and prevent dependence (1999-2001) makes the improvement and dissemination of available knowledge in these areas one of its main priorities. Over and above the support given to research on specific topics, one of the principal aims is to contribute to the structuring and networking of the various teams working in the field of psychoactive substances.

Structure and organisation of the research system

The research system was provisionally implemented (structure, programme, funding) and co-ordinated by the MILDT in preparation for transfer to the OFDT. The latter was to see these

tasks through to conclusion in the manners being defined. The current arrangement is made up of a steering committee including the main institutions concerned by this field: the Ministry of Research, the Genaral Health Authority and the principal public scientific and technical establishments (CNRS, INSERM, INRA, INRETS, IHESI, GIP-Justice).

A scientific council of 22 members was appointed for a duration of about two years to direct and programme the research during this period. These opinions were then ratified by the supervisory authorities of the steering committee.

The MILDT was responsible for programming, structuring and funding the research. This task is implemented through an annual call for offers supporting projects submitted by laboratories, research organisations and independent researchers.

In 2000, the MILDT issued a call for offers aiming to promote scientific work on the use and/or dependence on permitted and illicit psychoactive substances including alcohol, tobacco and psychotropic medicaments as well as psychoactive products used with the purpose of improving individual performance (psychotropic, synthetic and dope products). At the end of the consultation, 22 projects were selected.

The call for offers was addressed to all scientific disciplines and projects proposing an inter- or multi-disciplinary approach to the topics covered were particularly encouraged. The call for 2001, made jointly with INSERM, is currently in the consultation phase.

In 1999, a joint MILDT/INSERM/CNRS call for offers had been issued from which 28 research projects were selected. Finally, a joint MILDT/INSERM/NWO (France-Netherlands) call for offers was made in 2000 and led to the selection of 5 projects made up of teams from Dutch and French laboratories.

Further, the MILDT, in collaboration with the ministries of higher education and research, supports doctoral research through the funding of some ten grants for research in the area "drugs – dependent behaviour". The object is to encourage theses on use of and/or dependence on licit or illicit psychoactive substances including alcohol and tobacco and psychotropic medicaments as well as psychoactive products used with the purpose of improving individual performance (psychotropic, synthetic and dope products). The selection of the recipients and the follow-up of the research projects are carried out by the MILDT Scientific Council in consultation with the research supervisor.

The funds are now dispersed amongst the various ministerial departments active on the question of drugs and dependence. The level of expenditure for research therefore remains difficult to identify. Nevertheless, the MILDT research budget for 2000 amounted to 5 MF.

Summary reports

INSERM has established a procedure for providing responses to questions put by those responsible for public action that draw on all the latest scientific knowledge.
Two such summary reports are currently in preparation. The report on alcohol is in two sections: the first, in association with the CFES, deals with the health risks connected with the consumption of alcohol, the second deals more broadly with all the social risks connected with the consumption of alcohol (started in September 2001).

The summary report on cannabis deals with the contexts of use, the mechanisms through which the substance acts and its effects on health. The results were published in September 2001. The next planned summary report is to deal with tobacco and work on it will start in 2002.

INSERM has already made a summary report on ecstasy. An ad hoc multidisciplinary group made up of researchers and clinicians was set up in 1997. Their conclusions were made public in June 1998 in the form of a report whose first part is an analysis of the internationally available scientific, biological and clinical data on ecstasy (MDMA) while the second part is essentially devoted to an analysis of the context within which this substance is consumed in France.

Other research facilities

The mission of the ANRS is to stimulate, co-ordinate and finance research on HIV infection as well as, since 1 January 1999, clinical and therapeutic research on hepatitis C. It is distinguished in that it takes account of all scientific disciplines. The various research sectors co-ordinated by ANRS cover all the current concerns: biological research (virology, molecular biology, immunology and cellular biology), vaccination research, clinical research including clinical trials, epidemiological research and research in the sciences of man and society. Since 2000, the ANRS has issued two calls for offers each year for work on all aspects of HIV/AIDS, research on other retroviruses relevant to an understanding of the pathology of HIV infection and clinical research, public health research and therapeutic trials on hepatitis C.
Created in 1993, the PHRC contributes to medical research in the area of public health and seeks to encourage university hospital teams to contribute to research from their treatment work. The objective was, by providing these teams with funds of their own, to enable them to establish the required relations with upstream research partners, be they industrial teams or academics under the financial supervision of the Ministry of Education and Research, especially certain university laboratories and those of the public establishments with a scientific and technological purpose [*établissement public à vocation scientifique et technologique*] (EPST): the CNRS and, above all, INSERM, which, with more than 300 units is widely established in the university hospital centres [*Centres hospitaliers universitaires*] (CHU). The PHRC 2000 had a planned national budget volume to cover a restructuring of the DRC. It was sufficient to cover the recruitment of clinical research technicians and favour - in partnership with INSERM - the establishment of new clinical investigation centres.
More recently, a mixed (CNRS/university) unit has been set up for human and social science research on the question of drugs and dependence.

10.4 Training for professionals

In the field of drugs and the prevention of dependence, the workers involved can come from various institutional organisations: decentralised state services, local authorities etc. They may also come from associations, the education or social sectors, or organisations specialising in the reception of the users of drugs, alcohol or tobacco.
In order to contribute to the creation of a common culture, based on confirmed knowledge, amongst all these professional workers in prevention, education, treatment and enforcement, training sessions are organised along three main lines:

Promote the integration by various ministries of the problem of addiction in initial and further training:

A diploma of specialised further studies in addiction was created in 1999 in order to afford university recognition to competence acquired in the fields of alcoholism and addiction. Further training courses were organised in 2000 by the Ministry of Agriculture for boarding masters and initial training teachers. Five interdisciplinary meetings were organised by the Ministry of National Education in collaboration with the MILDT to support, in particular, the development of the Health and Citizenship Education Committees [*Comités d'éducation à la santé et à la citoyenneté*] (CESC).

Train officers of the police, gendarmerie, prison service and customs liable to encounter drug users:

The Ministries of the Interior, Defence, Justice (Prison Administration) and Economy and Finance (Directorate-General of Customs and Indirect Taxation) have agreed on the integration in initial and/or further training of a minimal course unit on public health aspects. The finalised module content was submitted to the ministries in February 2001. An experiment is also running on four sites of the module in order to deliver specific training to youth protection court professionals confronted with the problems of young consumers.
The content of the initial training for anti-drug training police officers (PFAD) and part-time anti-drug training gendarmes (FRAD) was revised in 2000 (see below). In addition, "drugs and addiction" contact officers have been nominated in each regional customs office.

Ensure that a common training is provided for all those working in the field of prevention:

An inventory was made of the main initial and further training for state employees on the basis of which it was possible to define a common knowledge foundation for state employees. A trial of this foundation knowledge was made on the occasion of an interministerial training course. With the circular sent to departmental project managers in December 2000, a common framework is now established for training courses of an interministerial nature at regional and departmental levels.

PART 4 KEY ISSUES

11 Multiple drug use: settings and drugs concerned

11.1 Patterns and user groups

11.1.a Drug combinations and effects sought

The information in 11.1.a comes from the TREND monitoring system which observes the emergence of new consumption patterns in the party scene: here it is essentially a question of use with the aim of regulating the effects.

The multiple consumption of psychoactive substances is a behavioural pattern observed in the settings studied by the system for monitoring recent trends (Bello et al, 2000) in both urban and party/festival settings.

An interpretation of this widely known behavioural pattern must take account of the reasoning behind the behaviour. Within the interpretative framework, it is preferred to drop the idea of multiple consumption in favour of that of "regulation of consumption", defined as the use of substances in combination with the purpose of modifying the effects of other substances already consumed where this use can be either concomitant or delayed in time.

In the case of illicit drugs, it can happen that, on their own initiative, users consume several substances at once. This is particularly frequent in the specific case of ecstasy as is shown by the analysis of the composition of samples collected in France.

Effects sought and regulation of consumption

Some forty different associations of psychoactive substances that can be classified as regulated consumption have been catalogued by the monitoring system's observers.

Functions and effects of the simultaneous or consecutive use of different psychoactive substances

Regulatory function	Effects	Two substances used simultaneously or consecutively
Maximisation of effects	Accelerate and accentuate the high	1) Laughing gas for LSD ; 2) Laughing gas for ecstasy ; 3) Cannabis for ecstasy
	Enhance the effects	1) Benzodiazepines for opiates ; 2) GHB for ecstasy ; 3) Cannabis for opiates ; 4) Ketamine for LSD
	Prolong the effects	1) Ecstasy for Ketamine ; 2) Cocaine for ecstasy ; 3) Alcohol/cannabis for LSD
	Restart the effects	1) Speed for LSD ; 2) Speed for ecstasy ; 3) Speed for LSD ; 4) GHB for ecstasy ; 5) Laughing gas for ecstasy
Balancing the effects	Add a component	1) Ecstasy for LSD (*love* component) ; 2) Speed for ecstasy (*speed* effect)
	Mask a component	1) LSD for ecstasy ; 2) Cocaine for ecstasy
	Counterbalance the effects	1) Cocaine for ketamine ; 2) Cocaine for alcohol (and vice versa) ; 3) Speed for alcohol (and vice versa)
Controlling the negative effects	Reduce a big high	1) Opiates for stimulants ; 2) Cocaine for ecstasy or LSD ; 3) Cannabis for stimulants ; 4) Alcohol for LSD ; 5) Cannabis for LSD
	Soften the come-down	1) Benzodiazepines for stimulants ; 2) *Rachacha* for hallucinogens ; 3) Cocaine for LSD ; 4) Cannabis for crack and speed ; 5) GHB for ecstasy ; 6) Alcohol for LSD ; 7) Ecstasy for LSD ; 8) Cannabis for LSD ; 9) Opiates for stimulants
	Cancel and neutralise the effects	1) Cocaine/speed for LSD (neutralise the "wandering thoughts"); 2) Cocaine for ecstasy.
Exchange	Manage shortage	1) Between opiates (Neocodion® for heroin)
	Substitute effects	1) Cannabis with speed to avoid taking LSD or ecstasy

Source: TREND 1999, OFDT

The associations of substances can be classified according to their effects and grouped under four functions:

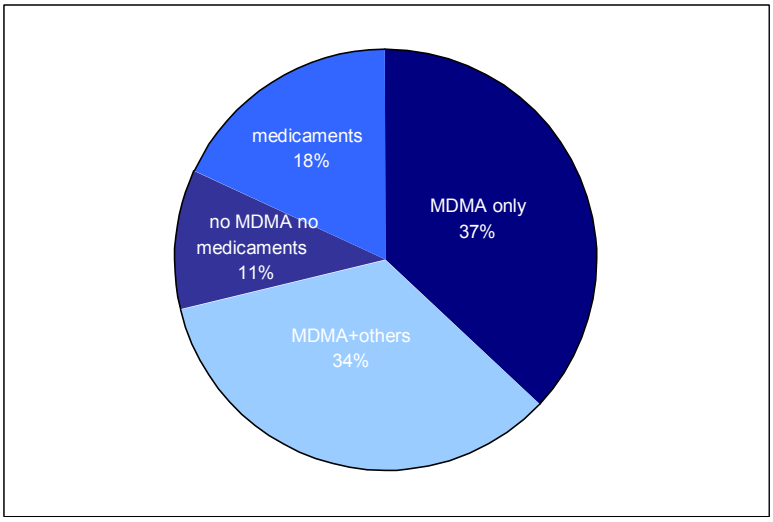
- maximising function: the object is to obtain the maximum "positive" effect from the association of several substances where the effect is not a simple quantitative cumulation but a qualitative modification,
- counterbalancing function: the effects are mutually corrective, allowing the user at any time to match the effects experienced to changes in circumstances or to experiment as he wishes with various states,
- cancellation function: the object is to cancel out the "negative" effects, leaving only the "positive"; this applies, in particular, to the "come-down" phase where the "positive" effects disappear, leaving only the "negative" (discomfort, sickness, deprivation),
- exchange function: fills the need to replace a product while retaining the effect, either because it is not readily available or because of a change in perception.

Involuntary multiple consumption: the case of ecstasy

The SINTES database enables a special analysis to be made of the products sold as ecstasy but not always containing MDMA. This analysis is made possible by the field data collected by the medico-social partners, in particular the product names, the supposed contents and the desired effects.

During 2000, 442 samples were collected that were considered by the users to be ecstasy or MDMA. Analysis showed that these samples did indeed contain MDMA in 78% of cases while in 15% of cases they were made up from medicinal substances, MDA (in 6%), caffeine (5%), amphetamines (5%), MDEA (2%) and 8% of samples contained no active ingredient.
A specific analysis of 262 samples collected during the first half of 2000 and sold as ecstasy showed that only one third contained MDMA as the sole active ingredient. In two thirds, other active ingredients, notably medicaments, were found.

Distribution of samples collected during 2000 and sold as ecstasy by composition *{302a}*



N = 262

Source: SINTES 2000, OFDT

11.1.b Patterns and user groups: historical perspective and new patterns

The information in 11.1.b comes from surveys amongst the general population. In surveys of the general population, multiple experimentation refers to the fact of having tried several psychoactive substances. Most of the time, the study is limited to the three most common substances: tobacco, alcohol and cannabis. In this sense, a person who admits to having smoked one cigarette and drunk one glass of wine at some time in his life is a multiple experimenter. Multiple consumption refers to the consumption, with a certain frequency, of several psychoactive substances and, most of the time, it is once again consumptions of tobacco, alcohol and cannabis that are studied.

This analysis, based on unconnected questions, ("Have you already taken cannabis?" then "Have you already drunk alcohol?"), fails to detect simultaneous or consecutive uses amongst the majority of successive uses. On the other hand, different questions aim precisely at the detection of substances being taken together (indicated here by the term "mixed"). The most effective way of obtaining information on this topic is to put an open question and note the names of the substances consumed on such occasions. The question was formulated in this way in two recent surveys, one amongst the adult French population (Beck et al, 2001), the other amongst young people at the end of adolescence (Beck et al, 2000). In the European survey of young people in schools (Choquet et al, 2001), a closed question was put and they were to tick how many times they had taken alcohol with cannabis and alcohol with medicaments. The thresholds used to define the indicators of repeated use are given in each part.

These are, therefore, very different observations from those presented earlier as the results of observations of recent trends in urban and party/festival settings (Bello et al, 2000).

The historical information is mainly based on qualitative work since the '80s, especially that carried out by the IREP (Ingold). This underlines the importance of associations such as medicaments and alcohol, and this since the '70s, as well as the development of a practice of associated consumption on the arrival of substitution (Indicators and trends, 1999).

Multiple consumption amongst the general adult population

Multiple experimentation

Since many of those over 18 have tried both alcohol and tobacco, multiple experimentation will be discussed here essentially from the point of view of illicit substances. In addition, since experimentation with these substances is very rare in those over 44, only the 18-44 age group will be studied here. Two complementary indicators are presented.

The first is the average total number of substances tried by those who have tried a given substance. Those who have tried cannabis admit to having tried an average of 1.4 substances out of the eight considered (cannabis, amphetamines, cocaine, LSD, heroin, ecstasy, medicaments "for the effect" and inhaled products), which is a relatively small number compared to the whole population. From this point of view, they are similar to those who have tried inhaled products whereas those who have tried heroin or ecstasy have experience of more than half the illicit substances considered (4.7 and 4.2 respectively) (Beck et al, 2001).

The second indicator is the proportion of those who have tried a given substance who have also tried another. This shows which multiple experimentations are the most frequent. Thus, nearly three quarters (72%) of those who have tried heroine have already taken cocaine and nearly four out of ten who have tried ecstasy have also tried amphetamines and vice versa. The level of experimentation with medicaments "for the effect" is very close to that for "hard drugs" (heroin, ecstasy, cocaine etc.).

Analysis of multiple experimentation with illicit substances amongst the general adult population from 18 to 44 years of age in 2000 by product

(% in line and average number)

Experiment-ation with…	Cannabis	Ampheta-mines	Cocaine	LSD	Heroin	Ecstasy	Medica-ments [1]	Inhaled products	Number of substances tried [2]
Cannabis	n = 2 099	4.4	7.1	7.4	3.4	4.3	2.7	9.7	1.4
Amphetamines	82.3	n = 113	45.1	53.1	25.7	36.6	18.6	25.7	3.9
Cocaine	94.1	32.3	n = 159	48.4	34.0	30.8	16.4	26.4	3.8
LSD	96.9	37.3	47.8	n = 161	29.8	30.9	21.0	29.6	3.9
Heroin	95	39	72	64	n = 75	35	23	41	4.7
Ecstasy	96	45	52	53	28	n = 94	18	26	4.2
Medicaments [1]	86	32	39	52	26	26	n = 66	36	3.9
Inhaled products	70.5	10.1	14.5	16.6	10.7	8.3	8.3	n = 289	2.4
Total of 18 - 44-year-olds	32.1	1.7	2.4	2.5	1.2	1.4	1.0	4.4	0.47

[1] *The full heading is "medicaments 'for the effect'".*

[2] *On average, of all the substances in the table*

Interpretation (heroin line): there were 75 in the sample who had tried heroin (n=75). Of these, 95% had also tried cannabis, 39% had tried amphetamines etc. On average, these people had already tried 4.7 different illicit drugs (including heroin).

Source: Health Barometer 2000, CFES, Annual Report OFDT

While nearly all those who have experimented with illicit substances have smoked cannabis, only a small group of users of relatively rare substances including the "traditional hard drugs" are particularly concerned in multiple experimentation. On the other hand, it is relatively rare for those who have tried more "common" substances, such as inhaled products and especially cannabis, to have tried other substances.

Multiple consumption

There are two major reasons for limiting the study of multiple consumption in the adult population to alcohol, tobacco and cannabis and a restricted age-range. On the one hand, these are the most frequently consumed substances while consumption of the other illicit substances is very rare; on the other hand, experimentation with cannabis is almost no-existent amongst those over 45 years of age. The type of multiple consumption selected is, therefore, the repeated consumption of at least two of the above three products with a minimum of: one cigarette per day, three alcoholic drinks during the last week, ten uses of cannabis during the last ten months.

Repeated multiple consumption affects 15% of the population from 18 to 44 years of age. The most common association is "alcohol-tobacco", followed by "tobacco-cannabis", "alcohol-tobacco-cannabis" and, "alcohol-cannabis". The cannabis users are younger than average, unlike others: indeed, the repeated consumption of alcohol rises with age. The majority of all multiple consumption groups are men, especially where the two substances most frequently consumed by men, alcohol and cannabis, are present together.

Repeated multiple consumption of tobacco, alcohol and cannabis amongst the general adult population from 18 to 44 years of age in 2000

Repeated multiple consumption of…	**In % 18 - 44-year-olds** % in line (numbers)	**% of men** % in line	**Average age** in years
Alcohol-tobacco	9.6 % (627)	70.0 %	33.5
Tobacco-cannabis	3.4 % (222)	67.1 %	24.5
Alcohol-tobacco-cannabis	1.7 % (109)	82.6 %	27.1
Alcohol-cannabis	0.4 % (27)	80.8 %	25.4
Total of 18 - 44-year-olds	100.0 % (6 535)	48.5 %	31.4

Source: Health Barometer 2000, CFES, Annual Report OFDT

It is amongst the consumers of cannabis that we find the highest proportion who have tried other illicit substances: consumers of tobacco and alcohol have tried 0.7 on average whereas the others have tried about 2 (1.8 to 2.3 on average for triple consumers). These results reflect, to a large extent, the spread of cannabis and these other substances amongst the population. Amongst repeated multiple consumers of tobacco, alcohol and cannabis, it is LSD and cocaine that have most frequently been tried.

Repeated multiple consumption of tobacco, alcohol and cannabis with other substances tried amongst the general adult population from 18 to 44 years of age in 2000

(% in line and average number)

Repeated multiple consumption of…	Other substances tried…								Number of substances tried [2]
	Cannabis	Amphet-amines	Cocaine	LSD	Heroin	Ecstasy	Medicaments [1]	Inhaled products	
Alcohol-tobacco	49.8	1.9	3.7	3.7	1.9	1.3	1.4	6.4	0.7
Tobacco-cannabis	100.0	11.7	16.7	18.6	10.4	16.2	7.2	18.9	2.0
Alcohol-tobacco-cannabis	100.0	12.8	26.6	25.7	13.8	18.3	9.2	20.2	2.3
Alcohol-cannabis	100	11	22	19	7	15	0	7	1.8
Total of 18 - 44-year-olds	32.2	1.7	2.4	2.5	1.1	1.4	1.0	4.4	0.5

[1] *The full heading is "medicaments 'for the effect'".*
[2] *On average, of all the substances in the table*

Source: Health Barometer 2000, CFES, Annual Report OFDT

Simultaneous use of a number of substances

Of the 18 to 44-year-olds, 19.2% admit to having taken at least two psychoactive substances on a single occasion ("mixing"). In 90% of cases, these are alcohol and cannabis; in the other cases, these are mostly mixtures based on alcohol and (or) cannabis with the addition of cocaine, medicaments or LSD.

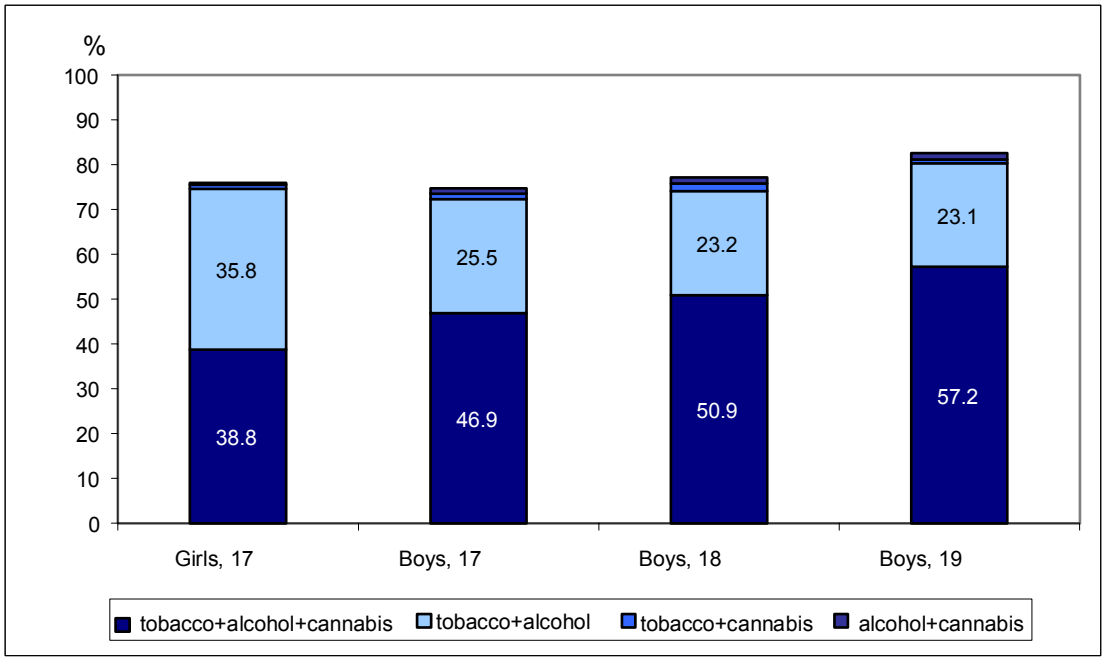
Nearly three quarters of repeated multiple consumers admit to having already tried such "mixtures", especially those who use cannabis (more than four fifths as against little more than half for the rest). There is little variation in the composition of these mixtures: once again, in 90% of cases, these are mixtures of alcohol and cannabis or of alcohol and (or) cannabis with another substance, most often cocaine or ecstasy. Medicaments are rarely involved in such consumption (less than 2% of cases, mainly with alcohol or cannabis) and other illicit drugs are rarely mentioned (Beck et al, 2001).

Multiple consumption in adolescence

Multiple experimentation

At the end of adolescence, almost 80 % of young people have tried a number of psychoactive substances. In most cases these are alcohol, tobacco and cannabis. Experimentation with the last in isolation is rare, even if a small handful of young people, almost all boys, is to be found amongst those who have never smoked tobacco. This confirms that cannabis users make a clear distinction between the two substances, even though cannabis is almost always smoked with tobacco, but also suggests that some users may, in fact, use it without tobacco.

Frequency of multiple experimentation with tobacco, alcohol and cannabis amongst young people at the end of adolescence in 2000, by sex and age *{301a}*



Source: ESCAPAD 2000, OFDT

The main difference between boys and girls at 17 years of age is that girls are in the minority in the category of those who have tried all three substances. This is yet another confirmation that girls are less likely to consume cannabis. Amongst boys, those who have tried none of alcohol, tobacco and cannabis are in fairly close proportions and only the category of those who have tried all three increases with age, showing that experimentation with them in adolescence is very commonplace.

Experimenting with cannabis, more so than with tobacco, is connected with trying drunkenness and psychoactive substances other than medicaments, the last being most frequent amongst those who have tried all three substances. On the other hand, almost all adolescents (93.4%) who have tried at least one stimulant (ecstasy, cocaine, amphetamines and LSD) have also taken alcohol, tobacco and cannabis.

As in the adult population, a more detailed study, limited to experimentation with illicit substances and to young people of 17, makes it possible to distinguish three different groups of experimenters from the point of view of the number of experimentations with: cannabis, amphetamines, cocaine, LSD, heroin, ecstasy, medicaments "for the nerves" hallucinogenic mushrooms and *poppers* (the latter being, in fact, a product whose sale is controlled).

The first group is made up of those who have tried medicaments "for the nerves" and, above all, cannabis, who are both the more numerous, and have tried the smallest number of different substances (on average, 1.7 and 1.4 respectively). Then come those who have tried

ecstasy, hallucinogenic mushrooms or *poppers*, who have tried slightly under half the nine products considered here. Finally, there is the group of those who have tried amphetamines, LSD, cocaine or heroin, who are both the least numerous and those who have tried the most substances (at least 5 on average). Amongst this last group, the trials of the various substances are particularly closely linked. Indeed, almost half of those who have experimented with one of these substances have tried the other three.

Analysis of the multiple experimentation with illicit substances at 17 years of age in 2000, by substance.

(% in line and average number)

Experimentation with…	Cannabis	Amphet-amines	Cocaine	LSD	Heroin	Ecstasy	Medica-ments (1)	Mush-rooms (2)	*Poppers*	Number of substances tried (2)
Cannabis	***n = 4,518***	1.9	2.0	2.6	1.4	4.5	23.0	6.9	5.0	1.4
Amphet-amines	86	***n = 92***	50	49	38	66	55	63	43	5.3
Cocaine	94	54	***n = 88***	57	42	68	55	57	38	5.3
LSD	95.2	36.7	41.1	***n = 115***	28.4	69.4	49.1	57.9	42.0	5.0
Heroin	96	57	61	56	***n = 61***	69	55	68	45	5.8
Ecstasy	94.7	31.6	31.0	43.4	21.8	***n = 199***	43.3	48.5	29.4	4.2
Medic-aments (1)	51.5	2.6	2.4	3.0	1.8	4.2	***n = 1,925***	4.7	4.1	1.7
Mush-rooms	98.5	20.5	17.4	23.2	14.3	32.4	31.7	***n = 295***	27.2	3.5
Poppers	93.4	16.9	14.1	21.4	11.7	24.5	34.6	33.9	***n = 227***	3.4
Total of 17-year-olds	45.5	1.0	0.9	1.2	0.6	2.1	19.9	3.1	2.4	1.4

(1) *The full heading is "medicaments 'for the effect'".*

(2) *On average, of all the substances in the table*

Interpretation (heroin line): there were 61 in the sample who had tried heroin (n=61). Of these, 96 % had also tried cannabis, 57 % had tried amphetamines etc. On average, these people had already tried 5.8 different illicit drugs (including heroin).

Source: Health Barometer 2000, CFES, Annual Report OFDT

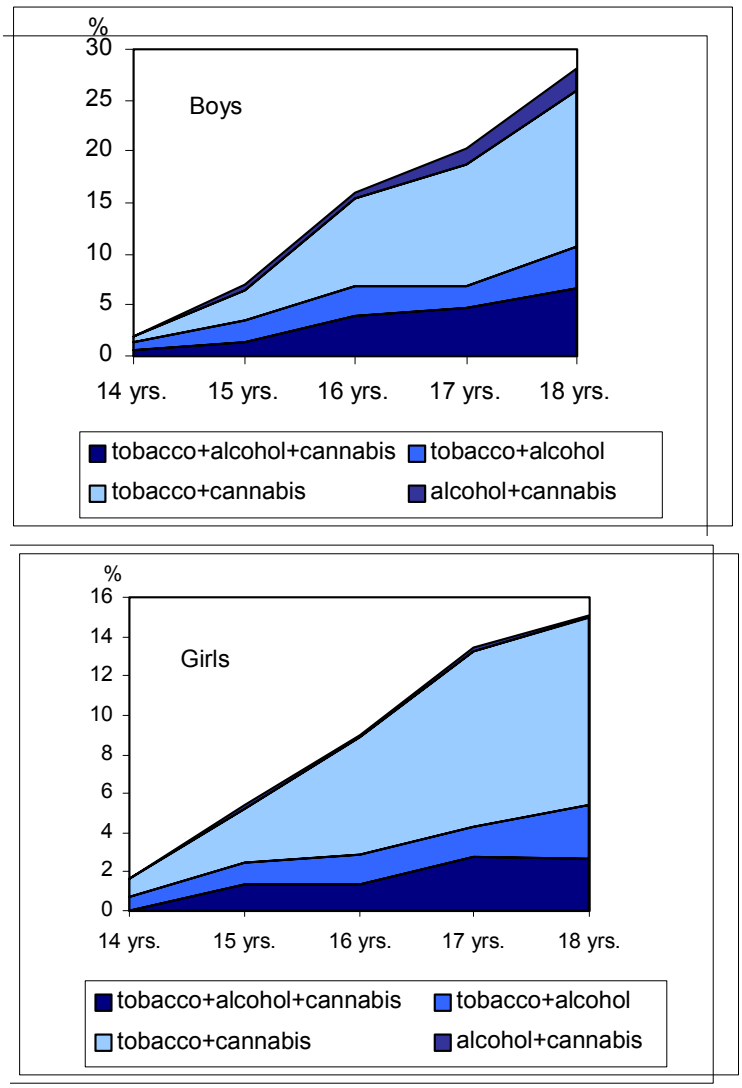
As amongst adults, we can see that there is a small group who have tried a relatively large number of illicit substances and, once again, cannabis appears as the substance that almost all users of illicit substances have tried (Beck et al, 2000).

Repeated multiple consumption

Repeated multiple consumption is defined here as the accumulation of repeated consumptions of alcohol (more than ten drinks per month), tobacco (at least one cigarette per day during the last thirty days), and cannabis (taken more than ten times during the year). As amongst the adults, four types can be envisaged (combinations of two or three of these substances).

In schools, 2% of 14 year-old boys admit to the repeated consumption of at least two products as against 28% at 18 years of age. Amongst the girls, these percentages are 2% and 15% respectively (Choquet et al, 2001).

Frequency of repeated multiple consumption amongst young people at school in 1999, by sex and age *{301b}*

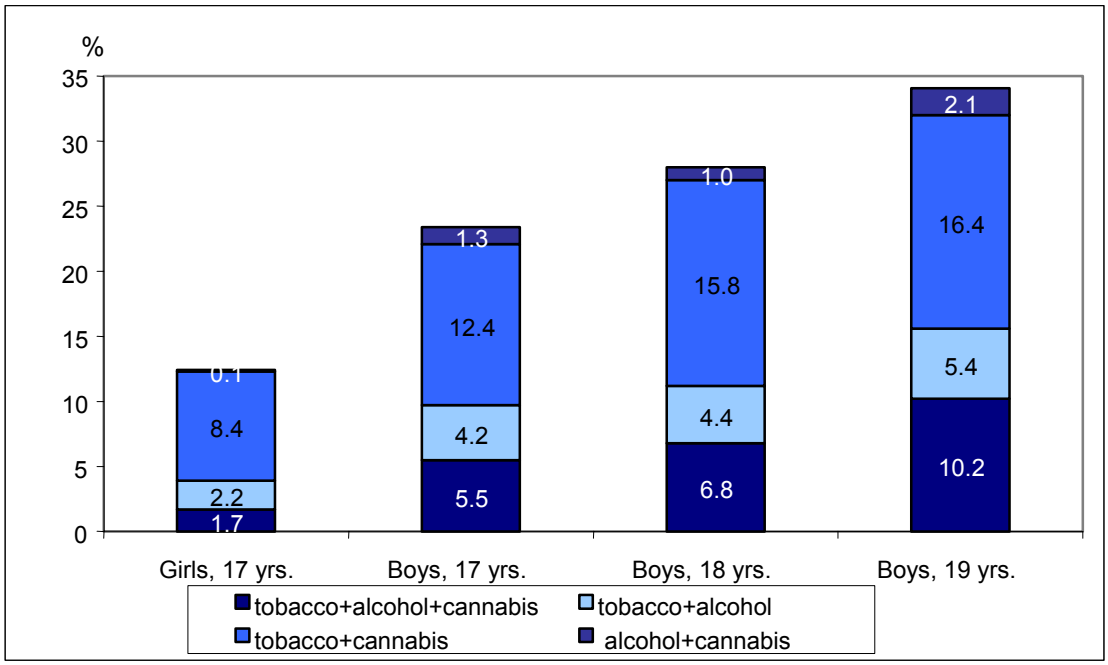


Source: ESPAD 1999, INSERM/OFDT/MENRT

For boys, the tobacco-alcohol combination changes little between the ages of 14 and 18 – from 1% to 4%. There is a clearer rise in the other three combinations, especially tobacco-cannabis, which becomes dominant with increasing age and affects 15% of 18-year-old boys.

Amongst girls, the various types of multiple consumption also rise with age but remain less frequent than amongst boys. As with boys, we see a dominance for the combination, tobacco-cannabis, which rises from 1% at 14 years to 10% at 18 years of age (Choquet et al, 2001).

Frequency of repeated multiple consumption amongst young people at the end of adolescence in 2000, by sex and age *{301c}*



Source: ESCAPAD 2000, OFDT

At 17 years of age, the main reason for any difference between girls and boys is the preponderance of the use of tobacco alone amongst girls (28.0% of the total). The only repeated multiple consumption to exceed 3% amongst 17-year-old girls is the combination, tobacco-cannabis. With increasing age, it is, above all, the association of the three products that rises amongst boys. At the age of 19, one boy in ten has used the three substances repeatedly.

The link between drunkenness and multiple consumption is very strong, including for consumptions that do not involve the repeated use of alcohol. The differences are less marked for experimentation with psychotropic medicaments, even if they remain significant: the more adolescents have experimented with these medicaments, the more likely they are to be repeated multiple consumers. On the other hand, experimenting with stimulating agents, hallucinogenic mushrooms or inhalants (*poppers* and inhaled products) is particularly high in combinations involving the repeated use of cannabis (Beck et al, 2000).

Simultaneous use of a number of substances ("mixing")

When asked at school, less than one young person in ten between the ages of 14 and 18 (8.4%) admits to having taken alcohol with medicaments ("mixing") and one quarter alcohol with cannabis. The number of declared repeat consumptions of the mixture, alcohol-medicaments, is relatively small (less than 1% of those who have taken it admit to taking it more than ten times); on the other hand, for alcohol with cannabis, 76% of those who have tried cannabis have already taken them together, 9% having done so more than 10 times (Choquet et al, 2001).

At the end of adolescence, 5.8% of young people mentioned at least a single simultaneous consumption of psychoactive substances. Two component "mixtures" are the most numerous (80%), followed by mixtures of three substances (17%); mixtures of four or five substances are much rarer. The substance most frequently mentioned is cannabis, in 99% of cases and ahead of alcohol (43%). However, the question, "Have you ever taken a number of these

substances together?" excluded *a priori* "mixtures" including alcohol by making implicit reference to a table listing psychoactive substances other than alcohol and tobacco. This suggests that the interaction between alcohol and other substances is particularly widespread. Then come ecstasy (in 16% of mixtures mentioned), mushrooms, LSD, *poppers*, cocaine and inhaled products (5%). Nevertheless, of the total, 28% contain stimulants (ecstasy, amphetamines, cocaine, LSD). As amongst adults, medicaments are very rarely mentioned (only one declared "mixture") (Beck et al, 2000).

Mixtures most frequently mentioned by young people at the end of adolescence in 2000

Substances mixed	Number of mentions	In % of mixtures mentioned
Cannabis-alcohol	261	31 %
Cannabis-mushrooms	98	12 %
Cannabis-other drugs	60	7 %
Cannabis-*poppers*	55	7 %
Cannabis-ecstasy	54	6 %
Cannabis-LSD	38	5 %
Cannabis-inhaled products	27	3 %
Cannabis-cocaine	20	2 %

Source: ESCAPAD 2000, OFDT

11.2 Health consequences and negative effects

Dependence on a number of products and their consumption in association make care and treatment more complex. Withdrawal, especially of opiates, is more difficult where a number of substances are regularly consumed by a single person. However, multiple consumption, as described by the specialists in the care and treatment of drug users, are difficult to measure in surveys. While the term may be frequently used, there is no consensus as to its definition. The approaches described below may only be considered as a contribution to the debate on the subject.

Requests for treatment

Taking account of the data available from surveys amongst users frequenting care facilities, multiple consumption can be approached from two directions: from the substances giving rise to the reception into care or from the substances consumed in the recent period (month or week, depending on the survey). To differentiate these two approaches, we shall speak in the first case of multiple dependence and in the second of multiple consumption. Multiple dependence characterises the situation of those for whom more than one substance gives rise to the reception into care and multiple consumption that of users admitting to the recent consumption of more than one substance.

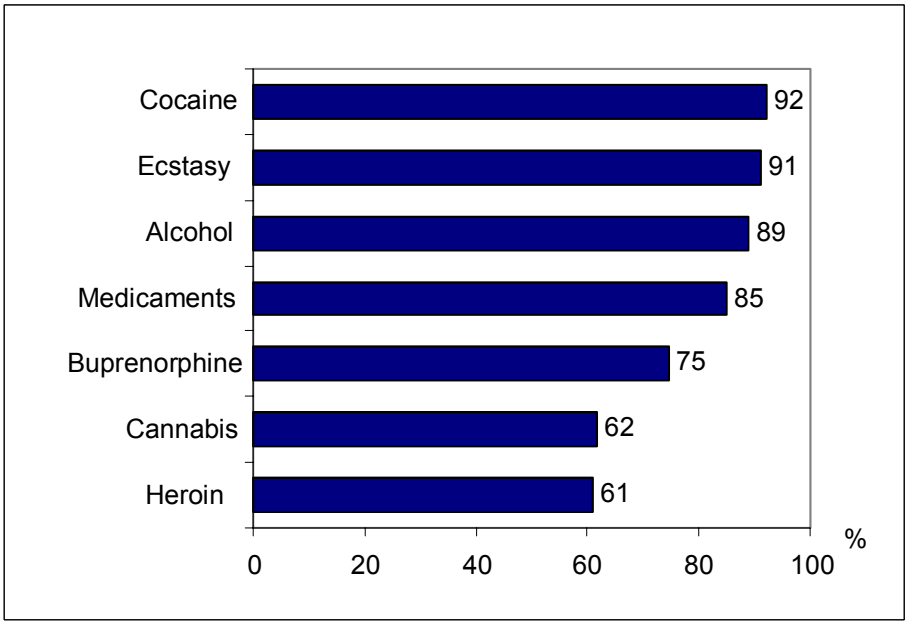
Multiple dependence

According to the results of a survey carried out in November 1999 (Tellier, 2001), multiple dependence is involved in slightly over one treatment request in two (56%). This percentage has risen slightly in comparison with the survey carried out in November 1997 (54%).

The proportion of multiple dependence varies according to the substances involved. Cocaine, ecstasy and alcohol are associated with another substance in about 90% of receptions into care for these substances. For cannabis and opiates this proportion is 60%.

Medicaments, chiefly benzodiazepines and buprenorphine without prescription, occupy an intermediate position.

Frequency of multiple dependence amongst drug users in 1999, according to the substance giving rise to the reception into care *{303a}*



Interpretation of the chart: where it appears as the substance giving rise to reception into care (primary or secondary), cocaine is associated with another product in 92% of cases, ecstasy in 91% of cases etc.

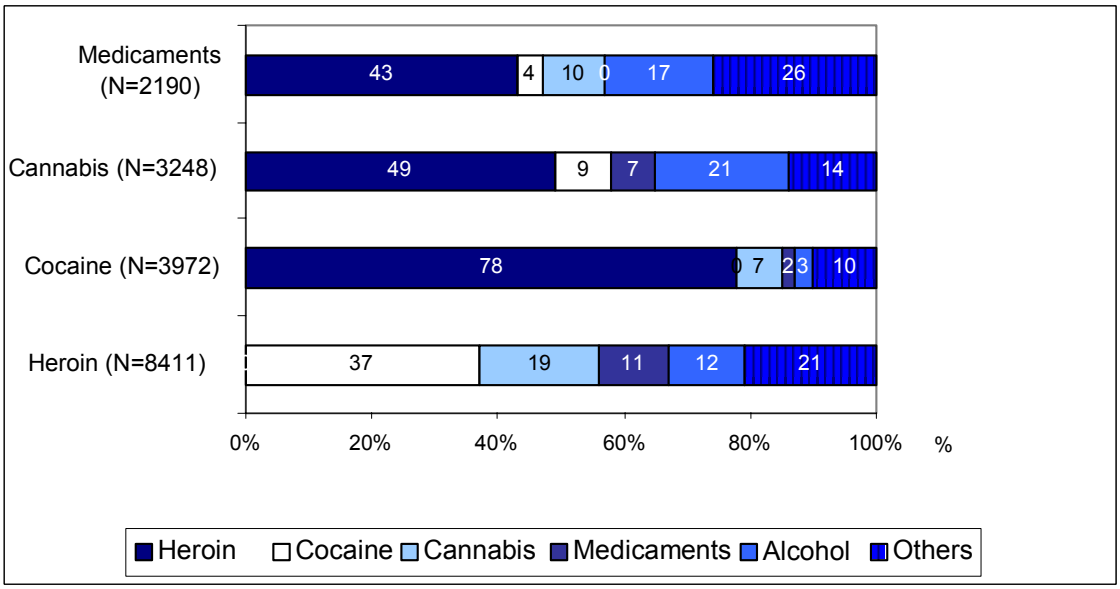
Source: Survey on the reception into care of addicts in November 1999, DREES/DGS

The relatively small proportion of multiple dependencies for cannabis is explained by the youth of some users, young people having only rarely a problem with a second substance in comparison with older users.

With regard to heroin, this is often mentioned as giving rise to reception into care of users undergoing substitution treatment and who, in large measure, are not in difficulties with other substances.

Taking account of the considerable global weight of opiates and especially of heroin in the substances giving rise to reception into care, this last substance is strongly associated with all the others. However, this association is particularly strong where cocaine is mentioned. The importance of the links between cannabis and alcohol and between medicaments and alcohol should also be noted.

Associations of psychoactive substances in multiple dependence amongst drug users in 1999, according to the substance giving rise to the reception into care in 1999 *{303b}*



Interpretation of the chart: as product 1 or 2 giving rise to the reception into care, medicaments are associated with other substances in 2,190 requests; in 43% of cases this is heroin, in 4% cocaine, in 10% cannabis, in 17% alcohol, in 26% other substances

Source: Survey on the reception into care of addicts in November 1999, DREES/DGS

In the survey of which the results are used here, only two substances could be mentioned as giving rise to the reception into care, which, without doubt, has the effect of minimising the weight of certain associations. Furthermore, it would also be interesting to have some information on substances recently consumed. The multiple dependence approach should therefore be complemented by an approach in terms of substances consumed.

Multiple consumption

Amongst receptions into care in specialised establishments and medical establishments, consumption during the previous 30 days is mentioned in 60% of cases[23]. Two substances are mentioned in 30% of cases and three in only 12%. Amongst those having taken at least one substance during the previous thirty days, the average number of substances taken is found to be 1.7. The substances most often involved in multiple consumption (at least two substances taken) are cannabis (53%), alcohol (40%), heroin (33%), benzodiazepines (27%) and cocaine (22%). This ranking is found to be largely repeated in the frequency of associations of substances in which cannabis, alcohol and heroin are most often mentioned.

[23] Users undergoing substitution treatment or having recently undergone withdrawal cannot have consumed during the previous month.

Associations of psychoactive substances consumed during the previous 30 days amongst drug users accepted into care in 1999

(in %)

Alcohol and cannabis	21
Heroin and cannabis	13
Heroin and cocaine	12
Benzodiazepines and alcohol	10
Benzodiazepines and cannabis	10
Cocaine and cannabis	7
Heroin and alcohol	7
Heroin and benzodiazepines	5
Heroin and buprenorphine	5

Interpretation of the chart: amongst 6,823 requests for treatment where at least two products were mentioned as having been consumed during the previous 30 days, alcohol and cannabis are associated in 21% of cases, heroin and cannabis in 13% etc. Only the most frequent associations are mentioned. The percentages in the column cannot be added.

Source: Survey on the reception into care of addicts in November 1999, DREES/DGS

The frequency of associations varies according to the product under consideration. Because of its widespread use, cannabis is generally linked with all substances. However, this association is particularly strong in the case of ecstasy: where this product is mentioned, cannabis is associated with it in 51% of cases. As for cocaine, its use is strongly associated with that of heroin (in 44% of cases) as is alcohol with cannabis (40% of cases).

Associations of psychoactive substances consumed during the previous 30 days amongst drug users accepted into care in 1999

(in %)

	Heroin N = 3,273	Cocaine N = 1,875	Benzodiazepines N = 2,404	Cannabis N = 6,718	Ecstasy N = 335	Alcohol N = 3,688
Heroin	-	44	15	13	21	13
Unprescribed buprenorphine	10	9	11	5	5	6
Cocaine	25	-	8	7	24	7
Benzodiazepines	11	11	-	10	4	18
Cannabis	27	27	27	-	51	40
LSD and other dysleptics	1	2	1	1	11	1
Ecstasy	2	4	1	2	-	2
Amphetamines	1	2	1	1	4	1
Alcohol	14	13	28	22	16	-

Interpretation of the table: amongst the 3,723 requests for treatment mentioning heroin consumption during the previous 30 days, unprescribed buprenorphine had also been consumed in 10% of cases, cocaine in 25% of cases, benzodiazepines in 11% of cases etc. Since one substance can be associated with two others, the columns of figures cannot be added. In order to avoid overloading the table, it does not include all possible substances.

Source: Survey on the reception into care of addicts in November 1999, DREES/DGS

The OPPIDUM survey, carried out at about the same time (October 1999) amongst a sample of some 2,000 users seen in the care facilities, supplies similar results on the frequency of the association of cocaine and heroin. However, differences that are not negligible appear for the associations with benzodiazepines, alcohol and cannabis. It is possible that, in the survey carried out in November, less attention was paid to collecting information on licit or commonplace consumption while the latter survey emphasised more visible and easily

detected drug use. This probably leads to an underestimation of the weights of benzodiazepines and medicaments.

Associations of psychoactive substances consumed during the previous seven days amongst drug users accepted into care in 1999

(in %)

	Cocaine N = 239	Benzodiazepines N = 511	Heroin N = 261	Cannabis N = 657
Benzodiazepines	28	-	17	25
Cocaine	-	13	34	15
Heroin	37	9	-	15
Alcohol	26	27	21	25

Interpretation of the table: amongst the 3,723 requests for treatment mentioning cocaine consumption during the previous 7 days, benzodiazepines had also been consumed in 28% of cases, heroin in 37% of cases, alcohol in 26% etc. Since any one substance can be associated with several substances at once, the sums of the percentages in columns can be greater than 100%. Further, to avoid overloading the table, only those substances with a substantial representation are mentioned.

Source: after OPPIDUM 1999, CEIP

11.2.b Specific social consequences of multiple consumption

Morbidity and mortality

During 2000, of the 119 deaths by overdose recorded by the police services, 38 showed the presence of a number of substances (roughly one third) (OCRTIS, 2001). Heroin being most frequently detected as the cause of overdoses, it is also found in 18 of the 38 deaths where several substances were detected. The other mixtures generally detected are associated medicaments frequently consumed by heroin addicts: methadone, Subutex®, Skenan®, Tranxène® etc.

The number of deaths by overdose in France where several substances are detected is increasing.

11.3 Risk assessment and local market

11.3.a Products and physical description

11.3.b Combinations of different substances on the local market

The most frequent associations are of the most usual substances: alcohol, tobacco and cannabis. Psychotropic medicaments are also very much implicated, especially in their interactions with alcohol. Amongst the rarer associations, we observe substitution products with alcohol, LSD with synthetic drugs and cocaine with heroin (Fontaine et al, 2001).
Combination: AWARE.

11.4 Specific approaches to the interventions

11.4.a Approaches to multiple drug consumption

There is no specific programme for multiple consumers. However, the MILDT three-year plan underlines the necessity of considering all aspects of the interaction between the user and the substance(s) that he consumes.

The last MILDT communication campaign, based on 4 posters and targeting young people, dealt, in particular, with multiple consumption (the others covered alcohol, cannabis and ecstasy).

11.4.b Evaluation results

No evaluation specifically addressing this particular question has been carried out.

11.5 Methodological issues

11.5.a Limitations in data availability

The collection of data on multiple consumption comes up against the classical stumbling blocks that lie in the way of gathering information on psychoactive substances. The significance of these difficulties, however, is amplified by the precision required in collecting this information, especially in surveys of the general population. The data coming from the facility for the observation of emerging trends (TREND) are highly reactive and can yield a great deal of qualitative and quantitative information on the consumption of products but, on the other hand, do not allow such drug use to be quantified in relation to the whole population.

11.5.b Future needs

There is no great need in the sense that TREND will continue to supply qualitative information and a survey of the general population does not, in any case, make it possible to explore these questions in great detail.

11.5.c Methodological proposal

No particular proposal.

12. Successful treatment: the effectiveness of the intervention

12.1 The approaches to treatments and the related concepts of success

12.2 Evaluation of the treatments

12.3 Methodological issues

This article has been transmitted separately to the EMCDDA for time reasons.

13 Drug users in prison

13.1 Epidemiological situation

Several surveys have been carried out with a view to estimating the proportion of drug addicts in the prison population. The oldest survey goes back to 1986 and was carried out by the study service of the Prison Administration (Kensey et Cirba, 1989). This survey estimated the proportion of drug addicts amongst new prisoners at 10.7%. These were defined as persons who declared themselves as such or reported taking drugs at least twice a week during the three months prior to imprisonment. The majority of these drug addicts were men (91%), 25% of foreign nationality and 70% consumers of heroin either alone or in association with other substances. It should, however, be emphasised that 22% of prisoners questioned were cannabis users. This survey indicated that 30% of drug addicts in prison declared that they had begun turning to drugs after being in prison. Half of the drug addicts in prison had been imprisoned for an offence other than an infringement of drug law (ILS). The proportion of ILS was greater amongst cannabis users than amongst heroin users. Finally, this survey showed that half the addicts questioned had been re-imprisoned after less than one year at liberty. This information already indicated that the control of addiction was inadequate both within and outside prison.

The description of the drug addicts seen in the CSST in 1994 confirms several of the observations above: namely, the predominance of men (90 %) and the high level of heroin use amongst prisoners considered to be addicts (78%) (Facy, 1997). The proportion of those who had been sentenced in the drug addicts of the sample (52%) was rising; 68% were recidivists and had, on average, been imprisoned four times. Françoise Facy also emphasises that 37% of imprisonments had occurred before the individual became a drug user, which underlines the necessity of primary addiction prevention amongst the prison population. The proportion of prisoners declaring themselves HIV positive was 18% in 1994; the proportion of HIV infected addicts with a methadone prescription was between 35% and 40%. A quarter of drug addicts reported at least one heroin overdose episode and 22% a suicide attempt. One third had already been in touch with a CSST.

The survey carried out in 1997 amongst 75,825 new prisoners probably gives the best estimate – in the sense of being representative – of the frequency of drug use amongst prisoners (DREES, 1999). Thirty-two percent declared that they had made prolonged and regular use of at least one drug during the twelve months prior to incarceration (apart from alcohol): 25.6% for cannabis, 14.4% for heroin, 8.9% for cocaine or crack, 9.1% for medicaments used addictively and 14.6% for multiple addiction. The use of intravenous injection at any time or during the previous twelve months was reported by 11.8% and 6.2% of prisoners respectively. Amongst minors, the situation also gives cause for concern with a quarter declaring that they had made prolonged and regular use of at least one drug during the twelve months prior to incarceration and 1.4% by injection.

Apart from these surveys on a national scale, other surveys have been carried out and have shown that the incidence of drug use could be even higher in certain prisons located in regions badly affected by addiction. Thus, two surveys carried out in the Marseilles prison estimated the proportion of injecting drug users at between 20% and 23%. These surveys made the distinction between those who had stopped injecting more than 12 months before imprisonment and those actively injecting at the time of imprisonment (one half of users) (Rotily, 1994; Rotily, 1997).

The European survey of 1997/1998 showed that, amongst the 1,212 questioned in French prisons, 43% had declared that they had used illicit substances – not by injection – during the 12 months prior to imprisonment (cocaine, cannabis/hashish, benzodiazepines etc.), 12% had declared that they had injected themselves with drugs at some time in their lives, of which 9% during the 12 months prior to imprisonment. Amongst these last, 45% declared that they had injected more than 10 times during the four weeks prior to imprisonment and 34% had shared their equipment for their last injection. The substances most frequently declared by these injecting users were heroin (62%), cocaine (42%) and benzodiazepines (37%) (ORS, 1999).

[*Note: the French favour the expression,* "usager de drogues par voie intraveineuse" (UDVI) *(user of intravenously administered drugs)*]

With regard to alcohol, the national survey by the Directorate for Research, Studies, Evaluation and Statistics [*Direction de la recherche, des études, de l'évaluation et des statistiques*] (DREES) reports that 10,3% of prisoners consumed alcohol regularly (≥ 5 glasses per day), 16.9% irregularly (≥ 5 consecutive glasses at least once a month) and 6% both regularly and irregularly, making a total of one third of inmates with an excessive consumption (DREES, 1999). Amongst new prisoners under 18 years of age, this alcohol problem is also acute with 16.1% declaring regular or irregular consumption.

13.2 Availability and supply

Tobacco is legally available in prisons. Two surveys on the health of prisoners, one carried out on a national scale, the other in the PACA [*Provence-Alpes-Côte d'Azur*] region, reported similar incidences of tobacco addiction: 80 % (DREES, 1999). The introduction of alcoholic beverages into prisons is forbidden. However, in a survey carried out in four prisons in the West and Southeast of the country, 61% of injecting inmates declared that they had consumed alcohol during their imprisonment (ORS, 1999).

In 1996, the Minister of Justice appointed a study group to consider the improvement of the care afforded to addicts in prison and the entry of drugs into prisons. The report of the group notes that seizures have been made by prison officers in three quarters of all prisons. 80% of these were of cannabis. Seizures of heroin were made in nearly thirty prisons but the quantities were minimal. Some thirty syringes are confiscated each year. Between three and eight overdoses are reported each year, of which half occur during release on licence. Medicaments accounted for 6% of incidents (Jean, 1997).

Surveys on the use of drugs in prison are not representative of the national situation. However, carrying them out on several site provides an indication of the extent of the problem. A survey carried out in 1996 showed that 13% (9/68) of injecting users active during the 12 months prior to imprisonment declared that they had injected drugs during the first three months of imprisonment (four of the nine using shared equipment) (Rotily, 1998). The European survey carried out in four other French establishments showed that 32% declared that they had already used non-injected, illicit substances in prison (ORS, 1999). In addition, 35% of injecting users declared that they had already injected in prison and 6% that they had started to inject in prison. Amongst injecting users still active just before imprisonment, 26% declared that they had injected themselves during the last month of imprisonment (of which 43% more than 20 times), half not having used bleach to disinfect their equipment.

The 1996 study also revealed that 3% of injecting users declared sexual relations during the first three months after imprisonment (essentially heterosexual relations in the visiting room

and without condom) (ORS PACA, 1999). Furthermore, 16% of actively injecting users declared that they had been tattooed during this period. The table below gives the results of the European survey of these practices as declared in prison. It can be seen that it is drug users who most frequently declare at-risk behaviour in prison (apart from homosexual relations); further, they were more likely to have already had themselves tested for HIV or HCV whereas vaccination cover against hepatitis B showed no differentiation according to drug use and was altogether inadequate (ORS PACA, 1999).

Table: Risk-related behaviours in prison (ORS PACA, 1999)

	Non-users (56%)	Non-injecting users (43%)	Injecting users (12%)	Actively injecting users (9%)
Heterosexuality	4.7%	11.6%	15.3%	13.6%
Homosexuality	1.3%	0.8%	1.3%	1%
Tattooing	10%	31%	39%	43%
HIV testing	59%	78%	76%	76%
HCV* testing	37%	58%	59%	
HBV vaccination	24%	34%	27%	24%

13.3 Contextual information

On 1 January 2001, France had 187 prisons with 47,837 inmates. The growth of the prison population in the course of the last 15 years was 39%, placing France amongst the high-inflation countries. By way of comparison, countries such as Portugal, Spain and the Netherlands experienced growth rates from 140% to 240%. On the other hand, Denmark and Sweden had growth rates of 6% and 18% respectively. In France, the inflation of the prison population was mainly connected with the increase in length of sentences, which increased from 4 to 7 months on average between 1975 and 1996. In addition, the population has been contained by the system of presidential pardons, which is an important regulator in our country. Since 1996, we have seen a decrease in the number of inmates (-13%) and of the proportion of remand prisoners (33.7% in 2001 versus 39.8% in 1996). The rise in the rate of imprisonment and the lengthening of sentences led to an overpopulation of the prisons, which were, therefore, faced with a considerable workload on both the administrative and supervisory side and on their provision of social and health rehabilitation. In 1996, the occupation rate in French prisons was between 100 and 120% in 22% of establishments and above 120% in 45% (Tournier, 2000). Finally, attention should be drawn to the increasing proportion of women prisoners. This rose from 2.5% in 1975 to 4.5% in 1995, a trend that has also been observed in other European countries (Tournier, 1998). However, this trend seems recently to have reversed, the proportion of women having fallen back to 3.6% in 2001.

Two important changes in the organisation of the prison system have been, on the one hand, the large numbers of non-government organisations and professionals from outside the Prison Administration now working in prisons, on the other, the reform of the prison hospitals, which have been run by the public hospital service since 1994. The law of 18 January 1994 guarantees prisoners the same quality of nursing and medical care as is available to the general population. They are also registered in the general Social Security sickness-maternity system. We thus see a strong tendency towards the application of normal rights inside prisons. It should also be mentioned that, for some 13,000 places (21 prisons), the maintenance, catering, occupation and occupational training services are managed by private companies. Up to 2001, they were also responsible for medical care in these establishments. This responsibility has now been transferred to the public hospital service.

* Hepatitis C virus

Drug use in France is controlled by the law of 31 December 1970, which imposes sentences of imprisonment on the users of illicit substances. This law also provides that the courts may propose medical treatment as an alternative to sentencing. This treatment order policy has not proved very effective with a wide geographical variation in its application and it has had very little positive effect on the drug use problem in France (Setbon, 1998). Recently, the National Aids Council [*Conseil national du Sida*] pronounced itself in favour of decriminalisation. There is, however, no parliamentary discussion of this question at present. France has between 100 and 150 thousand heroin addicts. In 1999, 74,651 persons were undergoing opiate substitution treatment. The great majority (88%) were being treated with buprenorphine (Subutex®), a medicament available since 1996 through general practitioners authorised to prescribe it in urban practices, the remainder being treated with methadone in Specialised Addiction Care Centres (CSST). Since 1996, it has been observed that sales of buprenorphine have risen steadily and deaths by heroin overdose have fallen, as have infringements of the legislation on stupefacients related to this same drug (Emmanuelli, 2000).

On arrival in prison, inmates are offered a medical check-up in the Consultative and Outpatient Care Units [*Unités de consultations et de soins ambulatoires*] (UCSA) with, in particular, a test for tuberculosis, a voluntary and confidential test for HIV infection and, more recently, HCV infection and a vaccination against hepatitis B. Regional Medico-Psychological Services [*Services médico-psychologiques régionaux*] (SMPR) have the responsibility for psychological and psychiatric care in 26 prisons while the UCSA have the responsibility for physical care. There are 16 CSST that come under the General Health Authority and whose task is to identify drug dependence and support drug addicts during their imprisonment. The regulatory documents place the co-ordination of the care and treatment of those presenting addictive behaviour in the hands of the psychiatrists (medico-psychological and socio-educational care, co-ordination of the specialist teams intervening inside prisons, establishing contacts with external facilities in order to provide follow-up and rehabilitation assistance on release, epidemiological records). It should be noted that the responsibilities for the identification of drug dependence and the care and treatment of addicts are shared, that the notion of risk reduction is not included in the tasks of the SMPR and the CSST and that a minority of prisons have a CSST. The personnel of the CSST is largely made up of psychologists and specialist workers and may include some nurses but never doctors. On the other hand, there are institutional and organisational links between the SMPR-CSST and the UCSA to define a policy for the care and treatment of addiction. It seems that the relationship between the two entities tends to be co-operative, centred essentially on individual attention to addicted inmates. Since conflict in this relationship sometimes becomes evident, which leads to unsatisfactory care of those with addictive behaviour, interministerial recommendations were addressed to the various services concerned in August 2001, requiring them to set up a more co-ordinated organisation and thus improve the care and treatment afforded to prisoners exhibiting dependence on or abusing licit or illicit substances.

13.4 Demand reduction policy in prisons

The prevention of drug use in prisons is primarily based on the control of drug entry. A note of 18 Feb. 1997 from the Ministry of Justice regarding police checks on visits to the visiting room with respect to preventing the entry of narcotic substances into prison establishments suggests that visitors and prisoners should be informed of these measures. Disciplinary measures and legal proceedings can be taken against prisoners caught in the act of using

illicit substances. Urine testing has only been used experimentally on prisoners released on licence (Jean, 1997).

The care and treatment of addicts is controlled by the circular DGS/DM No. 96-259 of 03 Apr. 1996. The SMPR and the health care personnel are obliged to distribute information on the damaging effects of drug use and the necessity of using clean injection equipment. The care made available to addicts by the psychiatric sectors should be diversified and equivalent to that available outside prison; that is, a care package integrating all aspects of dependence and the continuation of any substitution treatment started before imprisonment. The prescription of buprenorphine (Subutex®) or methadone can be continued or started in prison since the circulars of 1996. Methadone treatment can only be started in prisons with a CSST.

Injection equipment is not made available in France. This would be contrary to article D-273 of the criminal procedural code, which provides that prisoners may not keep accessible any object, medicament or substance that could be used for or in connection with suicide, an attack or an escape. In 1996, a circular from the Prison Administration provided for the free and general distribution of bleach to prisoners. However, it is not specified that the bleach is a means of reducing risks connected with the use of drugs. It is, therefore, very likely that the bleach is only seen as a general cleanliness and hygiene measure.

There is no law that explicitly prohibits tattooing. However, a prison governor could prohibit it on the grounds of the disciplinary prohibition of putting the safety of others at risk or possessing dangerous objects and of the requirement that the rules of hygiene must be respected in order to avoid the transmission of disease. The prohibition of sexual relations in prison is a question of decency and in no way intended as a deprivation of liberty or a part of the sentence. However, there is no law or regulation requiring the Prison Administration to make conjugal visits possible. Regulations do provide that condoms must be made available, in particular through the prison UCSA.

13.5 Evaluation of the treatment of drug users in prisons

A culture of medical evaluation is progressively establishing itself amongst health professionals in France, under the influence, in particular, of the National Agency for the Approval of Treatment and Care Establishments [*Agence nationale d'accréditation des établissements de soins*] (ANAES). The 1994 reform of the prison health-care system also allows a wider implementation of medical assessment. With regard to the social and administrative workers, it is difficult to evaluate the place of assessment in daily routine. However, field experience seems to show that medical and social assessment is little practised in prisons with regard to addiction.

The application of the "Evin" law, regulating the use of tobacco in public places, has not, to our knowledge, been evaluated in prisons. The same goes for the implementation of tobacco withdrawal treatments in prisons. With regard to alcoholism, here too, we have identified no evaluations of its prevention or treatment.

To our knowledge, no evaluation has yet been made of the impact of addiction care and treatments provided for drug users in prison.

A survey was carried out in 1997 amongst medical and administrative managers of the prisons in two regions of France (West and Southeast) (ORS PACA, 1999). The first conclusion is that the actions taken to prevent HIV infection, AIDS and hepatitis are not effective in all the prisons surveyed. By way of example, only 9 out of 24 establishments have implemented a co-ordination of the actions taken to prevent infection with HIV or HCV.

If doctors are questioned as to the obstacles standing in the way of current risk reduction policies, the majority emphasise information and the effort involved in providing treatment to addicted patients. Frequently mentioned are improved follow-up of drug users on substitution treatment and improved access to such treatments. An improved management of medical prescriptions is also recommended, specially to avoid trafficking, as is more rigorous checking of prisoners, cells and visiting rooms. In order to improve the implementation of risk reduction policy, prison governors suggest several lines of thought: Information and training of both prisoners and staff, in particular, through the medical service or associations; a wider availability of hepatitis B vaccination and of HIV and HCV testing. Overpopulation, promiscuity and a lack of communication between the medical and administrative sides are difficulties that are often put forward. Prison governors, who are unfavourable to risk reduction measures such as syringe exchange or the availability of buprenorphine, base their opinion on legal or security arguments. For their part, the doctors questioned emphasise the unsuitability of the prison environment for the provision of care and treatment for drug users (ORS, 1999).

A survey carried out by the Ministry of Health in 1998 enabled an estimate to be made of the number of prisoners undergoing substitution treatment and the way in which their treatment is organised (Tortay *et al*., 1998). 1.7% of inmates have a prescription for buprenorphine and 0.3% for methadone. About 80% of these prescriptions are issued in continuance of a previous treatment. The existence of considerable disparities should be noted; 44/168 prisons do not have a single inmate undergoing substitution treatment, one establishment alone holds more than a quarter of all prisoners so treated. Of the 597 buprenorphine substitution treatments recorded, 22% were interrupted (11% for methadone). The dispensing of substitution treatments is carried out chiefly by the UCSA and not by the SMPR, in spite of the fact that the latter are responsible for looking after addiction problems. A similar proportion of inmates undergoing substitution treatment is to be found in many prisons, whether they have a CSST or not. A second survey, using the same procedure, was carried out in November 1999. It found that there had been a slight increase in the number of inmates undergoing substitution treatment in prison but the overall proportion remained well below 5%. A third survey is to be carried out in November 2001. The most important fact confirmed by these surveys is the small number of substitution treatments in prisons.

Finally, we would draw attention (again) to the existence of prison leavers' units [*unités pour sortants*] (UPS), whose purpose, in theory, is to take responsibility for and assess the heaviest users, who are at the greatest risk (ORS, 2001). The first results appear to show a great number of both operational and conceptual difficulties with regard to the role of the UPS and the methods to be used. We may note, on the one hand, that the number of persons passing through this system is very small in relation to the size of the addict population and, on the other hand, that risk reduction is not an objective of the UPS. The programmes are centred, essentially, on the social rehabilitation of prisoners and may also apply to alcoholics. Further, it seems that these programmes find themselves in competition with the objectives of a more global prisoner rehabilitation policy. With regard to the results, the impact of the UPS seems limited and, in the absence of follow-up after release, it is not possible to evaluate the effects on the criminal population. A new task specification, intended to make this facility more pertinent, is currently being drawn up by the central administrations concerned.

The Directorate of the Prison Administration and the General Health Authority have now presented their conclusions on the question of the reduction of the risks of transmission of HIV and viral hepatitis in prisons (DAP/DGS, 1999). This report underlines the current

inadequacies in the implementation of regulatory measures to reduce risk and the lack of action and commitment of those concerned to the risk reduction policy. The report proposes a number of measures including raising the awareness of existing intermediaries, the training of prison officers and medical personnel, support for local initiatives, improvement of the reception procedures for new prisoners and, globally, the reinforcement of the risk reduction policy.

It should be noted that an evaluation of the reorganisation of the system for the care and treatment of prisoners presenting addictive behaviour is planned for 2002.

13.6 Methodological issues

As we have seen above, epidemiological data are patchy. The only continuous epidemiological record amongst addicted prisoners was that organised by the mental health epidemiological unit 303 of INSERM. The purpose of this record was rather to describe the active line of addicts monitored by the addiction offices [*antennes toxicomanie*] (ex-CSST). In the first place, the collection of data was not exhaustive; it only covered 16 prisons of the 187 in France. The sample described for 1994 included 2175 persons or between 2% and 3% of all prisoners on a given day, which is a proportion very much smaller than that of all prisoners exhibiting addictive behaviour and an under-representation of the Ile de France [Paris region] where, according to sources outside the prisons, addiction is particularly prevalent. Further the data collection methods were not uniform (different methods of selecting addicts, no systematic method of questioning) and came up against operational difficulties (training of the teams in data collection, reticence on the part of certain specialists) (Facy, 1997). In all, the monitoring of addicts through the addiction offices provided useful information for following-up this population but gave no clear view of the state and development of addiction in the French prison system.

The various work mentioned above and the considerations of the French Observatory of Drugs and Drug Addiction [*Observatoire Français des Drogues et des Toxicomanies*], the Directorate for Research, Evaluation and Statistics of the Ministry of Health [*Direction de la Recherche, de l'Evaluation et des Statistiques du Ministère délégué à la Santé*], the European Observatory of Drugs and Drug Addiction [*Observatoire Européen des Drogues et des Toxicomanies*] and the European network on HIV infection and viral hepatitis provides a solid foundation for the establishment of epidemiological monitoring of addiction in French prisons. A system of surveys on one particular day in all prisons or in a random sample based on a strictly anonymous and representative collection of data from inmates by filling in a questionnaire or carried out by independent researchers would give better information on the epidemiological situation and the main trends. Prospective studies could also be carried out to estimate the risk of infection with hepatitis C in prison and the impact of risk reduction strategies and treatments offered to addicts during detention.

In conclusion, the situation of drug users in French prisons gives great cause for concern. The high number of prisoners who are drug users and addicts, the severity of the health problems facing this group and the inadequate social rehabilitation of prisoners after release make epidemiological monitoring, the way in which health and social care are administered, the risk reduction policy and the way in which these measures are evaluated matters of priority in public health. It is a matter of urgency that the failure of imprisonment as a social response to drug addiction be recognised and that a more voluntary, more pragmatic and more innovative policy be established with regard to drug users, both within and outside the prison system.

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Databases

APPRE: database on preventive actions, available on CD-ROM (OFDT)

SINTES: database on the composition of samples of synthetic drugs collected within the framework of the TREND monitoring system, available on CD-ROM (OFDT)

Appendix

Drug monitoring system and sources of information

Monitoring system

The sources of information used in the report can be grouped in major categories whose principal characteristics and limitations with regard to their capacity to describe the phenomenon can be described. First, two remarks of a general nature must be made.

Assembling all the available sources of information gives an overall picture of the situation with regard to drugs and dependencies. The representation thus obtained is largely dependent on the sources of information - on that which they seek to and succeed in observing. The ambivalence of many sources (indicator of a trend in a situation and/or a trend in the action of an institution) and the lack of data in certain areas are the major limiting factors to be noted. Since the acessible field of view is often limited, it is difficult to arrive at the desired overall perspective. For example, it is difficult to find a common frame of reference for the health consequences of using the main types of drugs.

The focus on drug using populations that is inherent in this type of exercise should not lead us to forget that these are sub-groups of the general population and that certain perceived trends may only be a reflection of more general trends in the whole population.

Surveys of the general population

These surveys base their results on the replies furnished by those questioned. This type of investigation aims to measure the behaviour, attitudes or opinion of the whole population or a selected part of the same with regard to the use of permitted or illicit drugs. The method used is an interrogation of a representative sample of the target group. These surveys have the advantage of giving a direct measure of the scale of the problem in the whole population, as well as a fairly reliable measure of the trend. However, the measurement of relatively rare behaviour by this means is difficult. The results give a picture of declared consumption that does not necessarily mirror the reality.

Public records

The national statistics of legally notifiable events or conditions (death, AIDS etc.) also make it possible to estimate a part of damaging drug use from the point of view of the consequent damage.

Administrative statistics

The administrative statistics and certain studies that target a particular population, as defined by the institution intervening in the field (e.g. health / those seeking treatment, justice / persons imprisoned), give a partial view of drug use from a particular angle. There is, by

definition, a certain population, not visible to the institution, that remains hidden in these statistics.

Thanks to their continuity, regularity and availability, these sources of information are particularly valuable for the analysis of major trends. Nevertheless, a certain delicacy is required in using them and it is important to take full account of their limitations. The derived indicators are "indirect indicators", whose inertia, inherent in their derivation, does not, generally speaking, shed any light on recent trends. In addition, there are specific problems connected with these sources of information: limitation of their theoretical coverage, reliability, double entries…

Qualitative studies

Certain studies are interested in sub-groups of the population directly affected by drug use but not institutionally selected. Ethnographic studies are an example. Apart from the quality of the description of use and behaviour, this type of approach makes it possible to address the "hidden" side of the problem: the individuals are not seen by any particular institution. These special studies describe behaviour in a qualitative manner but do not allow any quantitative measurement.

System for monitoring emergent trends

Since 1999, the OFDT has had a system in place specifically for monitoring emerent trends (TREND). This consists of networks of observers in the "urban environment" (marginalised "problem" drug users) and on the "party scene" (drug users frequenting nightclubs or "techno"-parties), complemented by a system for collecting and analysing samples of synthetic drugs. This system, which cuts across the various methods described previously, sets out to observe a very specific object: emergent trends. Without excluding the use of statistical methods, the information that it delivers is principally of a qualitative nature: field observations, which, by cross-validation and analysis, can indicate trends that complement the findings from surveys and regularly maintained statistics.

Information and documentation systems

Toxibase, the national drug documentation network

Toxibase (a "law of 1901" non-profit association, largely state-funded) is a national network run by field professionals working in the addiction sector and who have established, in some cases since 1986, a body of documentation on the subject.

The nine Toxibase documentation centres are open to a wide public of decision-makers, professionals and private individuals. Their activity at the local or regional level makes them resource locations for information on addictive behaviour. Their field of competence covers all forms of addiction, to psychoactive substances and others (gaming, Internet etc.), and multiple consumption.

Today, the Toxibase bibliographic database includes details of some 25,000 works of reference, articles, reports, theses, acts of congress and brochures in French and in English. Toxibase publishes a three-monthly documentary revue, which was completely revised in

2001. It includes, in particular, special, topical reports, edited by specialists, and documentary sections. The network also maintains a database of articles (with bibliographic references) that deal with the subject area in the national and regional daily and weekly press. In addition, in order to respond to the most frequent demand, Toxibase publishes a series of practical guides.

Finally, for some years, Toxibase has catalogued specialised preventive tools in connection with psychoactive substances and primary prevention. The database describes some 300 French language tools with indexation and a descriptive summary.

Drugs and Dependence Information Centres

In 1999, the first seven Drugs and Dependence Information and Resource Centres [*centres d'information et de ressources sur la drogue et les dépendances*] (CIRDD) were set up as a part of the three-year plan. In 2000, their number reached 28, of which about ten were at the regional or interdepartmental level. Most frequently set up on the basis of existing resources, the majority of CIRDD are run by departmental and regional Health Education Committees; four are Toxibase centres. In 2000, 31 departments benefited from the support of a CIRDD. The number of these centres should have increased further in 2001, the objective of the three-year plan being to establish 40 CIRDD covering the entire national territory.

Their task is to provide technical support to institutional workers and professionals in the departments for the implementation of local activities, mainly in the fields of prevention, training and treatment. At present, the CIRDD are concentrating mainly on their task of documentation and information and on the support of "Drugs and Dedependence" project managers, in particular, in drawing up the departmental preventive program. Some CIRDD are already providing monitoring of locally implemented systems and activities or advisory services for project planning.

List of abbreviations / Liste des sigles

Analysis of the sexual behaviour of the French	ACSF	Analyse du comportement sexuel des français
French agency for the medical safety of medical products (formerly Medicaments Agency)	AFSSAPS	Agence française de sécurité sanitaire des produits de santé (ex-Agence du médicament)
Reception lodging reinsertion scheme	AHI	Schéma accueil hébergement insertion
Authorisation to place on the market (licence to sell)	AMM	Autorisation de mise sur le marché
National association for the prevention of alcoholism	ANPA	Association nationale de prévention de l'alcoolisme
National employment agency	ANPE	Agence nationale pour l'emploi
National AIDS research agency	ANRS	Agence nationale de la recherche sur le Sida
Census of prevention programmes and actions	APPRE	Actions et programmes de prévention – recensement
Sociological analysis and intervention centre	CADIS	Centre d'analyse et d'intervention sociologique
National health insurance fund	CANAM	Caisse nationale d'assurance maladie
Outpatient treatment centres for alcoholics	CCAA	Centres de cure ambulatoire en alcoologie
Tobacco information and documentation centre	CDIT	Centre de documentation et d'information sur le tabac
Departmental convention on objectives, justice-health	CDO	Convention départementale d'objectifs justice-santé
Departmental committees for the prevention of alcoholism	CDPA	Comités départementaux de prévention de l'alcoolisme
Drug addiction evaluation and information centres	CEIP	Centres d'évaluation et d'information sur la pharmacodépendance
Local education contract	CEL	Contrat éducatif local
Centre for psychotropic research, mental health and society	CESAME	Centre de recherche psychotropes, santé mentale, société
Health and citizenship education committees	CESC	Comités d'éducation à la santé et la citoyenneté
French committee for health education	CFES	Comité français pour l'éducation à la santé
Centres for food hygiene and alcoholism	CHAA	Centres d'hygiène alimentaire et d'alcoologie
University hospital centres	CHU	Centre hospitalo-universitaire
General hospital centre	CHG	Centre hospitalier général
WHO international pharmacopoeia, 10th revision	CIM 10	Classification internationale des médicaments de l'organisation mondiale de la santé en 10e révision
Centres for information and resources on drugs and dependence	CIRDD	Centres d'information et de ressources sur la drogue et les dépendances
Local security contract	CLS	Contrat local de sécurité
National health insurance fund for salaried workers	CNAMTS	Caisse nationale d'assurance maladie des travailleurs salariés
National centre for scientific research	CNRS	Centre national de la recherche scientifique
Departmental health education committee	CODES	Comité départemental d'éducation pour la santé
Centre for research, studies and documentation in health economics	CREDES	Centre de recherche, d'étude et de documentation en économie de la santé
Regional health education committee	CRES	Comité régional d'éducation pour la santé

Regional AIDS information and prevention centre	CRIPS	Centre régional d'information et de prévention sur le sida
Regional committees on health policy	CRPS	Comités régionaux des politiques de santé
Specialist addict care centres	CSST	Centres spécialisés de soins pour toxicomanes
Drugs alcohol tobacco info service	DATIS	Drogues alcool tabac info service
Central directorate of the criminal police service	DCPJ	Direction centrale de la police judiciaire
Central directorate of the armed forces health service	DCSSA	Direction centrale du service de santé des armées
Departmental directorate of health and social affairs	DDASS	Direction départementale des affaires sanitaires et sociales
Departmental directorate for youth and sports	DDJS	Direction départementale de la jeunesse et des sports
Directorate of school education	DESCO	Direction de l'enseignement scolaire
Directorate-General of customs and excise	DGDDI	Direction générale des douanes et droits indirects
General Delegation for the fight against drugs and drug addiction	DGLDT	Délégation générale à la lutte contre la drogue et la toxicomanie
General Health Authority	DGS	Direction générale de la santé
Hospitals directorate	DH	Direction des hôpitaux
Directorate for judicial youth protection	DPJJ	Direction de la protection judiciaire de la jeunesse
Regional directorate for youth and sports	DRJS	Direction régionale de la jeunesse et des sports
Directorate for research, studies, evaluation and statistics	DREES	Direction de la recherche, des études, de l'évaluation et des statistiques
	DSM	Diagnostic and Statistical Manual of Mental Disorders.
Standing survey on the conditions of domestic life	EPCV	Enquête permanente de condition de vie des ménages
Survey of representations, opinions and perceptions of psychotropic drugs	EROPP	Enquête sur les représentations, opinions et perceptions sur les psychotropes
Survey of health and consumption on the occasion of the call to preparation for defence	ESCAPAD	Enquête sur la santé et les consommations lors de l'appel de préparation à la défense
	ESPAD	European School survey Project on Alcohol and other Drugs
National file of the culprits in infringements of the legislation on stupefacients	FNAILS	Fichier national des auteurs d'infractions à la législation sur les stupéfiants
Part-time anti-drug trainers	FRAD	Formateurs relais antidrogues
	HBSC	Health Behaviour in School-aged Children
Institute for higher studies on domestic security	IHESI	Institut des hautes études de la sécurité intérieure
National institute for agricultural research	INRA	Institut national de recherche agronomique
National institute for research and study of transport and safety	INRETS	Institut national de recherche et d'étude sur les transports et la sécurité
National institute of pedagogic research	INRP	Institut national de recherche pédagogique
Nation institute of statistics and economic studies	INSEE	Institut national de la statistique et des études économiques

National institute for health and medical research	INSERM	Institut national de la santé et de la recherche médicale
	INTERPOL	International criminal police organization
Institute for scientific research on beverages	IREB	Institut de recherches scientifiques sur les boissons
Methylenedioxymetamphetamine	MDMA	Méthylènedioxymétamphétamine
Ministry of national education, research and technology	MENRT	Ministère de l'Éducation nationale, de la Recherche et de la Technologie
Mission for the fight against drugs	MILAD	Mission de lutte antidrogue
Interministerial mission for the fight against drugs and drug addiction	MILDT	Mission interministérielle de lutte contre la drogue et la toxicomanie
National mission for the control of chemical precursors	MNCPC	Mission nationale de contrôle des précurseurs chimiques
Central office for the repression of major financial delinquency (national fraud office)	OCRGDF	Office central pour la répression de la grande délinquance financière
Central office for the repression of drug-related offences	OCRTIS	Office central pour la répression du trafic illicite de stupéfiants
European drugs and drug addiction monitoring centre	OEDT	Observatoire européen des drogues et des toxicomanies
French observatory of drugs and drug addiction	OFDT	Observatoire français des drogues et des toxicomanies
French office for the prevention of tobacco addiction	OFT	Office français de prévention du tabagisme
WHO (World Health Organisation)	OMS	Organisation mondiale de la santé
National interministerial institute of road safety	ONISR	Observatoire national interministériel de sécurité routière
Regional health research institute	ORS	Observatoire régional de santé
(region of France)	PACA	Provence-Alpes-Côte d'Azur
Departmental rehabilitation programmes	PDI	Programmes départementaux d'insertion
Anti-drug training officer (of police)	PFAD	Policier formateur antidrogue
Hospital clinical research programme	PHRC	Programme hospitalier de recherche clinique
Access to prevention and care programme for those in insecure circumstances	PRAPS	Programme d'accès à la prévention et aux soins pour les personnes en situation de précarité
Regional health programmes	PRS	Programmes régionaux de santé
Minimum welfare payment	RMI	Revenu minimum d'insertion
National identification system for toxic substances and drugs	SINTES	Système d'identification nationale des toxiques et des substances
Regional medico-psychological hospital services	SMPR	Services médico-psychologiques régionaux hospitaliers
Regional health organisation schemes	SROS	Schémas régionaux d'organisation sanitaire
Community service	TIG	Travail d'intérêt général
Information processing and action against (illicit) financial channels	TRAFCIN	Traitement du renseignement et action contre les circuits financiers
Recent trends and new drugs	TREND	Tendances récentes et nouvelles drogues

Outpatient consultation and treatment unit	UCSA	Unité de consultations et de soins ambulatoires
	UNODCCP	United Nations Office for Drug Control and Crime Prevention
Hepatitis C virus (HCV)	VHC	Virus de l'hépatite C