OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

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REPORT TO THE EMCDDA
by the Reitox National Focal Point

FRANCE
DRUG SITUATION 2001

REITOX

Summary –main trends and developments

In France public policy since 1999 covers all psychoactive substances (including legal ones), yet this statement of the situation in the only domain of illicit drugs in France operates at a key point.

At the end of October 2002, six months after the French presidential elections and general elections, the government announced the appointment of a new chair, Didier Jayle, to the Interministerial Mission for the Fight Against Drugs and Drug Addiction [Mission interministérielle de lutte contre la drogue et la toxicomanie] (MILDT) which has the task of coordinating and implementing actions by public authorities in this regard.

Level of consumption

Experimentation with (use of a substance at least once in a lifetime), and indeed current consumption (use over last 12 months) of illicit drugs is marginal in France).

One particular exception should be noted - cannabis, use of which has expanded in the general population during the 90s and which, in 2002 had been tried by nearly one in four French people aged between 15 and 75 (EROPP 2002). Between 1992 and 2002, the figures for experimentation with cannabis nearly doubled for the 18-44 age group, rising from 18% (Health barometer 1992) to 35% (EROPP 2002). This experimentation is particularly commonplace among young people since at 18 it has been tried by one in two adolescents (ESCAPAD 2001). In general, this experimentation takes place shortly after the age of 15. Regular use (at least 10 times in the course of the previous month) of cannabis is much lower, however. at the age of 18, it applies to less than 7% of girls and less than 20% of boys. As a comparison, in 2000, this figure was 1.4% between 18 and 75 (Health Barometer 2000).

As regards the other illicit psychoactive substances, we also note a trend towards increasing experimentation, particularly among young adults and men. For all illicit drugs, with the exception of amphetamines, for which there is no significant difference between the sexes, two or three times more men than women have experimented at some time in their lives. After cannabis, cocaine is the illicit substance most often the subject of experimentation among the 15-75 age group, followed by ecstasy, mushrooms and LSD, all of which come ahead of heroin (EROPP 2002).

At the age of 18, the levels of experimentation among the girls (ESCAPAD 2001), all lower than 4%, are always lower than those of the boys (from 1 to 7%). Just under 5% of young people have experimented with hallucinogenic mushrooms, poppers, ecstasy and inhaled substances. Ecstasy, although the subject of much media coverage, has only been the subject of experimentation for 2.7% of girls (behind inhaled substances and poppers) and 5.0% of boys (behind hallucinogenic mushrooms, inhaled substances and poppers). Experimentation with amphetamines, LSD, cocaine, heroin or crack is even more rare: it involves less than 2% of boys and girls questioned, for each of these substances. When such experimentation does take place, it does so largely in the seventeenth year.

Emerging trends

Among populations of those who are already addicts, use of ecstasy is growing in the urban environment (treatment centres, streets, squats and low threshold institutions). Use of this drug is largely occasional and involves rather young, very diverse populations, including fully integrated people. In 2001, a downward trend was observed in the price of tablets and powder and a smaller quantity of MDMA per tablet (which represents a probable standardisation). Other trends: the increase in availability of cocaine and in its use both among urban users in temporary situations and among those taking part in the techno dance scene (locations where rave culture events take place). This greater availability (quantities seized are rising sharply in 2001) is accompanied by a fall in the average price of a gramme. In terms of perception, the fact that this substance has become more commonplace has brought about an alteration in its image in the urban environment. Even though distribution of ketamine remains highly secretive, there does appear to be more frequent use of this drug among drug users too. Its consumption seems to take place in large groups, since in parallel to its distribution on the dance scene, we can observe use of this substance by a small but not insignificant minority of people attending low threshold institutions. These are young users, mainly male, who start using this substance relatively early.

Public health problems

In total, the number of people with problematic use of opiates or cocaine is estimated to be between 150,000 and 180,000 in France. As regards the number of people registered by specialist organizations (which have increased greatly in number), the figures for November 1999 show 65,000 people, more than double the 1989 figures (28,000). As regards the substance giving rise to the registration, the proportion of heroin and opiates is still a majority (62% in 2000), but is in decline, while cannabis has increased its share correspondingly (24% in 2000). For recently consumed substances, 2001 represented a break from the trend, with a rise for heroin after the steady fall since 1995.

Regarding the number of patients undergoing substitution treatment, it is estimated that in France at the end of 2001, there were 90,000 such patients, including just over 10,000 treated with methadone. The other patients are treated with high-dose buprenorphine or Subutex®.

The practice of injecting is the origin of the main health issues suffered by drug users. But several sources now agree that this method of use is in decline, particularly among the youngest users and those who have been using for the least amount of time. This trend is undoubtedly explained by the influence of the risk reduction messages and actions produced by public authorities or by associations in the field: injection is a less attractive practice than it was and the perception of the risk of contamination by the HIV virus or hepatitis B and C is greater. The increase in the accessibility of the substitution treatment substances and the influence of the techno dance culture which basically promotes the non-intravenous methods of use also seem to have contributed to release a proportion of opiate users from the restrictions of injecting.

The total number of deaths due to illicit drugs cannot be estimated. However, deaths by overdose recorded by the police totalled 107 in 2001, the lowest level since the start of the 90s and in particular the maximum recorded in 1994 (564). Deaths associated with heroin are falling while those associated with cocaine and medications are rising. The year 2001 was marked by the

emergence of deaths associated with ecstasy: 8 in total including 5 for which it was the only substance recorded. The number of deaths from AIDS amongst drug users continued its fall in 1994 (1044) and settled at 101.

French public action and perception

The transmission of reliable data amongst professionals and also the public was one of the objectives of the 1999-2001 three-year plan (extended to 2002) adopted by the government and implemented by the Inter-ministerial mission against drugs and drug addiction. There are slightly more French people, questioned in 2002 (EROPP 2002), than in 1999 that feel informed about the subject, 61,0 % as opposed to 57,9 %. As far as the 'information' flow is concerned, we also note the very slight increase in connections to the internet sitewww.drogues.gouv.fr, opened in December 1999 and making data and information about drugs and addiction available for all, finally the number of calls to DATIS, the national help line is also increasing (although it is reducing questions about drugs are still more frequent that those about alcohol and tobacco).

As in 1999, more than 8 out of 10 French people (EROPP 2002) think that simple experimentation with heroine or with cocaine is dangerous. In relation to 1999 the image of ecstasy has reduced and rejoins that of these two other substances. Half of the population continues to think that experimentation with cannabis is dangerous and two thirds of people questioned believe in the « escalation theory ». Only the proportion surveyed in favour of legally selling cannabis clearly increased between 1999 and 2002 rising from 17 to 24%. Debates. Besides, the law dated 31/12/1970 (in spite of changes in its implementation and the fact that it has in particular been asked to prosecutors to avoid imprisoning users that haven't committed other crimes) continues to have the principle of the suppression of use. Thus, during 2001 almost 80,000 arrests for use or reselling of drugs were made in France. 93% are arrests for infringement of drug law; the remaining 7% is related to drug dealing. As far as arrests for use are concerned, cannabis is the substance in question, in 90% of cases. Of users questioned by police in 2001, 31 % were "without declared occupation" and 28% were high school pupils and students.

As far as the major objectives of the health policy are concerned, French people accept them. Only 5% of them are opposed (the figure rises to 21,5% when people are questioned about their immediate environment) to the establishment of care centres for drug-users. Almost three quarters of French people (EROPP 2002) think that it is not possible to achieve a world without drugs, which implicitly shows that it should be a priority for French policy: if unable to suppress drug use, then to be in a position to reduce as much as possible the different results of it. Seven out of ten French people know of the existence of the substitution and 8 out of 10 are in favour of prescribing these products. As far as the sale of syringes without a prescription is concerned, 6 out of 10 French people know of it and they are also 6 out of 10 in favour of it. The French are also in favour of information on the subject of drugs (including illicit drugs) at school, therefore, in favour of prevention.

The three-year plan of 1999

The three-year plan for the fight against drugs and the prevention of dependence (1999-2001, extended to 2002) has made the reduction of

demand one of its priority areas. The main strategic orientations and actions undertaken to achieve this objective have been the following.

systemisation of prevention, in particular through:

generalisation of committees on education for health and citizenship [comités d'éducation pour la santé et la citoyenneté] (CESC) to ensure prevention in the educational environment. Set up around the head of the establishment, the educational community and the organised forces of social life and the local area, these committees exist in nearly 7 out of 10 schools and secondary establishments.

the development of departmental prevention programmes, in order to provide departmental coordination of prevention actions locally under the responsibility of the 'drugs and dependence' project managers. In spring 2001, more than half of all French departments (53) had produced a departmental prevention programme.

early identification combined with continuity of registration:

In order to guarantee early specialist registration (particularly for those teenagers who use several substances) the structures and professionals of the field need to be brought together in a network and to strengthen the liaison function between the registration structures. Over the three-year period, the multidisciplinary liaison teams in hospitals, responsible for guiding the patient towards the most suitable service or treatment centre have gained in strength – in 2000/2001, there were 252 of them. Furthermore it can be seen that 40% of teams up to then divided by substances used have come together to deal with all addictive behaviours. In addition, nearly 8 out of 10 professionals are aware of the existence of a treatment network.

Reduction of risks and damage:

An initial wave of actions concerned the extension of this approach to young people on the dance scene making use of the combined support of the network of organizations and the network of departmental programmes of prevention. The first concern, building on the rave missions of the major subsidized associations, is to help to reduce dangerous use and its consequences (e.g. in terms of road safety). Actions are set up via the departmental prevention programmes: in 2001, 40% of the French departments took preventive actions or provided first aid at dance events.

Operating this policy and developing it for the most marginalized users in particular means strengthening the system: we note a sharp increase in credits while 87 out of 99 departments are now covered. In 2001 there were 227 automatic dispensers of sterile injecting kits, 118 needle exchange programmes, 42 boutiques (emergency health and social provisions) and 4 'sleep'in' (emergency accommodation system). The intention to promote social mediation, while contributing to establishment of a dialogue between users on one hand and risk reduction organizations and neighbours on the other is also

acknowledged as is shown by the pilot project set up in the 18th arrondissement.

Development of the substitution policy

In order to reduce the lack of balance between the two substitution treatments in France by promoting use of methadone, the circular of 30th January 2002 extended its initial prescription authorization to doctors working in the hospital (before 2002 treatment instigation was limited to doctors in specialist centres) and therefore made it more accessible to marginalized users seen at the hospital.

At the same time, and in order to fight against the misuse of Subutex®, the limitation of its supply to 7 days was authorized by the decree of 20th September 1999.

PART 1 NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORK

1. Development 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) is responsible for implementing the public policy decisions taken by the Permanent Interministerial Committee for the Fight Against Drugs and Drug Addiction. On the basis of decisions taken by the MILDT, a three-year (1999-2000-2001) plan to fight against drugs and prevent dependence, extended to 2002, has been adopted by the government. A status report and prospective elements of this plan were produced by MILDT and sent to the new government, formed in spring 2002. The appointment of a new chairman of MILDT (Didier Jayle), in October, should have been followed by a new plan extending over 3 or 5 years.

1.2 Legal framework

The **law of 31st December 1970** assigns three main objectives for public action undertaken in the fight against drugs:

- 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 principle of repression of use, subject of recurrent political debates, has not been changed throughout all these years. 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. Changes to the list of narcotic products covered by this law and additions of new substances recognized as dangerous can be made by 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.

This relative legislative continuity on repression of use hides fairly significant changes in the implementation of the law, as expressed through the circulars and other provisions drawn up by the administrations in charge of justice and health (cf. part 1.3).

During 2001, a new direction was taken with regard to trafficking, with the promulgation of the **law on new economic regulations (NRE - nouvelles**

régulations économiques) 15th May 2001[1]. This law aims to take into account the sophistication of trafficking and of money-laundering methods as a result of the spread of use of new information and communication technologies (NICT). The anti-money laundering aspect of the law on the new economic regulations aims to improve the national system, in particular by initiating a system of automatic declaration for certain significant financial operations and setting up a 'liaison committee to fight against the laundering of the proceeds of crimes and misdemeanours'. These legal developments should receive a short or medium-term extension, with the entry into domestic law of **directive 2001/97 of 4th December 2001, making modifications to anti-money laundering directive 91/308 of 10th June 1991.** The new European text consolidates the process of extending the fight against money-laundering to include non-financial professions, in particular to target those in the accounting and legal professions.

1.3 Laws implementation

The legal framework did not change much in 2001. Nevertheless, the following key elements may be distinguished:

In the light of the local difficulties observed in implementation of these two circulars, the application of the legislative provisions for the fight against trafficking has been clarified. The **circular of 9th May 2001 from the Minister for Justice about security** sets objectives for improving local coordination of the law enforcement services responsible for fighting against trafficking in narcotics within the framework of the Local Security Contracts: it recommends that the prosecutors should define high-priority public action sites requiring major action against underground economies and the gang phenomenon (by setting up local groups to deal with delinquency). This guideline was relayed by an **interministerial circular from the Ministers for Home Affairs and for Justice, dated 5th September 2001** which recommended actions to be put into place, with the same perspective, with the goal of breaking down the gangs and fighting against the underground economies established around local trafficking of narcotics or organized thefts and receipt of stolen goods.

On 1st October 2002, at its first reading, French MPs adopted a bill creating a new offence, prohibiting driving under the influence of plant or other substances classed as narcotics. The sanction proposed by this document, which is to be examined next by the Senate, is the same as that for driving under the influence of alcohol 'but without the threshold effect): 2 years in prison and a fine of 45,000 euros.

1.4 Developments in public attitudes and debates

Some thirty surveys dealing to a greater or lesser extent with drugs and addiction have been carried out in France between 1988 and 2002. The most recent opinion polls concerning drugs were undertaken by the OFDT in 1999 and again in 2002 (2009 people aged 15 to 75, selected by the quota method and questioned by telephone).

In 2002, 61.0% of those surveyed considered themselves to be informed about drugs, a slightly higher figure than in 1999 (57.9%). As in 1999, 70.4% knew of the existence of substitution treatment, but there has been a small

[1] Law No. 2001-420 of 15th May 2001 regarding new economic regulations, Gazette of 16th May 2001, p.7776 (NOR: ECOX0000021L).

drop in the percentage who know about the sale of syringes without medical prescription (from 68.4% to 63.8% in three years). This fall undoubtedly represents the fact that this measure has become commonplace and has not received so much media attention for the last few years. Also, 5.1% of those surveyed stated that they had read the booklet 'Know more, risk less', which represents about 2 million people. The same proportion declared that they had had direct contact with the booklet (without having read it) and 13.9% had heard of it, making in all about a quarter of the French population. When those surveyed were invited to estimate how many people in France today have smoked cannabis at least once in their lives, in general, their estimates were somewhat higher than figures published recently for this point: if the figure of about 20% of the adult population having experimented is used as a reference, it seems that among those who suggested a percentage, seven out of ten of those surveyed put the figure higher than this, and more than half put it above 30%.

In response to the question 'What are the main drugs that you know of, even if you only know the names of them', the French list an average of 3.8 drugs. The 'notoriety' of cocaine, which had fallen between 1997 and 1999, takes a position above heroin and opium, as does cannabis, which is still the most frequently mentioned drug. LSD is nearly as well-known, while knowledge of ecstasy, which had become much more frequently mentioned between 1997 and 1999, is no longer expanding.

The French seem to have become slightly more tolerant with regard to cannabis, with an increase in the proportion of people who only consider it dangerous with daily consumption (32.9% from 28.1%). However, half of the population still considers it dangerous even to experiment with cannabis (51.3% in 1999 as against 50.3% in 2002). In other words, cannabis is considered a little more favourably by the marginal percentage of the population that had been least hostile to it, but overall, its image remains unchanged.

The 'theory of escalation' (according to which using cannabis leads to the use of more dangerous drugs) is supported by two-thirds of the population, an identical result to that of 1999. However, it must be noted that the proportion of people in complete agreement with this theory has fallen, from 30.6% to 27.3%. In other words, the image of cannabis is improving in the margin, in terms of both its own degree of risk and its connection with more dangerous drugs. It benefits from a separated status – considered a lot less dangerous than the other illicit substances, and yet considered less addictive than legal substances (alcohol, tobacco).

The proportion of people who consider it dangerous even to experiment with ecstasy had increased, from 75.6% to 78.6%, while over the same period, the proportion of people who had not heard of the substance had fallen, dropping from 5.8% to 3.3%. The substance considered most dangerous by the French is still heroin, with ecstasy and cocaine not far behind, followed by alcohol and tobacco. Cannabis came last, with only 2.0% of those questioned considering it to be the most dangerous drug, a figure lower than that recorded in 1999 (3.4 %).

In 2002, as in 1999, a large majority of those questioned accepted the conclusion that gave rise to the risk reduction policy: almost three quarters do not think it possible to achieve a world without drugs (73% in 1999, 74% in 2002). Acceptance of the existing measures also proves to be stable: in 2002,

82% of those questioned approved of the prescription of substitution drugs (81% in 1999), while 60% approved of the unrestricted availability of syringes (63% in 1999).

The consensus on mandatory treatment for users of illicit drugs when they are arrested is also very strong (91% favourable in both surveys), but this result undoubtedly comes from two very different attitudes, one of which values the aspect of coercion while the other values the fact that legal proceedings can be avoided by favouring alternative therapy. Where cannabis is concerned, in particular, the consensus is lower (77% favourable in 2002), perhaps because the benefit of medical treatment for the user is considered less obvious.

Those questioned still remained in favour of prohibitive measures. In 2002, as in 1999, 65% stated that they were against authorizing use of cannabis in certain conditions and 88% were against authorization of the use of heroin in certain conditions. However, the proportion claiming to be in favour of cannabis being sold openly has risen dramatically: 24% in 2002, as against 17% in 1999. If this change took place partly as a result of use of cannabis becoming more commonplace (+10 points among those who have taken it at some time in their lives), the increase is also noticeable among those who do not use the drug (+4 points).

On the other hand, where use of illicit drugs is envisaged for therapeutic purposes, under medical supervision, the opinions expressed are very different: A good half of those questioned stated that they were in favour of heroin being supplied under medical supervision, in 2002, as in 1999 (respectively 51% and 53%); and a large majority, increasing sharply, declared themselves in favour of medical prescription of cannabis for certain serious illnesses (67% in 1999, 75% in 2002).

With regard to treatment centres for drug addiction being created in consultation with local partners, only 5% of those questioned were opposed to this, but the proportion rose to 21.5% if such a centre was to be opened in their own district.

Finally, for alcohol, as for tobacco and other drugs, more than nine out of ten of those questioned considered that the information they were given at school was useful, but three-quarters believed it to be insufficient, while less than one in ten thought it potentially harmful.

1.5. 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 comes from credits from the budget of the Ministry of Employment and Solidarity. As well as credits specifically for this purpose, those associated with the prevention of AIDS amongst drug users must be added, 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 budget proposals in 2001

(in millions of Euros)

Interministerial credits	45,46
Health and Urban credits – centralized expenditures (chapter 47-15 article 30)	1,14
Health and Urban credits – decentralized expenditures (chapter 47-15 article 40)	120

Source: MILDT

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 in 2001 – article 30

(in thousands of Euros)

fight against drug addiction	54
Fight against alcohol	686
Fight against tobacco	396
Total	**1136**

Source: MILDT

Use of Health credits allocated to drug addiction in 2001 – article 40

(in millions of Euros)

Global allocation for the CSST functioning	101.2
Reimbursement of methadone	2
«City» part of the 51 drug addiction-city-hospital networks	1.1
Advice centres for young people and parents	6.5
Social integration workshops	1.8
Centres for outpatients	0.8
Structures called « low threshold »	4.2
Mobile, teams close-by	0.5
Other	1.9
Total	**120**

Source: MILDT

Interministerial credits

Relatively stable between 1992 and 1997, the Interministerial credits were significantly increased in 1998 and in 2001.

Interministerial credits in 2001

(in millions of Euros)

Health, social affairs	2.20
National education and research	3.47
Youth and sport	1.67
Interministerial delegation for the urban life	/
Justice	0.26
Internal affairs (police)	0.52
Defence (gendarmerie)	0.53
Economy and finance (customs)	1.00
Foreign affairs Cooperation	1.5
Others	/
Activities of the MILDT	15.04
Total	**26.5**

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 2001

(in millions of francs)

CDO	9.4
Local action	8.5
CIRDD	2.9
Total credits decentralised MILDT	20.8
Total credits MILDT	47.4

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.

PART 2 EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Devlopements in Drug Use

2.1 Main developments and emergent trends

Overall view

The tendency for experimentation with cannabis to become commonplace is confirmed year after year. In 2001, one in two 18-year olds have already used it. In 2000, more than one in five of the French population aged between 18 and 75 had also experimented with the drug. This drug still represents the most frequent grounds for arrest in France in 2001 for illicit use of narcotics.

Use of heroin and other opiates is still the action of a small minority in France. Consumption of this drug, to the extent that it can be observed in the traditional environment of users, seems to be stable or falling. The steady decline in three indicators - arrests for use, quantities seized and deaths by overdose – seems to offer evidence of the impact of the development of opiate substitution treatments in France. However, it seems that we are witnessing the emergence of a new generation of heroin users, more socially integrated than the traditional users and injecting less frequently, preferring to sniff or inhale instead. Some of these new users are using heroin to regulate their use of stimulants. High-dosage buprenorphine (Subutex®) is easily available on the black market in major urban areas and, for a number of people, constitutes a gateway leading to opiate addiction.

The increase in frequency of cocaine use both among urban users in temporary situations and among those taking part in the dance scene is confirmed. The price of this drug is falling. Cocaine and crack continue to be made available in these two environments. This distribution pattern incorporates a growing heterogeneity in the profile of the users. Recent cocaine users have different methods of use: they are less likely to inject and more likely to sniff and inhale than older users.

Among urban users in temporary situations, the use of hallucinogenic drugs (LSD and ketamine) is observed to be on the increase. This still only involves a limited group of people who are quite young and who use more than one drug. It mainly consists of occasional use. On the dance scene, the situation changes depending on the drug. Use of LSD, mushrooms and GHB does not seem to have changed since the previous year. Use of ketamine has expanded into new regions whilst having less of a presence in the regions where it was previously reported.

Analysis of trends in relation to social contexts

In terms of consumption, the boundary between the environments of the dance scene and the street is tending to disappear. Drugs such as ecstasy, LSD and cocaine, which were characteristic of the dance scene environment several years ago, are now increasingly showing a presence in urban areas. At the same time, heroin and crack are becoming more and more available on the dance scene. However, the specific characteristics of the different environments endure, with regard to the methods of administering the drugs –

sniffing in the dance scene environment and injecting in the urban environment – even if changes are also observed that confirm the mutual influences between the two environments. A downward trend in the use of injection can nevertheless be observed in the urban environment, particularly among recent users of cocaine and heroin, with a preference for sniffing while there is a tendency for the use of injection to increase in the dance scene environment.

2.2 Drug use in the population

Measuring the extent of drug consumption

Before quantifying the users and their characteristics, it is necessary to define the level of 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.

These four categories are defined using the indicators currently used internationally: use of a product at least once in a lifetime, at least once a year, every day (or evening). The various groups are not exclusive; regular users are a sub-set of occasional users who are, in turn, a sub-set of experimenters.

These data must be interpreted as a simple guide to the scale of the different modes of consumption of the main psychoactive.

The use of illicit drugs amongst adults

Measuring declared consumption of various drugs

The use of psychoactive substances is described here for the age groups most concerned and for the whole 15-75 age group from the results of a survey of declared consumptions amongst a representative sample of the adult French population.

Prevalence of experimentation with illicit drugs at least once in lifetime according to declarations by those aged 15-75, 15-34 and 35-75

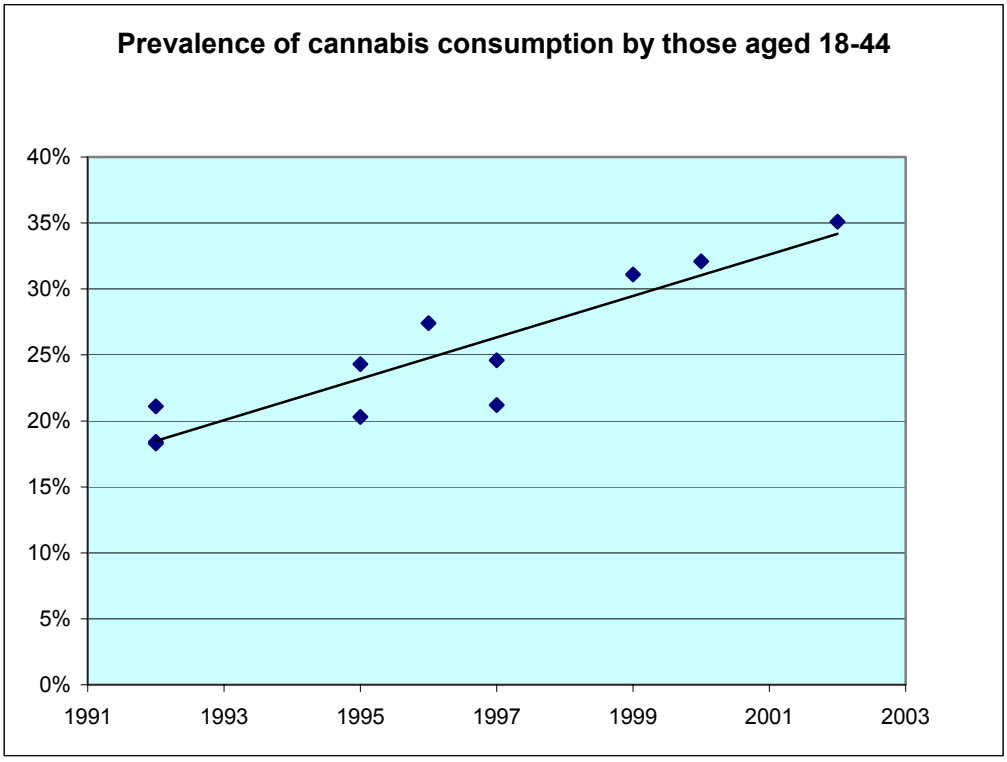
	15-75	15-34	35-75
cannabis	24.0%	39.9%	13.7%
cocaine	1.9%	3.0%	1.3%
LSD	1.0%	1.5%	0.8%
ecstasy	1.1%	1.9%	0.2%
hallucinogenic mushrooms	1.1%	2.1%	0.6%
heroin	0.7%	0.5%	0.9%
amphetamines	0.4%	0.1%	0.6%
others	0.1%	0.3%	0.1%

Source: EROPP 2002, OFDT.

This declared consumption of illicit drugs is largely dominated by cannabis and chiefly concerns those under 35. This is why it is also interesting to relate the declared consumptions to the population between 18 and 44. In 2002, two out of five French people had already tried cannabis and about two in ten used it more continuously, either occasionally or regularly. The declared experimentation with drugs other than cannabis appears fairly marginal. The incidence of use at least once a year is very rare in the general population, no more than 0.3% for 15-75 year olds and rising to 0.8% for ecstasy, 0.7% for cocaine and 0.6% for hallucinogenic drugs (LSD and hallucinogenic mushrooms) for 15-34 year olds.

Changes in declared consumption of cannabis

The use of cannabis increased significantly between 1992 and 2002. This development is confirmed by surveys, in particular those carried out amongst young people, and by observations made in the field. All these surveys tend to confirm the observations made in the field: the use of cannabis is becoming commonplace.

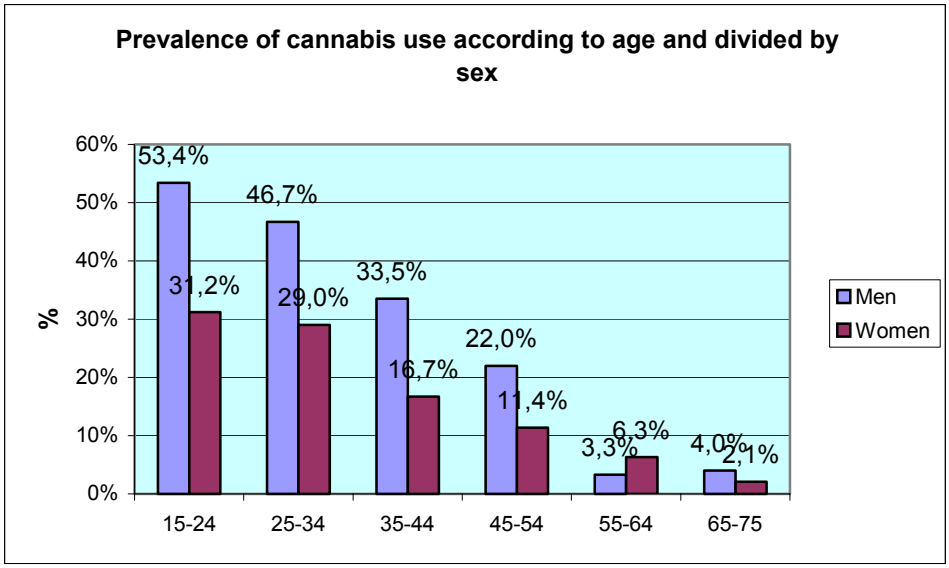


Sources: SOFRES 1992 ; CFES 1992, 1995, 1996, 2000 ; IFOP 1997 ; Publimétrie Grande Ecoute, 1997 ; EROPP-OFDT 1999, 2002.

Discriminating factors in cannabis consumption

Experimentation with cannabis is strongly linked to age and to sex, with younger persons and men declaring themselves users of illicit drugs more frequently than older persons and women, as shown by the following chart:

Experimentation with cannabis according to age and divided by sex



Source: EROPP 2002, OFDT.

School children and youth

The use of illicit drugs amongst adolescents 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.

The most recent data are those from the Survey on Health and Consumption during the Call to Preparation for Defense [*Enquête sur la Santé et les Consommations lors de l'Appel de Préparation A la Défense*] (ESCAPAD) conducted in 2001 by the OFDT.

Frequency of experimentation with psychoactive products amongst the young at the age of 18, in 2001, according to sex

	Girls	Boys	Overall
cannabis	45.2 %	55.7 %	50.5 %
hallucinogenic mushrooms	2.5 %	6.9 %	4.8 %
poppers	3.4 %	5.7 %	4.6 %
inhaled products	3.7 %	5.8 %	4.8 %
ecstasy	2.7 %	5.0 %	3.9 %
amphetamines	1.2 %	2.5 %	1.9 %
LSD	1.3 %	2.3 %	1.8 %
cocaine	1.3 %	2.5 %	1.9 %
heroin	0.8 %	1.0 %	0.9 %
crack	0.6 %	1.0 %	0.8 %

[1]: Heading used in the questionnaire: "medication for the nerves, to sleep"

Source: ESCAPAD 2001, OFDT

At 18, after cannabis, the drugs most frequently tried are hallucinogenic mushrooms, poppers, inhaled products and ecstasy and, to a lesser extent, amphetamines, LSD and cocaine. There is always a higher frequency of experimentation for boys. Among the boys, the frequency of experimentation exceeds 5% for five drugs: cannabis, hallucinogenic mushrooms, poppers, ecstasy and inhaled products.

The use of cannabis within the previous 12 months applies to more than a third of girls (37.5%) and one out of two boys (50.0%). The use of cannabis within the previous month applies to 23.6% of girls and 39.2% of boys. Finally, there are almost 3 times as many boys declaring that they have smoked cannabis more than 10 times within the previous month (regular use): 19.7% for boys as against 6.9% for girls.

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. Its main difference was the inclusion of 14-18 year olds. Since the results from the latter were developed extensively in the previous report, we will not deal with them here.

2.3 Problem drug use

Estimate of the number of "problem" users of opiates

The most recent estimate of the number of problematic users of heroin or cocaine was undertaken in 1999 and was largely dealt with in the previous report. In 1999, it should be noted, the application of the European protocol

gave a range of estimates for problem users of opiates and cocaine from 150,000 to 180,000.

Intravenous injection

We have no available data produced later than 1999.

3. Health consequences

3.1 Drug treatment demand

France still does not have a system for recording requests for treatment in accordance with the European protocol. From 1987 to 1999 the data used came from a survey undertaken at institutions attended by drug users over one month (November). This survey, which does not conform with European protocol, has not been repeated since 1999 and it has not been possible to set up a new survey to be compatible with the European indicator for requests for treatment.

The work of defining a minimum common core set of questions, able to be used both by specialist organizations (drug addiction treatment centres and outpatient alcohol treatment centres) and by liaison staff in the hospital environment or local doctors, has been undertaken with the institutions and professionals concerned. These questions are intended to be able to be used both in surveys of an epidemiological nature and in the activity reports of the various organizations involved. This core list of questions must also be compatible with the recommendations of the European Observatory aiming to make comparisons between different EU countries possible. This process conducted in particular by the IDI (Illicit Drug Indicator) work group, which meets at the OFDT, was the subject of an executive summary, formulating a number of proposals. The common core questions have been selected and confirmed, or are in the process of being confirmed, by professionals representative of the various types of organization. Now that these instruments for collecting data have been developed, they need to be implemented.

In the absence of a survey compatible with European protocol, this year this report will be based only on data obtained from the annual activity reports of the drug addiction treatment centres, which have been sent to the Ministry of Health since 1998, with the last available figures dating from 2000 (figures for 53,000 patients). The 'typical' activity report from drug addiction treatment centres contains a set of questions that provide a summary description of the patients registered during the year. The data is provided for the set of patients attending the institution and not on the basis of individual patients, which means that the cross-referencing required for the indicator about requests for treatment cannot be provided. The data obtained from the activity reports, however, does have the benefit of relating to an annual period which makes it more comparable with the data from the other countries. It can be used temporarily, while waiting for the establishment of a data collection system that complies with the European protocol.

The results of the other two surveys will also be used in this report, even though they were produced using a data collection method differing from the European protocol recommendations. The first is a survey on the consumption of the users registered with a group of organizations, mainly drug addiction treatment centres, during a given month (OPPIDUM survey, number of patients included in 2001: 2858). The second is a survey specifically of users frequenting 'Low-threshold' programmes (Low threshold Survey) conducted in

the seven sites integrated into the French system for observing recent trends (TREND, number of patients included in 2001: 799).

Annual number of registrations at drug addiction treatment centres

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Total patients	28262	31762	35464	37236	41803	52913	51700	57990	58946	nd	64916
New patients (never previously registered)	nd	15352	17234	18191	21679	22942	26849	27954	30064	nd	30095

Source: survey on registration of drug addicts with health and social services, SESI/DREES/DGS

A very large number of patients in France are registered by general practitioners, particularly for the prescription of substitution treatment using high dosage buprenorphine. According to some theories, an idea of the number of patients in treatment over the period of a given month may be obtained using the sales figures for high dosage buprenorphine and methadone. At the end of 2001, the number of people per month undergoing substitution treatment was estimated at more than 90,000, probably including more than 20,000 whose prescription was made by a specialist organization. On the other hand, the number of patients who have come to their doctor to ask for other forms of treatment, is not accounted for, along with the number of patients who attended both a specialist institution and a general practice. This number is based on the assumption of average posology in accordance with the recommendations issued with medications when they are sold (8mg per day for high-dose buprenorphine, 65mg per day for methadone). There is a possibility that the average posologies are higher by between 10 and 20%. The estimate of the number of users undergoing substitution treatment would be lower in this case than the numbers shown above.

Patient characteristics

The sex of users

Since the end of the 1980s, the sexual divide among registered users of illicit drugs has undergone minor fluctuations about the basic figure of one woman to every three men. Men represented 77% of all registrations in specialist centres in 2000. In the Low threshold Survey, the proportion of men reaches 80%. In the drug addiction treatment centres, the percentage of men tends to be a little higher among new patients.

Age of the users

The tendency for an increase in the age of users seeking assistance in specialist centres, observed since the end of the 1980s in the November survey has continued up till 1999. Between 1997 and 1999, the proportion of those under 30 decreased, while the over-34 age group increased. The annual data supplied by the drug addiction treatment centres in the activity reports for 2000 seems nevertheless to show a stabilization, and even a slight decrease, in the age of the patients, due to the increase in the proportion of those under 25 among new patients (31% in 1999 as against 36% in 2000).

Substances leading to the registration for care

In the annual figures obtained from the activity reports of the drug addiction treatment centres, the proportion of opiates is lower, while that of cannabis is clearly higher. It is possible to over-estimate the proportion of registrations related to cannabis, since this substance may sometimes be mentioned as the secondary drug for a single patient. This over-estimating should not be substantial, however, and would only be able to explain a small proportion of the difference seen between the results from the two sources (November

survey and activity reports). It is first and foremost the over-estimate of the number of users undergoing substitution treatment, in the 'one month' surveys, that gives rise to this discrepancy. A very high proportion of the users whose registration is opiate-related are undergoing substitution treatment and are therefore more likely than cannabis users to attend their registration institution regularly.

Over the 1998 to 2000 period, the proportion of heroin and opiates is in decline, while cannabis has increased its share. This development, already observed in the November survey between 1997 and 1999, seems to be continuing in 2000.

Substances leading to registration at drug addiction treatment centres (in % of registered number of patients)

	1998	1999	2000
Heroin	55.3	49.4	48.8
Buprenorphine and methadone (without prescription)	9.1	12.0	10.2
Codeine	4.0	3.5	3.1
Total opiates	68.5	64.8	62.0
Cocaine and crack	5.6	6.1	6.1
including crack	1.4	1.1	1.5
LSD	0.7	0.6	0.7
Cannabis	17.5	21.5	24.0
Amphetamines	1.9	1.5	2.1
including Ecstasy	0.6	0.6	1.0
Solvents	0.2	0.2	0.4
Psychotropic medicaments (not including opiates)	5.7	5.3	4.7
Total	100.0	100.0	100.0

Source: typical activity report from CSST, DGS/OFDT

Note: This data was compiled using a sample group of drug addiction treatment centres that provided response levels close to 100% to the question on the substances leading to registration, with 80% of the drug addiction treatment centres responding to this survey in 2000 but only 60% in 1998 and 1999.

It is possible to distinguish two different age groups among the patients:

- **The people whose registration is primarily connected to opiate use**, whose average age is around 31 and increasing from year to year. This group is very much the majority, which explains why the overall average age is about the same. The people registered for use of cocaine and crack as the primary drug are fewer in number and close in age to the opiate users.
- **The people whose registration is primarily connected to cannabis use**, whose age is around 25 at registration. This group includes a large number of young people, aged under 25 and much smaller number of older people (over-30s).

Recently consumed substances

The surveys on people 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 undergoing substitution treatment, heroin may have led to registration, although it is no longer being used and has not been 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 (14% in October 2001, according to the OPPIDUM survey). Recent cocaine use is mentioned in 8% of cases in 2000 and 2001. Among users attending low threshold institutions, levels of use over the last 30 days are higher (23% for heroin, 39% for cocaine, 82% for cannabis) The users who attend this type of institution are more active in drug use, on average, than those who are registered with the drug addiction treatment centres.

Use of high-dose buprenorphine raises a special problem as regards measurement, since it may function as a treatment (prescription by a doctor, monitoring of treatment), or be used in a non-treatment context, or may even be used partly for treatment and partly not. In the OPPIDUM 2001 survey, 45% of patients use high-dose buprenorphine, 41% in a treatment context and just under 4% in a non-treatment context. The users of Low threshold facilities are characterized by a much higher proportion of patients who have used high-dose buprenorphine (21%), while the overall percentage of users of this medication is quite similar in both surveys (47% in the low threshold survey).

The downward trend in heroin among substances used has already been mentioned in the earlier reports. This development was initially accompanied by an increase in the proportion of cocaine but this then decreased and seemed to be stabilized in 2000 and 2001. In contrast with the tendency recorded for heroin since 1995, the proportion of patients using this substance rose in 2001. The proportion of users of high-dose buprenorphine in a non-treatment context, however, remained stable.

Percentage of registered patients who have used benzodiazepines, heroin and cocaine in the course of the last year

	1998	1999	2000	2001
Benzodiazepines	25.5	25	26.6	25
Heroin	15.2	13	11.2	14.5
Cocaine	12.9	12	8.2	8

Source: Oppidum/CEIP

Method of use

Among the users who attended the drug addiction treatment centre in the month of November 1999, nearly 15% declared that they had injected a drug within the previous month, a variable proportion depending on the drugs that had led to the registration (18% in the case of heroin, 15% for cocaine). In total, 59% of patients had already used drugs intravenously at some point in their life, a proportion quite similar to that found in the activity reports of 2000 (61%). The proportion of injecting users was much higher amongst those who stated that they had used a substance within the last 30 days. In the OPPIDUM survey of October 2001, intravenous injection involved 31% of current heroin users, 40% of cocaine users and 13% of Subutex users. In the Low threshold Survey, conducted mainly in syringe exchange programmes, the proportion of injecting users (over the last 30 days) was much higher: it represented 65% of the heroin users, 62% of Subutex users and 58% of cocaine users.

For the last few years, there has been an observable tendency for the practice of injection to decrease. This development is noticeable in the data in the November survey, where the percentage of people who have injected within the last 30 days dropped from 18 to 15% between 1997 and 1999. According to the data of the OPPIDUM survey, this trend continued between 1999 and 2001. Among heroin users, the proportion of injectors fell from 39 to 31% between these two dates, for cocaine users, the drop was from 50 to 40% and for Subutex from 17 to 13%. The practice of injecting has decreased, while taking drugs via the nasal duct (sniffing) has increased correspondingly. We also note a considerable increase in use of heroin by inhalation (smoking heroin) in 2001.

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. 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) Death directly and indirectly attributable to drug use

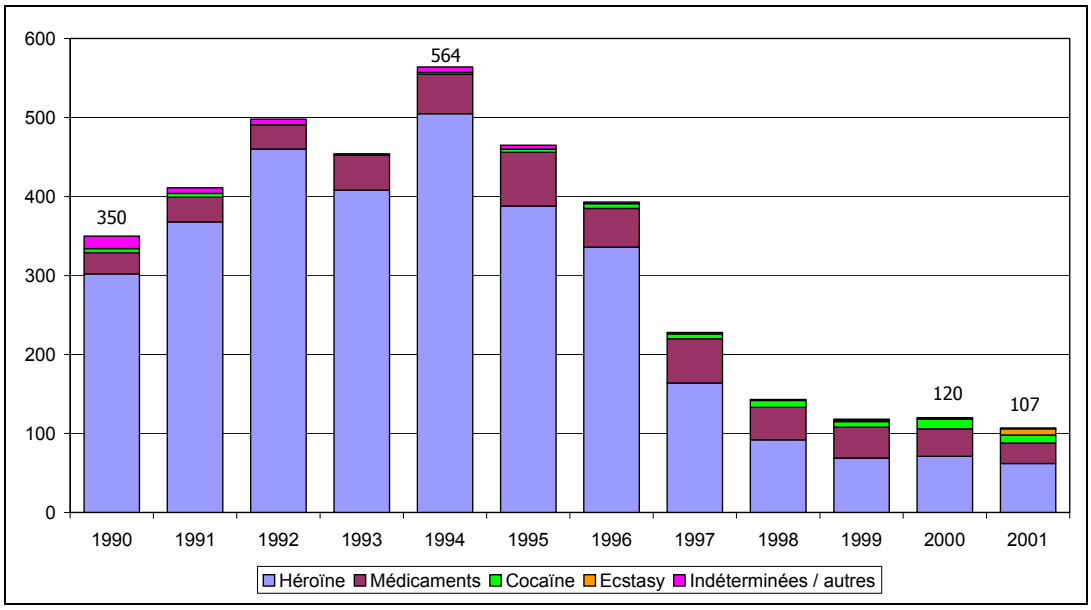
A proportion of the deaths from illicit drug use can be measured with the help of the national register of causes of death maintained by the National Institute of Health and Medical Research [*Institut national de la santé et de la recherche médicale*] (INSERM), which collects its information from death certificates. The data that is most easily available comes from the Central Office for

Repression of Drug-related Offences [*Office central pour la répression du trafic illicite de stupéfiants*] (OCRTIS). The data represents overdoses recorded by the police services or the National Gendarmerie.
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 between the maximum recorded in 1994 (564 deaths) and the lowest level, reached in 2001 (107 deaths). In 2000, 30% of deaths by overdose were caused by several substances being combined. This proportion was equal in 2001.

Deaths by overdose recorded by the police, from 1990 to 2001



Heroin, Medicaments, Cocaine, Ecstasy, Unknown/Others

Source: FNAILS, OCRTIS (2001).

The downward trend is explained in particular by the fall in deaths due to heroin overdose. These overdoses have fallen in both absolute and relative terms, and the proportion of these deaths within overall deaths recorded by the police fell from 86% in 1994 to almost 58% in 2001. The development of substitution treatments and the fall in use of the drug are the main factors providing an explanation of this development. Since 1999, and although the 2001 figure is lower again, it seems that a limit threshold has been reached.
Since 1994, it is medications and cocaine that are increasingly responsible for death by overdose. Nearly one death in 3 is due to a medications overdose, and 1 in 10 is due to cocaine. Of the deaths that are attributable to medications, the drugs concerned most frequently are those used in substitution treatments (Subutex®, methadone) and morphine sulphates (Skenan®, Moscontin®). In nearly half of the cases of overdoses associated with medications, several substances were found by toxicological analysis - Subutex® and methadone were the most frequently associated.
It has proved difficult to trace a development in deaths by overdose associated with these two substances. However, we note that the proportion of deaths associated with Subutex®, out of all deaths, declined between 2000 and 2001: 6.5% as against about 9% from 1998 to 2000. In 1998, deaths associated with methadone represented 2.8% of all deaths and 7.5% in 2001 after reaching 9.5 % in 2000.

The year 2001 was marked by the emergence of deaths associated with ecstasy: 8 deaths by overdose were recorded, a figure never again reached. In 5 cases, ecstasy is the only product shown up by the toxicological analysis and in the other 3 other cases, alcohol, Subutex® and cannabis were also present.

Other measures of deaths in connection with drug use

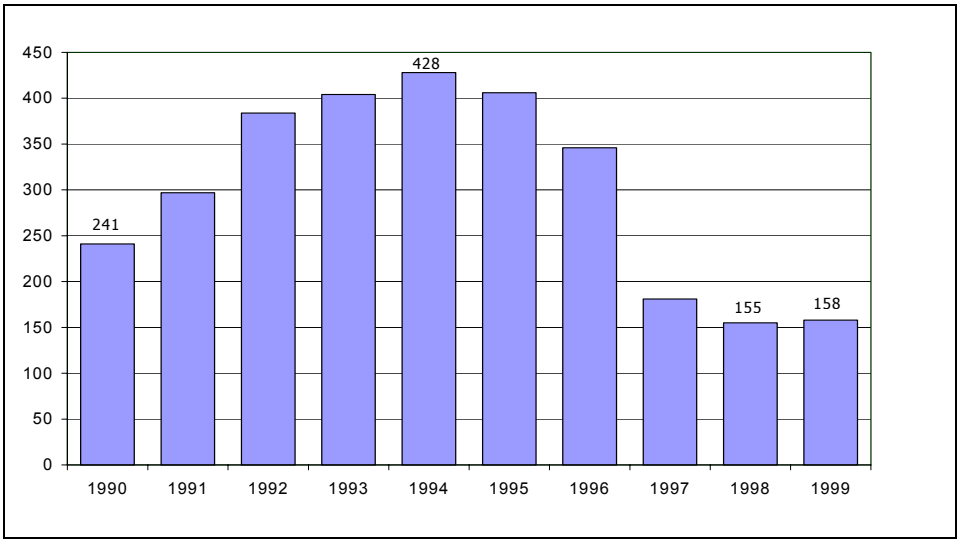
The deaths to be found in the INSERM causes of death file are not only overdoses since all deaths where drugs are implicated are likely to be recorded. This source does not act as a reliable indicator of overdoses in the strict sense, as certain deaths where the cause is not immediately identified are 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 new international classification of diseases (CIM 9), deaths connected with drugs are grouped under three distinct causes: psychoses caused by drugs (no.292), dependence (no.304), and abuse of drugs without dependence (no.305). 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. Since 1990, only a few cases of psychosis have been recorded (7 cases, the last of which was in 1998).

The most recent available figures are from 1999, because INSERM is currently conducting an update of the causes of death file (transition from CIM 9 to CIM 10).

Deaths from drug dependency as recorded in death certificates from 1990 to 1999



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 between 1996 and 1997, reaching a relatively stable threshold in 1998 and 1999.

At least half of these deaths are associated 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.

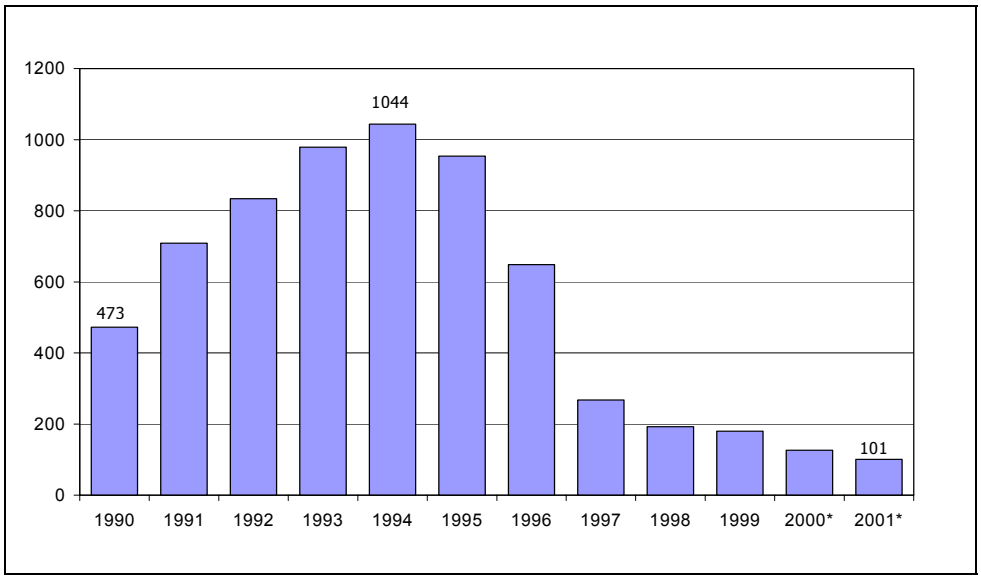
Finally, data can be added from the information gathered by the DRAMES (Death Related to Abuse of Medicaments and Substances: *Décès en relation avec l'abus de médicaments et de substances*) monitoring system and fed to it by the CEIP, Centres for Evaluation of and Information on Drug Dependency

[*Centres d'évaluation et d'information sur la pharmacodépendance*][2]. In 2000, 154 deaths were recorded (as against 120 by OCRTIS): in 143 cases, the substance absorbed is the direct cause of death; in 11 cases it was the indirect cause. The non-exhaustivity of the DRAMES data and that of OCRTIS has been demonstrated by comparing the two databases. By applying the capture-recapture epidemiological method at regional level to these databases a fairer estimate of the total number of deaths is obtained.

Deaths of injecting drug users from AIDS

The number of deaths from AIDS amongst drug users continued to fall in 2001. After the peak in 1994, these deaths have fallen by an average of 25% each year till 1997. A similar development can be observed for the total deaths from AIDS, independent of mode of contamination.
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 2001



** Corrected data*

Source: AIDS monitoring system, InVS

b) Mortality and cause of death of drug users; trends

Currently, no information is available but a study using a cohort of arrested users is currently underway[2] and the first results will be available during the year 2003.

3.3 Drug-related infectious diseases

Prevalence of HIV infection

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 was unknown for 37% of the first group against 14% of the second. The prevalence of HIV infection amongst injecting users registering for the first time, was 13%.

[2] Study undertaken by OFDT, approved by the Commission nationale de l'informatique et des libertés (CNIL) using the FNAILS file of OCRTIS.

New cases of AIDS

In 2001, the number of new cases of AIDS amongst drug users was falling. 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 and 2001.
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 2001

1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000 *	2001 *
640	905	1 079	1 218	1 342	1 493	1 377	1 319	963	424	347	298	241	204

** Corrected data*

Source: AIDS monitoring system, InVS

Hepatitis C

Of those seen by the specialised centres in November 1999, 20% of non-injecting users were HCV positive as against 63% of injecting users.

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 driving issue, the OFDT, in the context of the law of 18th June 1999 and its supporting legislation, has coordinated an epidemiological study, running since 1st October 2001 (for 2 years) to study narcotics use among drivers involved in a fatal road accident.

The results of this study are expected at the end of 2004. This time period is necessary so that a sufficient number of cases (10,000) and their accidentological analysis can be collected. This number of cases had been specified for study in order to resolve the ambiguities generated by many earlier projects that produced divergent results. If the studies conducted in the laboratory highlight alteration in driving ability caused by the consumption of psychoactive substances, no epidemiological studies conducted in a real driving situation have shown the implication of narcotics in the incidence of road accidents. On the role of cannabis in the incidence of road accidents, the INSERM expert report (published in November 2001), which had the objective of summarising international knowledge on the subject, concluded 'that no study has managed to demonstrate that use of cannabis alone increases the risk of being responsible for a serious accident in which death or injury occur'.

4. Social and legal Correlates and Consequences

4.1 Social problems

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

In 2000, about 30% of drug users registered with the specialist institutions did not have stable housing (23% in temporary accommodation, 6% homeless) A third of these users were living on income earned from work and slightly less than half (45%) were living on income from social welfare. The group of users attending low threshold institutions in 2001 is characterized by lower proportions of people earning their income from professional activity (just under one in five, on average, as against one in three in the drug addiction treatment centres) and of people with children to look after (17% as against 30% in the drug addiction treatment centres).
For the indicators relating to housing and income, it may be observed that the situation of drug users attending specialist institutions is tending to improve, albeit slowly. The proportion of users that are in stable housing and an income earned from work has increased between 1998 and 2000. As regards housing, the improvement seems roughly equal among those people that were already registered and those who have had contact with an institution for the first time. However, this positive development is largely associated with the increase in the proportion of people who are in stable accommodation provided by their family. The percentage of people receiving income from employment is rising faster among new patients than others. The improvement in the situation of users in terms of employment appears to be confirmed by the results of the OPPIDUM survey which shows that the incidence of professional activity among registered users has increased from 38% to 43% between 1999 and 2001.

Housing situation of registered users

	1998	1999	2000
Stable housing	68.2	68.6	70.9
independent	35.5	35.8	34.9
with family	23.9	23.9	25.1
Temporary accommodation	24.2	23.7	22.6
with family/friends	11.0	10.4	8.9
hostels/hotels/housing and social reintegration centres	9.2	9.3	8.6
No accommodation	7.6	7.5	6.2

Prison	-	0.3	0.3
Total	100	100	100

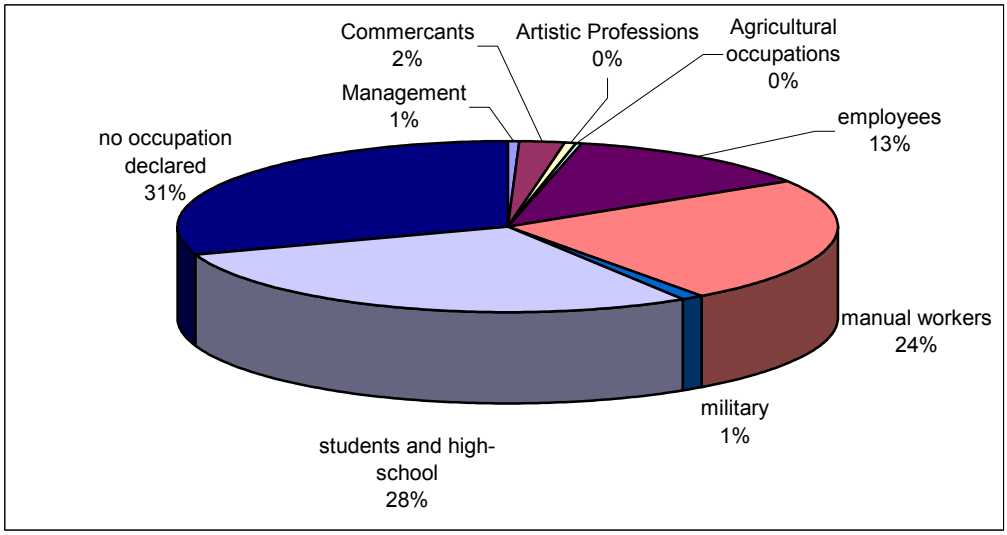
Source: typical activity report from CSST, DGS/OFDT

b) Socio-professional category and status of registered users and arrested users

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.

Of users questioned by police in 2001, 31 % were "without declared occupation". The difference observed here can be explained largely by the very high proportion of pupils and students amongst the users questioned (28%), the proportion being much smaller amongst registered users in November 1999 (7%). Using the same definition as in the survey of registered users, we find a proportion of 59% 'inactive' among users questioned by police. The active/inactive distribution is thus fairly similar from the two sources.

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



Source: FNAILS 2000, OCRTIS

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 of heroin or cocaine are more often without declared occupation (half) and much less often students in higher education or high school (around 5 to 6%).

Over the total of arrests, the trend noticed since the beginning of the 1990s is a reduction in the proportion of people declaring themselves without occupation with a corresponding increase in students and labourers. The other socio-professional categories remain stable or are barely represented.

For more information on social exclusion, refer to part 4 of 'key issue'.

c) Public nuisances

No data available.

4.2 Drugs-offences and drug-related crime

a) Arrest for use/possession/trafficking

The number of arrests is lower than in the preceding year, with a general drop of 19%, whether it concerns arrests for use or for dealing. This drop seems to have more of a connection with changes in the activity of the police services than with a change in the number of users of various substances.

During the year 2001, just over 79,000 arrests for use or use with resale of narcotics were made in France. They represent 93% of all arrests for infringement of drug law (ILS). The remaining 7% are cases of trafficking.

Arrests for use and use with dealing, and for trafficking in 2001, by drug

	All arrests for use and use with resale			Use with resale (n=7,323)	Total of arrests for trafficking			Local trafficking and resale (= 5,286) (= 4,355)
	numbers	% in column	change from 2000 to 2001	%	numbers	%	change from 2000 to 2001	%
Cannabis	69 285	87.7	-18.9	8.1	3 004	55.24	-20.7	59.8
Heroin	4 442	5.6	-31.3	14.5	928	17.07	-32.3	17.3
Cocaine	1 855	2.3	-25.2	19.9	963	17.71	-12.9	13.8
Crack	696	0.9	-24.9	17.7	210	3.86	4.8	98.6
Ecstasy	1 956	2.5	1.8	22.2	365	6.71	14.5	5.6
Others*	756	1.0	-38.1	21.3	74	1.36	-5.4	3.5
Total	78 990	100.0	-19.4	100.0	5 438	100	-20.1	100

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

Source: FNAILS 2001, OCRTIS

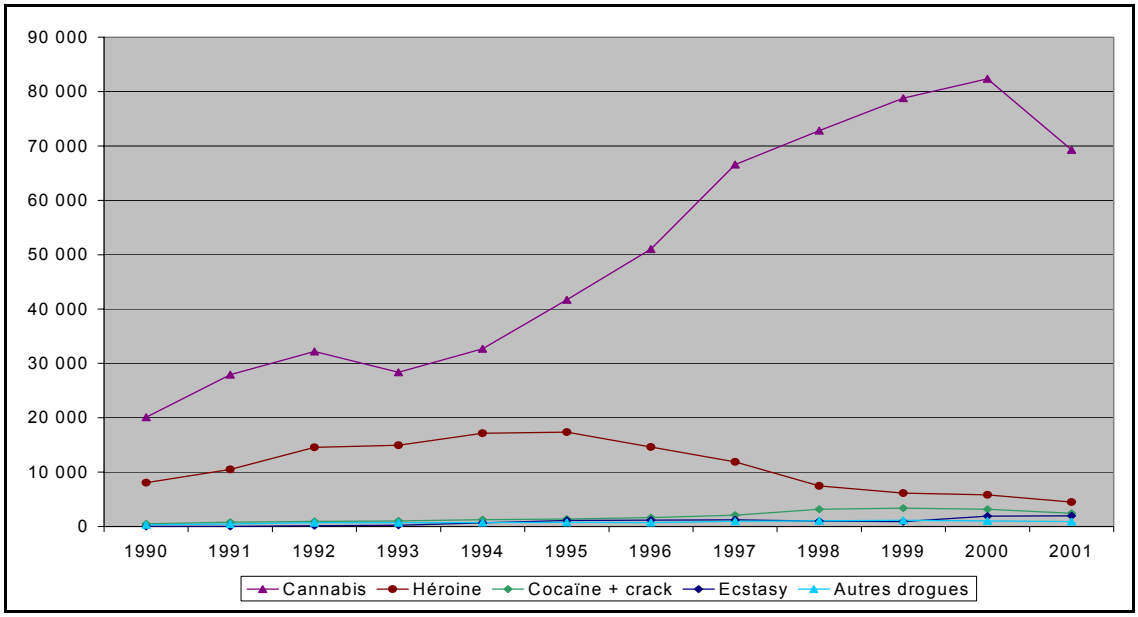
In 90% of arrests for use, cannabis is the substance in question. Far behind in second position comes heroin, followed by cocaine and ecstasy. The proportion of this last substance within total arrests has increased sharply over the last decade: 0.1 % in 1990 as against 1.7 % in 1996 and even 2.5 % in 2001.

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 traffickers arrested show a greater diversification in terms of substance involved than do the users. Cannabis, representing 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.

Over the last decade, there have been four major trends in arrests for use: an explosion in arrests in connection with cannabis, a fall in those for heroin use in the second half of the 1990s, the growth in arrests for cocaine and crack use and the emergence and increase in those for ecstasy use.

These very significant trends are not confirmed in the 2001 figures. Given the lower level of police service activity in the area of narcotics, associated with internal restructuring, the changes recorded in 2001 are difficult to interpret.

Arrests for narcotics use from 1990 to 2001, in terms of substance used



Cannabis, Heroin, Cocaine + Crack, Ecstasy, Other drugs

Source: FNAILS, OCRTIS

Where arrests for trafficking are concerned, the 1996-1999 period was marked by a fall (or even a stability) in arrests except for cocaine and crack. In 2001, the downward trend was confirmed, following the peak in 2000 even including cocaine - only ecstasy-related arrests are continuing to rise.

b) Conviction and sentencing for drug-related offence/Imprisonment

The sentencing statistics taken from the national police records [*Casier judiciaire national*] provide information about 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 may be made in consideration of the principal offence only, the method used by the Statistical Justice Yearbook [*Annuaire statistique de la justice*] or in consideration of all the associated offences. The second approach expands on the first, but here we will only deal with convictions in terms of the principle offence.

Convictions and imprisonments for use

During 2000, slightly over 6,600 convictions for illicit narcotics use as principal offence were pronounced. This figure has been relatively stable for some years (apart from the drop recorded in 1995 following the presidential amnesty). The number of convictions for use shows an increase parallel to the total number of convictions for drug-related offence and represents no more than one third of this total.

Convictions for illicit narcotics use (as principal offence), from 1992 to 2000

	1992	1993	1994	1995	1996	1997	1998	1999*	2000
Number of convictions for use	7 374	8 157	6 201	4 670	6 751	6 640	6 622	6 742	6 616
% in the total of convictions for infringement of drug law	33.7	25.8	28.3	22.6	28.3	27.6	27.8	28.8	25.0

** 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. As the increase in arrests concerns cannabis users only, these figures could show that this group are rarely convicted.

The incidence of the offence of narcotics use is greater than is shown by the method of counting applied to principal offences. It most frequently appears in association with other drug-related offences (76% of convictions mentioned use in 2000). The most frequent combinations of offences are those combining use and transport, use and possession or use and supply.

In 1 out of 2 cases, use as a principal offence leads to a prison sentence (34% of these sentences are fixed) and use as sole offence receives less severe sentencing with nearly 40% of convictions resulting in fines.

Convictions for narcotics use and nature of sentences pronounced in 2000

	Total (number)	% imprisoned	% fined	% other penalties [(1)]	Total	% unconditional [(2)]	average period of imprisonment
Use as principal offence	6616	55.4	29.7	15.0	100	34.1	5
Use as sole offence	3397	42.2	40.8	16.9	100	30.4	1.9

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

[(2)] Note: 38.2% of imprisonments for use as sole offence are unconditional

Source: CJN, SDSED - Ministry of Justice

It is difficult to obtain an accurate count of the incidence of imprisonment following conviction for use alone. The data from the prisons will only refer to a single offence, the offence that appears first in the conviction (generally the most serious). in all cases where use is combined with a more serious offence, therefore, the case will not appear under use in the intake statistics.

During 2001, nearly 500 persons were imprisoned for narcotics use in mainland France. They constituted less than 1% of prison intake in that year and a little over 7% of imprisonments for infringement of drug law (ILS).
Imprisonments for the use of narcotics, which have been falling since 1993 in both absolute and relative terms, increased in 2001: while the number of imprisonments for infringement of drug law overall is falling, the proportion of imprisonments for use is growing.

Imprisonments for narcotics use (as principal offence) from 1993 to 2001

	1993	1994	1995	1996	1997	1998	1999	2000	2001
Number of imprisonments for use	1 213	1 034	892	870	700	468	471	395	505
% of all imprisonments for infringement of drug law	10.2	8.6	7.1	7.3	6.6	5.1	5.2	4.4	6.8
% of all imprisonments	1.5	1.2	1.1	1.1	0.9	0.7	0.7	0.6	0.8

Coverage: mainland France

Source: FND, DAP/ SDSED - Ministry of Justice

On 1st January 2001, the prison administration counted less than 234 people imprisoned for narcotics use, making 6.8% of those imprisoned for infringement of drug law and 1.1% of the total prison population. These proportions have increased in comparison with 1st January 2000 when the prisoners convicted for use of narcotics represented 4.4%.

Convictions and imprisonments for trafficking

Unlike the arrests, the convictions for trafficking are more numerous than those for narcotics use:

Convictions for trafficking in narcotics relate to four types of offence in particular: possession and procurement; trade, employment or transport; import or export and offer or supply of narcotics. In 2000, the count also included 65 convictions for aiding and abetting in the use of narcotics, 7 cases of failure to justify income (infringement currently called 'living on the earnings from drugs') and 48 other infringements of drug law.

Convictions for trafficking in narcotics (as principal offence) and nature of sentence in 2000 by type of offence

Trafficking	Total (number)	% imprisoned	% fined	% other penalties (1)	Total	% unconditional (2)	Average period of imprisonment
Possession/procurement	8662	77.2	12.7	10.2	100	48.0	13.7
Offer and supply	2300	83.8	6.1	10.0	100	52.5	7.9
Trade/employment/trans-port	3484	88.1	6.5	5.5	100	55.7	19
Trafficking (import/export)	1744	95.9	2.1	1.9	100	68.1	32.7

(1) *'Other penalties': alternate sentence, care/training order, suspension of sentence*

(2) Note: 49.2% of imprisonments for possession/procurement as principal offence are without remission.

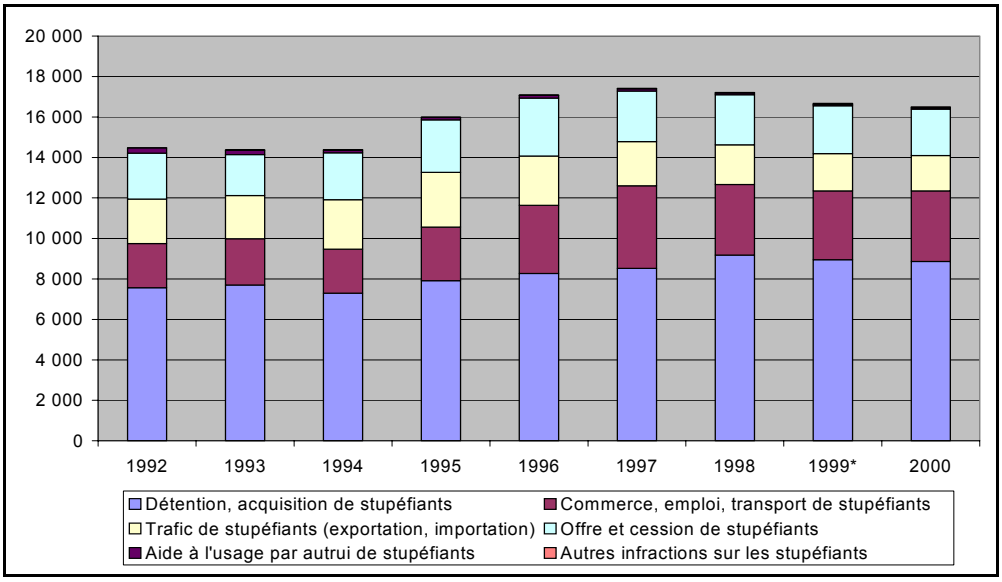
Source: CJN, SDSED - Ministry of Justice

The higher an offence is on the scale of trafficking, the more likely it is that a sentence of imprisonment is imposed. The proportion and period of unconditional imprisonment are also increasing as a consequence.

Trafficking offences are more likely than use to be mentioned as principal offence. Nevertheless, multiple classification of cases is frequent.

After a period of relative stagnation, the rise in convictions for trafficking in narcotics observed in 1995 mainly concerned 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. It should be noted that there is an increase, in both absolute and relative terms, in convictions of minors for infringement of drug law:

Convictions for trafficking in narcotics (as principal offence) from 1992 to 2000



Possession/procurement of drugs
Trafficking in drugs (export, import
Aiding and abetting drug use

Trade, employment, transport of drugs
Offer and supply of drugs
Other drug-related offences

** Provisional data*

Source: CJN, SDSED - Ministry of Justice

The prison statistics also use a nomenclature that is different from that above for imprisonments for trafficking. The level of detail is less because it is concerned only with distinguishing between cases of trafficking, supply, use and other infringements of drug law. Furthermore, the figures are only categorised by principal offence.

It is logical at this stage in the penal process that the offences most severely punished under the penal code represent a greater proportion amongst imprisonments. During 2000, those imprisoned for trafficking in narcotics represent 61% of all imprisonments for infringement of drug law and 7.2% of total intake (compared with 6 and 0.7% respectively for use).

Imprisonments for trafficking in narcotics (as principal offence) from 1993 to 2001, by type of offence

	1993	1994	1995	1996	1997	1998	1999	2000	2001
Trafficking	7 845	7 726	7 991	7 842	6 869	5 720	5 867	5 538	4 512
Supply	686	1 140	1 053	987	910	863	491	616	446
Other infringements of drug law	2 091	2 158	2 653	2 244	2 115	2 074	2 296	2 345	1 944
Total infringements of drug law	11 835	12 058	12 589	11 943	10 594	9 125	9 125	8 894	7 411
Total offences	82 201	84 684	81 398	78 778	75 098	71 768	72 172	66 862	62 651

Coverage: mainland France

Source: FND, DAP/ SDSED - Ministry of Justice

As with the figures for total imprisonments for infringement of drug law, those for trafficking and, to a lesser degree, for supply of narcotics have been falling since 1993. At the same time, an increasing number of imprisonments fall into the category of other drug-related offences (18% of all drug-related offences in 1993 as against 26% in 2000).
The number of those convicted (not on remand) for drug-related offences, who are in prison on a particular day is also falling, in both absolute and relative terms. On 1st January 2001, the prison administration counted 3,936 people convicted for infringement for drug law, making 12% of the population of convicted prisoners. On 1st January 1995, the 6,118 people held for drug-related offences represented 21% of convicted prisoners.

c) Crimes connected with drugs (theft, violent crimes, etc.)

'NO DATA AVAILABLE'

4.3 Social and economic cost of drug consumption

A study published in 2000 by the OFDT[3] attempted to measure the overall social costs connected with illicit drugs, alcohol and tobacco. This study is based on calculation of social costs using the cost-of-illness approach defined by experts at international level to the social .

Illicit drugs generate a social cost of 2 billion euros, or a per capita expenditure of 17 euros and 0.16% of GNP. Loss of productivity accounts for nearly 46% of this figure. The total amount for this proportion is 930 million euros, divided between 800 million euros for imprisonments for drug-related offences and 130 million for premature mortality. The cost of implementing the law takes second position (29.3%) and represents 596 million euros as a result of the fact that these drugs are illegal. Health care costs come next (11.4%), with 232 million euros divided between the costs of hospitalisations without surgical interventions (141 million euros) and urban medical practice (91 million euros). In fourth place (7.1%) come the research and prevention costs, totalling 144.5 million euros and, finally, the losses of tax and social security contributions (6.5%) totalling 132 million euros.

3 **:** Kopp, P., Fenoglio, Ph. . The social cost of legal (tobacco and alcohol) and illicit drugs in France. OFDT, study No. 22, September 2000, 277 p

5. Drug Markets

5.1 Availability and supply

An overall view of the availability of the main psychoactive substances brings out the following trends:

- The availability of heroin, as estimated from seizures and arrests for use, is falling, continuing the trend of preceding years. However, observers in the field, whether in the urban environment or on the dance scene, have recorded that the availability of this substance has stabilized, or is even increasing slightly. It is still very difficult to obtain the drug, given the absence of an 'open drug scene' and the fact that small-scale dealing in the street has almost disappeared.

- The volumes of cocaine seized showed a sharp rise in 2001. The increasing availability of cocaine is confirmed, both in urban environments and on the dance scene.
Although seizures of ecstasy are falling, the number of users arrested is rising, continuing the trend of the preceding years Ecstasy and amphetamines are still easily available on the dance scene and their availability is growing in urban environments - it is very difficult to assess the availability of substances such as GHB and ketamine, given the highly restricted nature of the user groups. Regarding ketamine, two contradictory phenomena have been observed in relation to its availability: on one side an expansion of use in geographical terms on the dance scene and in urban environments, on the other, a decrease in distribution where it was previously observed.

- Seizures of LSD have fallen in comparison with 2000. LSD, always easily available on the dance scene, seems to be increasingly available in urban environments.

5.2 Seizures

a) Developments in numbers of seizures and quantities seized

It is difficult to compare the quantities of the different substances seized. First of all, the values of a given quantity vary widely between the substances. Cannabis, having a low price per gram, is often trafficked in large quantities, sometimes several tonnes, while heroin circulates in much smaller batches. This means that several tonnes of cannabis may be seized in a single operation, which never happens with heroin. Moreover, since France is a transit country, part of the quantities seized is not destined for the domestic market. For these reasons, it is changes in seizures that are of interest.

Recent changes in seizures

Quantities of drugs seized from 1998 to 2001, by product

	1998	1999	2000	2001
Cannabis (herb, resin, oil) (kg)	55 698	67 480	53 579	62 121
Heroin (kg)	343	203	444	351
Cocaine (kg)	1 050	3 687	1 311	2 096
Crack (kg)	25	10	22	6
Amphetamines (kg)	165	232	230	57
Hallucinogenic mushrooms (kg)	4,8	5,6	11	7,5
Ecstasy (doses)	1 142 226	1 860 402	2 283 620	1 503 773
LSD (doses)	18 680	9 991	20 691	6 718
Total number of seizures	47 647	51 303	58 421	53 534
Change	*13.7*	*7.1*	*12.2*	*-9.1*

Sources: FNAILS, OCRTIS

In 2001, 3,922kg of cannabis herb (grass) were seized in France, representing a decrease of 19.4% in comparison with the previous year. Since 1998, the European countries, with the Netherlands in the lead, have become the main sources of supply of grass, with the supply from Asia and South America decreasing correspondingly.

Great Britain, (destination of 33.5% of seizures), is the major destination in geographical terms for seizures, ahead of France, Italy and Belgium.

With regard to cannabis resin, seizures rose to 58,195kg, as against 49,179kg in 2000. The resin comes from Morocco and travels via Spain, which has become the top country for procurement of cannabis resin, with 68.1% of quantities seized. As with last year, Great Britain and France are the two primary destination countries for cannabis resin seizures, with 29.5% and 24.4% of the total seized, respectively.
The increase in quantities of cannabis seized between 2000 and 2001 results from a rise in seizures of resin by nearly 10 tonnes. This seized quantity is the largest recorded to date, with the exception of 1999, when an exceptional seizure of 23 tonnes destined for Poland, produced a record year.

In 2000, after this record year, the quantities of cannabis seized returned to their 1997 and 1998 levels. In 2001, the total number of seizures fell for the first time since 1998, with immediate consequences on the quantity seized of some drugs (heroin, amphetamines, crack, LSD).

The quantity of heroin seized in 2001 has fallen by 20.9% from the previous year, with 351.3kg as against 443.9. For the eleventh year running, the Netherlands was the leading procurement country with 36.5% of heroin seized for which the origin could be identified. Next come Belgium, Italy and Bosnia.

About 55% of heroin seized, for which the destination can be identified, was destined for the French market, with Great Britain, Spain and Italy the other destinations.

The quantity of cocaine seized in 2001 was 2,096 tonnes, an increase of 60% from 2000. This sharp rise is due to an exceptional quantity of more than one tonne, seized on 29th December 2001. The procurement country is only identified for a very small percentage of cocaine seizures (7.3% of total seizures). South-America is the main region for direct procurement (17.2%),

followed by Spain and the Netherlands. Outside of the French market, the Netherlands, Italy and Spain are the primary destination countries for cocaine seized in France.

The considerable rise in quantities of cocaine seized can be explained by an exceptional quantity of 1,194kg seized offshore of Finistère and probably destined for the Netherlands. If this seizure is not included, the total volume is close to the 1998 level.

After a record year, seizures of ecstasy fell by 34.2%. More than half of the ecstasy for which the country of origin was able to be identified came from the Netherlands, while about a quarter of seizures came from Belgium. While Great Britain was the primary destination country in 2000, this year it came after France and Spain, which have become countries with high use.

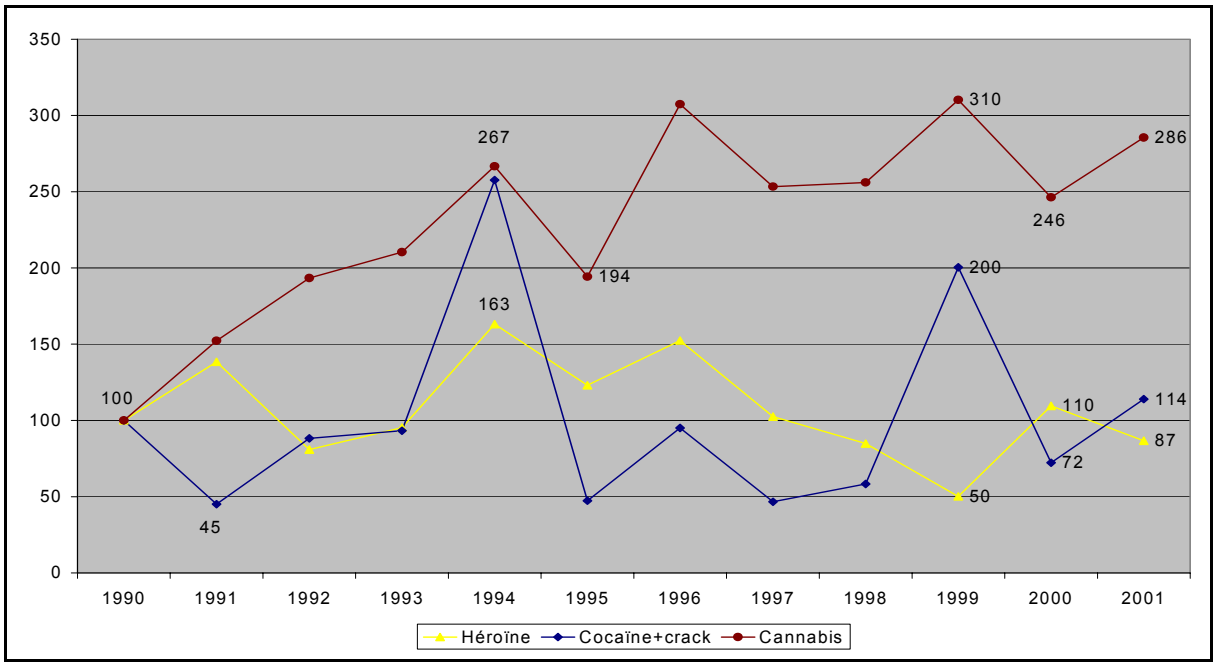
After a long period of being limited, the quantities of ecstasy seized have risen sharply since 1998. This trend is also linked to an increase in the quantities of ecstasy destined for Great Britain. France is the destination of only a small share of the ecstasy seized (less than 10% in 2000), although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

In 2001, the law enforcement services seized 57.2kg of amphetamines as against 229.6kg in 2000, a fall of 75%. The Netherlands is by far the leading country of procurement, ahead of Thailand and Belgium. Great Britain, France and Spain were the three top destination countries for amphetamines seized in France.

Changes in seizures between 1990 and 2001

The last decade was marked by a considerable increase in seizures of cannabis, with a rapid and continuous rise up to 1994 (quantities seized multiplied by a factor of 2.5) followed by fluctuations around this level until 2001.

Quantities of cannabis, heroin, cocaine and crack seized from 1990 to 2001 (normalised to a base of 100 in 1990)



Heroin, Cocaine + Crack, Cannabis
Source: FNAILS, OCRTIS

This trend over the whole decade is not apparent for heroin and cocaine, for which the level reached in 2000 is comparable to that in 1990.

The quantities of heroin seized, tending upwards between the end of the 1980s and the mid-1990s, despite showing sharp fluctuations, fell sharply between 1997 and 1999, before turning upward again in 2000.

The quantities of cocaine seized are fluctuating a little below the 1990 level, apart from the years 1994, 1999 and 2001, when exceptionally large seizures were made.
Outside of the annual variations, about a third of cannabis and ecstasy seized was destined for resale in France, as against half of the heroin and a fifth of the cocaine.

5.3 Price, purity

Heroin

- Price: In 2001, the median street price per gramme for white heroin in mainland France, recorded from eleven observation sites, was 95 euros and the price for brown heroin was 63 euros. Large variations were found between the different sites (see table).

Average street price, in euros, of a gramme of both forms of heroin at TREND sites (urban environment) in 2000 and 2001

	White heroin (hydrochloride)			Brown heroin (base)		
SITES	2000 Average	2001 Average	Change	2000 Average	2001 Average	Change
Bordeaux	229	107	-53%	46	65	+42%
Dijon	114	99	-17%	53	65	+21%
Lille	-	-	-	43	46	+7%
Lyon	61	-	-	61	-	-
Marseilles	117	107	-9%	84	61	-23%
Metz	-	84	-	46	50	+8%
Paris	84	-	-	57	18	-68%
Rennes	91	84	-8%	91	69	-25%
Seine St Denis	102	76	-25%	61	-	-
Toulouse	72	91	+26%	72	69	-5%
Guyana	-	59	-	-	95	-
Martinique	-	46	-	-	-	-
Réunion	-	122	-	-	69	-
Median Mainland	96	95		59	63	

Data and processing: TREND/OFDT

- Purity: the results of the toxicological analyses performed on a proportion of the heroin seized (base and hydrochloride) by the police services show that, in 2001, 45% of samples have content less than 10% and 8% have content greater than 50%. Between 2000 and 2001, the proportion of samples with average content (between 20 and 50% of active ingredient) rose from 17 to

22%, and samples with less than average content (0 to 20% of active principle) fell from 75 to 70% of the total. Globally (Police and Customs), there is an increase in the proportion of samples found to have content between 20 and 50% (see table)

Distribution of heroin samples seized in 1999, 2000 and 2001 by Customs and Police services, in terms of level of purity

	1999		2000		2001	
Level of purity (%)	N	%	N	%	N	%
Police and Customs						
0-20	299	69%	441	73%	636	67%
20-50	78	18%	98	16%	251	27%
50-100	52	13%	69	11%	57	6%
Total	429	100	608	100%	944	100%

Sources: LPS Lyon and LIRD Paris. Processing: TREND-OFDT.

Cocaine:

- Price: in 2001, the median street price for a gramme of cocaine in mainland France, from eleven sites, was 63 euros for a gramme, representing a decrease of 23% in comparison with the previous year. This figure does not reveal the diversity found over all the sites, with prices ranging from 53 to 107 euros in mainland France and an even wider range when the overseas departments were included (see table).

Average street price, in euros, of a gramme of cocaine in urban environment at TREND sites, in France for 2000 and 2001

SITES	2000 Average	2001 Average	Change over 00/01
Bordeaux	84	53	-36%
Dijon	84	72	-14%
Lille	81	62	-23%
Lyon	84	61	-27%
Marseilles	61	61	0%
Metz	76	65	-15%
Paris	94	76	-19%
Rennes	61	84	-8%
Seine St Denis	107	107	0 %
Toulouse	53	53	0 %
Mainland median	82	63	
Guyana	–	24	-
Martinique	–	122	-
Réunion	–	152	-

Data and processing: TREND/OFDT

- Purity: as with heroin, the results of the toxicological analyses of cocaine samples over the 1999-2001 period reveal an increase in the proportion of samples with average content, which represented, in 2001, 29% of total as against 15% in 1999. On the other hand, the proportion of samples with greater content (between 50 and 100% active principle) has decreased from 83 to 64% of the total of samples (see table).

Distribution of cocaine samples seized between 1999 and 2001 by Customs and Police services, in terms of level of purity

	1999		2000		2001	
Level of purity (%)	N	%	N	%	N	%
Police and Customs						
0-20	15	2%	42	5%	90	7%
20-50	99	15%	201	25%	398	29%
50-100	522	83%	543	70%	858	64%
	636	100%	786	100%	1346	100%

Sources: LPS Lyon and LIRD Paris. Processing: TREND-OFDT.

Ecstasy

- Price: in 2001, in France, the median street price of an ecstasy tablet is 11 euros, both in the urban environment and on the dance scene. The median street price of a gramme of powder ranges from 31 euros in the urban environment to 65 euros on the dance scene (see table).

Street price in euros of an ecstasy tablet and of a gramme of powder, from observers at sites in the urban environment and on the dance scene in France in 2001

	Urban environment		Dance scene	
SITES	Tablets	Powder	Tablets	Powder
Bordeaux	12	11	11	69
Dijon	15	15	23	31
Lille	11	46	8	–
Lyon	11	–	15	91
Marseilles	13	–	11	61
Metz	8	–	6	–
Paris	11	–	11	–
Rennes	11	46	–	–
Seine St Denis	–	–	–	–
Toulouse	11	–	–	–
Median	11	31	11	65

Data and processing: TREND/OFDT

- Purity: in 2001, an analysis of the data collected with the OFDT SINTES system shows that:

- the substances presented as synthetic drugs most commonly contain molecules from the amphetamine family. This was the case for more than three quarters of samples collected and seized in 2001.
- Medications are common (9%) and are becoming increasingly diverse, with a hundred different medicinal items identified since the monitoring system was set up.
- One in eight samples contains no active principle.
- The average content of MDMA per tablet (63mg) has fallen in comparison with 2000 (71mg).
- Some new psychostimulant substances have been found (DXM (Dextromethorphan), Tiletamine, PMA (paramethoxyamphetamine), 2CB).

Cannabis

Price: in 2001, the median street price per gramme for cannabis resin in mainland France, recorded from eleven observation sites, was 7 euros and the price for grass was 5 euros.

- Purity: according to the analyses performed by police laboratories, the average level of THC in the samples of cannabis resin analysed in 2001 was between 5 and 10%, and the level in cannabis herb (grass) samples was less than 2%. According to the analyses performed by customs service laboratories, the average level of THC in the samples of cannabis resin analysed in 2001 was 11% and the level in cannabis herb (grass) samples was 7%.

6. Trends per Drug

6.1 Cannabis

Use of cannabis in France

In 2001, cannabis is still the illicit substance whose consumption is highest in France.

In 2000, among the 18—75 year age group, more than one individual in five has experimented with the drug. Amongst adults aged eighteen, this experimentation applies to 55.7% of boys and 45.2% of girls. These figures seem to show a slight increase over those found in 2000, continuing the rise observed throughout the 1990s. For young people aged eighteen in 2001, the average age at which they experimented with cannabis was 15 and 2 months for boys and 15 and a half among girls.

Repeated use of cannabis (at least ten times a year) applies to 3.6% of French people in the 18 to 75 age group in 2000. There is a marked generational difference, since repeated use applies to 14.6% of the 18-25 year olds (20% of men and 9.1% of women) as against 1.6% of the over-26 age group. This development seems to be continuing as, in 2001, amongst young people aged eighteen, half (49.9%) of boys and nearly a third (37.5%) of girls admitted repeated use of cannabis. Among this group, regular use of cannabis (at least ten incidences of use within the last thirty days) applies to 19.7% of boys and 6.9% of girls. This figure is now higher than that for regular use of alcohol (16.6% of boys and 4.4% of girls).

At the age of eighteen, regular use of cannabis (10 times or more over the last 30 days) is associated with alcohol (10 times or more over the last 30 days) and/or with tobacco (at least one cigarette per day over the last 30 days) among 16.7% of boys and 6.4% of girls, i.e. the large majority of those who report repeated use of cannabis. Multiple substance use seems to be strongly connected with how frequently the respondents go out over the course of the year, whether to musical events or not.

The prevalence of cannabis consumption among 15-44 year olds over the preceding twelve months is significantly higher in three of the twenty-three French regions (Aquitaine, Brittany and Ile de France)

Health and social consequences

In 1999 (last year for which data is available), cannabis appears as the primary substance in 15.5% of registrations for treatment as against 12.7% in 1997. It involves a younger group of users (25 and a half on average) than that of opiates (31 and a half on average) and less likely to be dependent on several substances.

Over the last thirty years, current statistical systems (French national register of causes of death and overdoses recorded by the police) have not recorded any deaths directly attributable to cannabis.

Criminal consequences

During the year 2001, the number of arrests (63694) arrests for cannabis use fell by 13.5%, after increasing for three years (1998-2000). Cannabis nevertheless remains the illicit drug most often leading to arrest, as it represents 88.9% of arrests for use only. In 2001, 31.0% of those arrested were students or attending high school and 23.6% were manual workers.

Supply and trafficking

The number of traffickers arrested (8593) in 2001 has fallen (-30.7%) in comparison with the preceding year. The quantity of cannabis resin (62121kg) seized in France increased (+19.5%) in 2001 while that of cannabis herb (3922kg) fell (-19%). Cannabis resin comes mainly from Morocco (84.5%), either by direct procurement (10.2%), or by procurement in Spain (68.1%), in Belgium (4%) and in the Netherlands (1.6%). Every year, it becomes more apparent that the European countries (Netherlands, France, Italy, Belgium) are becoming a major source of supply of cannabis herb (41.8%).

6.2 Opiates

Use of opiates

In the general adult population, experimentation with heroin is extremely rare and mainly involves men whose age is somewhere around thirty. Amongst the 18-44 age group, between 1995 and 1999, use of heroin at least once in their lifetime rose from 0.3 to 0.4% for women and from 0.9% to 1.7% for men. Amongst young people aged 18, in 2001, 1% of boys and 0.8% of girls reported having already taken heroin at least once at some point in their lives.

A study conducted in 2000 in five French urban areas judged that the incidence of problematic use of opiates and cocaine among those aged 15 to 54 ranged from 6.5 per thousand in Toulouse to 15.3 per thousand in Nice. At national level, the number of people with problematic use of opiates or cocaine is estimated to be between 150,000 and 180,000.

In 2001, among young people aged 18, 0.2% of boys and 0.2% of girls reported having used heroin in the course of the previous month. Among those people attending low threshold institutions in 2001, 33% reported having used heroin in the course of the previous month. This proportion, probably falling in relation to earlier years, is explained partially by a shift towards consumption of opiate medications, whether by medical prescription or not: high-dose buprenorphine (47%), methadone (17%), morphine sulphates (12%) and codeine derivatives (8%).

The most common method of use (58%) is still by injection. However, although the prevalence of heroin use is not visibly changing, the most recent users (since less than five years ago) have noticeably different characteristics from those of the traditional heroin addict. These users are likely to be younger and less marginalized in social terms. They sometimes use heroin as the main substance but also as an additional substance in combination with stimulants (to control coming down). Also, they inject less (46%), even though this is still the most common method of use, and they more often use the nasal duct (sniffing, 39%) and the respiratory tract (inhalation, 21%). Furthermore, regarding high-dose buprenorphine (Subutex®), there is evidence to confirm the existence of opiate users who start their drug use with this substance.

Health and social consequences

In 2001, it is estimated that 12,000 patients benefited from substitution treatment using methadone, 80,000 using high-dose buprenorphene and just under one thousand using morphine sulphate, adding up to more than half of those with problematic use of opiates.
Between 1997 and 1999, the proportion of opiates as primary substance in the total registrations of drug users fell from 76 to 70%. Within the category of opiates, heroin remains largely in the majority as the substance giving rise to registrations, with 85% of the total opiate-related registrations, while non-prescription buprenorphine, which represents 6% of these registrations, having risen sharply from 1997. Other opiates (codeine, non-prescription methadone, morphine, opium) were recorded in 9 % of these registrations.

In 2001, prevalences reported by heroin users attending low threshold institutions were 14% for HIV (39/273), 49% for HCV (122/249) and 18% (41/228) for HBV.

The number of deaths recorded by the police and attributable to heroin use has been falling since 1994. In 2001, 62 deaths due to overdose were attributed to heroin, a fall of 13% in comparison with the preceding year. Furthermore, 7 overdoses were reported with high-dose buprenorphine, and 7 others with methadone. Also, some deaths were linked to other opiate medications such as Skenan® and Moscontin®.

Criminal consequences

Since 1996, arrests for heroin use have been falling steadily. In 2001, they rose to 3,796kg, a fall of 21.4% compared with the previous year. These arrests represent 5.3% of the total number of arrests for use, all substances combined. This proportion has reached its lowest ever level, this year.

The typical profile of the arrested user is as follows: a man aged 28.5 with no profession. The proportion of users with no profession among those arrested is higher (46.0%) than among cocaine users (44.5%) or ecstasy users (34.3%). It should be noted that there was a significant proportion (5.7%) of students or those attending high school among arrested users.

Supply and trafficking

In 2001, the median street price in mainland France, from 11 observation sites, is stable in comparison with the preceding year. 95 euros per gramme for white heroin and 63 euros for brown.

After a year in which seizures increased in 2000, the trend is now downwards again (351kg). The Netherlands (36.5%) is the leading country of procurement, ahead of Belgium and Italy. Apart from France, in 2001, Great Britain was the main destination country.

6.3. Cocaine/crack

Consumption

Despite having increased in recent years, experimentation with cocaine is still an activity of only a minority of the French population. Amongst the 18-44 age group, between 1995 and 1999, experimentation with cocaine went from 0.5 to 1.2% for women and from 2.8% to 3.7% for men. In 2001, among young people aged 18, 2.5 % of boys and 1.3 % of girls reported having used cocaine at least once. For this same population, experimentation with crack has risen to 1% of boys and 0.6% of girls.
Use of cocaine within the previous month is reported by 1.0% of boys and 0.4% of girls aged 18. In 2001, among low threshold institution users, use of cocaine during the previous month applied to 39% of people, while use of crack in that period was reported by 20%. Among drug users contacted in 2001 by a self-support association (ASUD), 55% reported having used cocaine in the course of the previous month.
In the last three years, the TREND observers report a greater frequency of use of cocaine and its smokable forms (crack, freebase) both among those on the dance scene and generally on the streets.

The dominant methods for use of cocaine are still injection for street users and sniffing for those on the dance scene. However, as for heroin, it has been observed that in the urban environment, the most recent users of cocaine(<5 years) are more likely to sniff the drug (64%) and inhale it (26%) than are the longer duration users.

Health and social consequences

Between 1997 and 1999, health or social registrations for cocaine or crack use have increased, but remain a minority within registrations as a whole (4.8% as primary substance and 14.9% as secondary substance).
In 2001, cocaine was the substance involved in 10 deaths as against 11 in the previous year out of the 107 total deaths by overdose recorded by the police.

Criminal consequences

After increasingly sharply for several years, arrests for cocaine (1486) and crack (573) use are falling, by 23.6% and 19.0% respectively in 2001. These represent just over 2% and 0.8% of the total arrests, respectively. The typical arrested user of cocaine is a man approaching thirty with no profession. For crack the typical user is slightly older and more marginalized in social terms.

Supply and trafficking

Overall, cocaine is increasingly available and, especially because its price has fallen, is coming within reach of a wider and wider public. The median street price from 11 sites of mainland France has fallen from 82 euros per gramme in 2000 to 63 euros in 2001 (-23%). This fall in price encourages greater accessibility, involving a growing heterogeneity in the profile of the users. As

regards crack, it seems that the street-level supply is developing and that it is no longer a phenomenon limited to the Parisian region, Antilles and Guyana.

The rise in the quantities of cocaine seized (2096.2kg) by more than 60% is substantial in comparison to the previous year. This is difficult to interpret, however, given the variations depending on the occurrence or otherwise of major special operations. In 2001, Spain was the leading country of procurement for cocaine seized in France, while the Netherlands was the primary destination country.

6.4 Synthetic drugs

Consumption

Within the French population, experimentation with ecstasy and/or amphetamines is still rare. Amongst the 18-44 age group, between 1995 and 1999, it rose from 0.7 to 1.6% for women and from 1.8% to 3.5% for men. In 2001, among young people aged 18, 5.0% of boys and 2.7% of girls reported having used ecstasy at least once. Experimentation with amphetamines is reported by 2.5% of boys and 1.2% of girls aged 18. Among these young experimenters, the average age of experimentation is 16 and 4 months for boys and 16 for girls.

Use of ecstasy within the previous month is reported by 2.2% of boys and 1.1% of girls aged 18. In 2001, among low threshold institution users, use of ecstasy during the previous month applied to 24% of people Among those contacted by a self-support association (ASUD), the figure is 14%. On the techno dance scene, use of ecstasy is observed to be common, but no estimated figures are available. Observers report a growth in the method of use via the nasal duct, for use of ecstasy.

Use of amphetamines within the previous month is reported by 1.0% of boys and 0.3% of girls aged 18. In 2001, among low threshold institution users, use of amphetamines during the previous month applied to 13% of people Among those contacted by a self-support association (ASUD), the figure is 5%. In the urban environment, the spread of amphetamines, observed in 2000, seems to be confirmed in 2001. Unlike the techno dance scene, although use of amphetamines here is rare, its image seems to be deteriorating.

Health and social consequences

In 1999, the proportion of ecstasy and amphetamines in total registrations of drug users was extremely low (respectively 0.7% and 0.4% as primary product in 1999 and 1.3% and 0.6% as secondary product).
In 2001, 8 deaths associated with ecstasy use were recorded by the police as against 1 in 2000.

Criminal consequences

In 2001, 1,521 ecstasy users were arrested, representing an increase of 6.2% in comparison with the previous year. The continuing upward trend in arrests over the last ten years is therefore confirmed. The profile of the arrested users is very close to that of the user in general: young, 23 on average, likely to be male.

For the last 4 years, a noticeable and regular decrease in arrests for amphetamine use has been observed. In 2001, 86 users were arrested, representing a decrease of 16.5% in comparison with the previous year. The profile of the arrested users is very close to that of the ecstasy user in general:

Supply and trafficking

Ecstasy and amphetamines are still very accessible in the party scene. The downward trend in the price of ecstasy tablets is confirmed in 2001, since the median price is established on mainland France at 11 euros as against 15 euros (last year). The price of amphetamines remains stable at 15 euros per gramme.

Since the second half of the 90s, seizures of ecstasy have stabilised. In 2001, 1,503,773 ecstasy tablets were seized, representing a decrease of 34.2% in comparison with seizures in 2000.

The Netherlands is the leading country of procurement of tablets seized (56.3% of total), ahead of Belgium. It should be noted that Spain and France have become the two main destination countries, although first place was occupied by Great Britain up until 2000.

6.5 Hallucinogenics

Consumption

Among the French population, experimentation with LSD is still rare. Amongst the 18-44 age group, between 1995 and 1999, it rose from 1.2 to 1.5% for women and from 3.7% to 3.5% for men. In 2001, among young people aged 18, 2.3 % of boys and 1.3 % of girls reported having used LSD at least once. Among these young experimenters, the average age of experimentation is 16 and 5 months for boys and 16 and 2 months for girls.

Use of LSD within the previous month is reported by 0.8% of boys and 0.3% of girls aged 18. In 2001, among low threshold institution users, use of LSD during the previous month applied to 18% of people Among those contacted by a self-support association (ASUD), the figure is 3%. On the techno dance scene, use of LSD is observed, but no estimated figures are available.

Use of ketamine at some point in their lives is mentioned spontaneously by 10 of the 12512 young people aged 18, surveyed in 2001. In 2001, among low threshold institution users, use of ketamine during the previous month applied to 7% of people The method of use is mainly sniffing (67%). On the techno dance scene, in 2001, the geographical spread of use is observed. However, this use only involves a small minority of people present within this space.

Health and social consequences

LSD represents 0.4% of requests for treatment as primary product and 1% as secondary product.

Criminal consequences

In 2001, 72 LSD users were arrested, representing a decrease of 52% in comparison with the previous year. With regard to ketamine, 17 users were arrested in 2001, against 8 in 2000.

Supply and trafficking

In 2001, the price of a tab of LSD, according to the observation sites, rose from 7 to 15 euros and that of a gramme of ketamine rose from 35 to 45 euros.
In 2001, 6718 doses of LSD and 0.28kg of ketamine were seized by the police services.

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 produced 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 changes 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 Methodological limits 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 that concerning telephone surveys (reporting bias and coverage: in the face of the development of "red lists" and the mobile telephone). An initial methodological study on a sample of young people who did not have a mobile telephone, produced by the OFDT as part of its survey on drug use among 18 year olds (ESCAPAD), nevertheless gives interesting indicators relating to the specific characteristics of this population in relation to drug use.

The available indicators on the health consequences of drug consumption are still too fragile. Whilst waiting for the European protocol to be set up, for data relating to requests for treatment, and since the cessation, in 1999, of the survey of organizations receiving drug users, we have available national data on requests for treatment, based on the main indicators that allow the question of health consequences to be documented. For example, it is impossible to determine a recent national trend in the development of the incidences of HIV and HCV among drug users in treatment. While awaiting the results of a retrospective study of a cohort of drug users arrested by police, we still do not have a global indicator of drug user mortality. 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.

The available indicators on the social consequences of drug consumption are still too sparse.

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.

PART 3 DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at national Level

8.1 Major strategies and activities

The national strategy in terms of reducing demand, as defined by the current government plan, is polymorphous. The major priorities of relevant interministerial policy, described in chapter 1.1., may be summarized in a few points. It concerns extending the prevention approach to all behaviours in the use of psychoactive substances (and no longer only for the substances); spreading the risk and damage reduction policy to all areas of consumption; setting up a system of early health and social registration (before users of psychoactive substances have become dependent) to provide users of psychoactive substances with appropriate support; integrating a public health approach into public safety using an appropriate criminal policy, whether it concerns arrested users or those placed in detention; at the supranational level, developing the international action of France based on a global approach, balanced between reducing supply, reducing demand and reducing risks. this will involve a redefinition of geographical priorities and favour the development of actions for demand and risk reduction.

8.2 Approaches and new developments

In the course of the 1990s, the implementation of the demand reduction policy for the fight against drug addiction has undergone substantial changes, 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 21st September 1993(i), even if it was approached at that time with prudence. In particular, this recommended:
Strengthening prevention (cf. chapter 9)

- The improvement of registration of drug users, not only in the specialist system but also in the general health care system (increase in the number of spaces, improvements in hospital registration and establishment of town-hospital-addiction networks linking professionals in the town with those in the hospital for registration of addicts) – cf. chapter 11.
- The development of risk reduction facilities (cf. chapter 10),
- The establishment of substitution treatments (cf. part 11.2).

The majority of the recommendations made in 1993 were confirmed and further developed later. The plan of 14th September 1995 followed in the lines of the previous plan as did that of 1999-2001, now extended to 2002.

9. Prevention

2001 was not marked by changes in the field of prevention. The major recent development in the prevention field was dictated by the governmental plan for fighting against drugs, 1999-2001. It consisted of expanding the prevention policy to cover all psychoactive substances, both legal and illegal, favouring a behavioural approach and taking account of use, harmful use (abuse) and dependence.
Note: The quantitative data provided in this section on prevention, concern specific actions on illicit drugs as well as those also including legal psychoactive substances (alcohol, tobacco).

a) National strategy

Prevention in the 1999-2001 MILDT three-year plan. The 1999-2001 three-year plan laid the foundations of an innovative approach to prevention. While the traditional objective of avoiding initiation into use is maintained, the measures must go further, preventing the transition from use to harmful use or dependence too. Intervention in accordance with a prepared plan is encouraged in order that various objectives can be established that are adapted to the specific needs of the population concerned and to strengthen the consistency and continuity of the actions. In this model, availability of validated scientific data to the largest number of people – with an ideal objective of a common approach should facilitate adoption by the general population of appropriate behaviour regarding drug use. The spread of a common information base should also encourage consistent discourse from all the different actors in prevention: the state services, the professionals, the media, consumer groups, or other community groups.

Tools for professionals working in prevention. A Commission to validate the tools for preventing use of psychoactive substances was set up in January 2000. Consisting of representatives of the member organizations of the MILDT Interministerial Committee, the CFES, scientific experts and those working in the field, it aims to make an assessment of the items that are submitted freely to it[4], guarantee the reliability of the contents and ensure greater consistency in messages of prevention sent by various entities active in the field. In June 2002, 70 tools for prevention were examined (at twelve working meetings), 30 of which were validated. On examining the list of tools assessed by the Commission, the proportion of 'ministerial' productions remains limited in relation to the global production of the ministers concerned.

In the dynamic operated by MILDT around training of professionals, two publications connected with prevention were created over the 2000-2001 period: 'Knowledge base: a polythematic approach to issues of prevention and use of drugs' and 'Guidelines for training in prevention'.

b) Organization and coordination in national structures

Local coordination of prevention policy.

In the field of drugs, departmental coordination (sub-regional) of policies is the task of the 'drugs and dependence' project managers. They have a budget specifically for running the prevention policy, calculated on the basis of a pool of indicators[5]. The 'drugs and dependence' project manager, has the objective in particular of defining a departmental prevention programme, working closely with the State departments, the local authorities and the associations. In spring 2001, 53 departments had produced a departmental prevention programme. In 37 departments, the process of consideration was under way but had not yet resulted in a written timetable. It had not progressed very far for the other 10 departments.

In parallel the urban contracts are the sole political framework of concerted action through which the state, the local communities (decentralised administrations) and their partners undertake to implement policies and provisions under common law contributing to the fight against the degradation of defined areas and all forms of social and urban exclusion. Thus, the Local

[4] The quality criteria relate to the accuracy of data, respect of individuals and of laws, scientific and technical nature of items and appropriacy of the item for the target public. The tools used obtain a special label.

5 Statistics related to use of illicit drugs, death due to alcoholism or cirrhosis, deaths due to tobacco-related diseases, volume of population from 12 to 25 years.

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

Coordination within National Education Administrations

The issue of the prevention of dependence is 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). The main principal of this policy, laid down from the start of the 90s, is the prevention of all at-risk behaviour in young people[6]. The technical, academic (on a regional level) or departmental advisors are associated in the implementation of the local systems contributing to health and prevention in school populations: access programme to prevention and care[(ii)], dependence prevention programme etc.

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. The health and citizenship education committees (CESC) are organisational provisions for prevention, the development of which is widely encouraged. In parallel to these structures, there is no prevention model that is imposed for all establishments. However, the National Education programmes must, henceforth, be included in the departmental prevention programmes.

c) Expenditure linked to prevention

[Data not available]

9.1 School programmes

a) Policy specificities

The Health and Citizenship Education Committees or CESC are the organisational provision for prevention in schools. It is their mission to co-ordinate prevention and training for life in society in public primary and secondary establishments of general or vocational education. Their constitutional text (19998)[7] 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. 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, for example, the anti-drug training officers (FRAD), etc.) in order to create a link between the school and its environment. In practical terms, 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 1998 Circular also lays down the principals for the generalisation of the CESC throughout the country, also supported by the three-year plan 1999-2001. Globally, after significant expansion between June 1999 and June 2000 (+13 centres) and more modest in the following year (+7 centres), the CESC

[6] Circular No. 93-137 from 25 February replaced the provisions in Circular No 98-108 from 1 July 1998 relating to at-risk behaviour and the health and citizenship education committee, *BOEN* from 9 July 1998 (NOR : SCOE9801172 C).

7 Circular No. 98-108 from 1 July 1998 relating to at-risk behaviour and the health and citizenship education committee, *BOEN* from 9 July 1998 (NOR : SCOE9801172 C).

are present on average in 67 % of schools and public secondary establishments in 2001.

b) Prevention models in schools

The relative silence concerning the prevention of drug use in the legislative and statutory texts and the early implication of the associations in the general field of drugs has resulted in the multiplicity of active participants in prevention, the major share left to particular initiatives without any modelisation or action theory being imposed or particularly encouraged, neither by administrators nor professional networks established in the domain. The guidelines of the three-year plan 1999-2001 will not change this trend.

c) Prevention programmes available in schools in France

Prevention tools proposed by the National Education system. The tools have been created by the Ministry of National Education for management personnel, teachers and health care and social welfare personnel.
The collection of "Reference Points for the Prevention of At-Risk Behaviour in Schools" has been edited by the Secondary Schools and Colleges Directorate (Ministry of National Education) in collaboration with the MILDT. This document consisting of a practical guide, proposes possible lines of consideration and scenarios for the resolution of problems in relation to situations taken from real everyday school life. A theoretical guide is also included that proposes analyses on subjects relating to the adolescent's knowledge of the law, the organisation of prevention, the development of consumption behaviours including information on psychoactive products. A second guide ""Reference Points for the Prevention of At-Risk Behaviour in Elementary Schools" has also been created according to the same principle.

These tools, however, remain relatively general.

Actions ruled by the administrations responsible for application of the law. The Mission for the Fight Against Drugs (MILAD, Ministry of the Interior) runs and manages a roving information and drug addiction prevention campaign directed particularly at schools. The group of vehicles used is able to accommodate (30 to 40 people) and is staffed by MILAD officers supported by local PFAD (local anti-drug training officers), cf infra.

d) Global results

According to the data extracted from the "drugs and dependency" project managers' activity reports, relating to the school year 2000-2001, 10% of secondary school pupils on average, benefited from a dependence prevention action. This proportion varies greatly between 1 and 26% depending on the academy[8].

9.2 Youth programmes outside school

a) Types and characteristics of youth interventions outside schools

The year 2001 did not see particular development with regard to prevention amongst young people outside school. Reminder of provisions and guidelines:

8 The academy is the administrative subdivision in force with regard to the national education system.

Actions under the supervision of the Ministry for Youth and Sport. The dependency prevention actions run by the Ministry for Youth and Sport are co-ordinated by the Youth and Adult Education Directorate. In recent years, the decentralised services of the Ministry for Youth and Sport have been extended the special invitation to support the implementation of preventive actions in summer camps and in leisure centres without accommodation.

National Police actions outside schools. Since 1995, during the summer break, the MILAD mobile unit (cf. preventive actions in schools) has visited tourist spots. There the police meet not only with young people but also their parents, who generally express a strong demand for information.

b) Specific professional training in this field

A training module "at-risk behaviour of adolescents" has been prepared by an interministerial work group under the guidance of the Judicial Youth Protection Department. Issued to education, initiation, and rehabilitation professionals, its objective is to facilitate the detection of at-risk behaviour amongst adolescents. This module was refused at four voluntary sites in 2000 (Lille, Paris, Marseille and the Normandy area).

9.3 Family and childhood

a) Types and characteristics of family and childhood interventions

This domain is not the object of any centralised action by state structures and prevention initiatives aimed at children remain uncommon, the incentive potential of informing people about drugs being the main curb in the development of actions intended for this particularly vulnerable audience. The report framework[9] of the guidelines in the last governmental plan 1999-2001 regarding prevention, a report which was generally well received by the professional community concerned, outlined the requirement for early intervention with pre-adolescents (10-12 years) in order to delay initiation in psychoactive substance usage. Since few of the occasional meetings are organised between secondary school (in the framework of CESC) and primary school teachers to define protocols for the prevention of problems involving violence and those associated with psychoactive substance usage amongst pre-adolescents.

b) Available results

In 2000-2001, of the 306 drug prevention actions intended for young people, recorded in the APPRE[10] database, 24 (11%) concerned children from 6 to 10 years. The main objective of these actions is to avert early usage using a generalist health education approach. The concrete prevention messages are based most frequently on examples associated with licit psychoactive substances because they are more accessible.

The same information source records 60 actions aimed at families in 2000-2001. A number of these actions actually target a very large audience in which the families form part of the general population. In the majority of cases, the

[9] PARQUET (P.-J.), For a prevention policy regarding the consumption behaviours of psychoactive substances, Vanves, CFES, 1997, 107 p.

[10] Retrospective information programme (n-1) on prevention programmes financed by decentralised credits.

action within these families consists of the simple distribution of information on the risks associated with the usage and/or problems associated with adolescence in order that they may provide an intermediary role in the actions intended for adolescents.

9.4 Other programmes

a) Peer approaches

No updated data available.

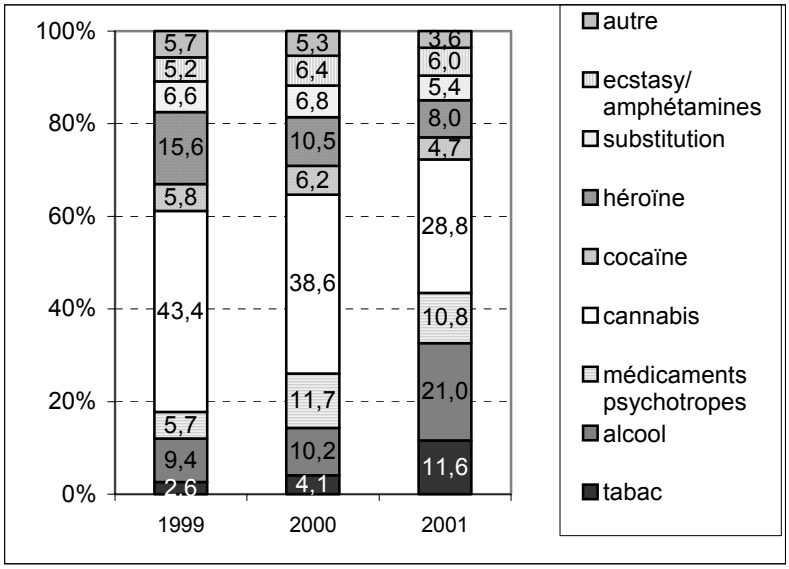
b) Telephone help lines

Drugs alcohol tobacco info service, national telephone help line. The expansion of the drug problem to psychoactive substances as a whole and the voluntary policy of the MILDT to supply all validated knowledge on the subject, is illustrated in the change in name from “Drugs info service” to “Drugs alcohol tobacco info service” (or DATIS) in June 2001 and at the same time by the adoption of a short number, 113, easy to memorise and dial.

In 2001, the year marked by the above-mentioned changes, the number of calls with content (other than calls due to errors, jokes, etc.) handled by DATIS increased by 3.5% compared to the previous year, from 57170 calls a year in 2000 to 59169 in 2001. These figures, however, are lower than those recorded in 1998 (60214) and 1999 (64049). The slight increase recorded in 2001 coincides with an increase in the average duration of calls: from 9.5 minutes in 2000 to 12.6 minutes in 2001.

The main trends observed. Between 1999 and 2001, a decrease in the proportion of requests about illicit drugs in favour of those concerning tobacco and alcohol is established. The 15-20 year age category remains the most significant (a quarter of calls), but a partial readjustment seems to take place in favour of the 31-40 year olds (21%): in 2000, the former accounted for 33% of calls, the latter for 17.5%.

Distribution (in %) of products named by callers between 1999 and 2001



Others, ecstasy/amphetamines, substitution, heroin, cocaine, cannabis, psychotropic medicaments, alcohol, tobacco

Other telephone help lines. The decentralised services, family or user associations (e.g. *Narcotics anonymous)* also suggest permanent telephone lines on a local level.

c) Community programmes

"Counselling" Centres, neighbourhood reception and monitoring centres.
Since 1997, structures called "youth counselling centres" have been established by the Addictions Division of the General Health Department (SD6B). Focusing on social urgency (deviation and exclusion), they based their activity on a principle of global prevention of drug addiction and marginalisation. The target public consists of young people from 18 to 25 years, outside of institutions and, in particular, those from deprived social and family circumstances. 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.

There were 100 counselling centres in 2000 and 2001. If this figure is stable for the last two years, the distribution of these services concerns 53 departments in 2000 compared to 41 in 2001[11]. This situation goes against the objective for better accessibility to help and counselling services defined by the three-year plan, through consistent geographical distribution. An evaluation (Jacob et al., 1999), completed in October 1999, identifies four main classes of strategy in the 40 Counselling Centres taken into account: a "community" approach (involving the public in the identification of needs and reinforcing local solidarity), a "psychoclinical" 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. The available data does not allow evaluation of the diversification of operational methods, the second method targeted by the three-year plan to improve access to these structures.

d) Press campaigns and communication actions

The communication programme of the MILDT created for the years 1999/2000/2001. The three-year plan announced a voluntary policy to raise the level of knowledge of the whole population on the problem of psychoactive substances (general public and professionals). The motives of this strategy are the coherence and credibility of messages on these subjects, owing to the clear presentation of scientifically validated knowledge and its wide distribution. The work undertaken in 2001[12] seeks to consolidate this approach.

Media campaigns. After the completely public campaign in 2000, more precisely targeted communication strategies are planned. During summer 2001 a second general public communication campaign "there is no better influence than yours" aims to make reference adults – parents, and the educational community in general, aware of their responsibilities by reasserting their educational role. A third campaign will follow in 2002, dealing with at-risk behaviour, especially on the party scene, cf. table below.

[11] Data provided by the General Health Department, Addictions Division.
[12] Details of the actions implemented in 1999 to 2000 are provided in the preceding national report.

Table 1. General public communication actions and campaigns implemented in 2000, 2001 and 2002.

	Objectives (Target public)	Actions implemented
Drugs : know more risk less (April and October 2000)	Question the general public on their realistic knowledge of the dangers of different drugs; promouvoir le livre d'information « Drogues, savoir plus risquer moins »	Media actions : 4 spots Tv out of all national channels Actions outside the media : publishing of the information booklet « *Drugs: know more risk less* » ; 650 000 copies sold (1.5 €)
Their is no better influence than yours (Summer 2001)	Encourage the adult community to intervene on behalf of young people. Develop the role of adults	Media actions : 4 full page adverts (alcohol, cannabis, ecstasy, polyconsommation) in the national daily press and other media Actions outside the media: re-publishing of the information booklet – 20 000 copies sold (3 €) and edition of 5 brochures (*flyers*) on different psychoactive products

The 2001 campaign was associated with intermediary measures aimed at ensuring the continuity of information and to direct the public towards the adapted services: the national telephone reception service, DATIS (113), the www.drogues.gouv.fr web site (in particular the section: "*Your questions, our answers")*.

The 2001 campaign aimed at the adult community prompted objections both in its form, poor quality and visual readability and also in the content, considered generally too alarmist by the parents of adolescents even though they recognised the seriousness of its messages. The target public of 35-55 years are not always recognised as a main target of the campaign, with three quarters of people questioned believing young people to be the main target. The particularly high rate of motivation is balanced if it is considered that only 42% of the homes sheltering adolescents effectively spoke about it.
This campaign, however, obtained more satisfactory impact scores[13] :
39% of people instinctively remember the campaign (average reference score: 35%) and 73% enjoyed the campaign (average reference score: 74 %);
86% of people saw the campaign but 25% declared themselves directly involved in their home, felt involved (motivation rate higher than average).
80% of people questioned think the campaign may lead to a dialogue with young people (reference score - smoking, alcoholism, drug addiction, taking all media into account: 44%), but 42% of homes sheltering adolescents effectively talked about it.

Information booklet for the general public "Drugs: know more, risk less"[14]. Incentive to buy the information booklet, "*Drugs: know more risk less"* aimed at the general public[15] was followed indirectly on the occasion of the 2001 campaign by the multiple edition of *flyers* aimed at young people.

[13] Average reference scores observed for national campaigns of general interest using the same media as the pre-tested campaign. Face to face survey from a sample of 1000 people aged from 35 to 65 years, regular readers of any of the media plan titles, throughout the territory (BVA, 27/31 August 2001)

14 At the request of the national public bodies, a Spanish and French Canadian adaptation has been created.

15 1st edition on 26 April 2000. "Drugs: know more risk less" is a 145 page book, in pocket format. It consists of 4 parts: "behaviour, usage, abusive usage and dependence"; "know the effects of drugs on the brain", the best known products in France"; "act, react, help, be helped".

The strategy of distribution to the general public generally occurred through sales via the publishing house route and at an attractive price (1.5 €). In parallel, approximately 3 million copies were distributed, free of charge, in pharmacies, some doctors' surgeries, various associations and state services.

e) internet information site "drogues.gouv.fr".

An internet site www.drogues.gouv.fr, providing the general public and professionals with data and information relating to drugs and dependence was launched in December 1999. Co-ordinated by the MILDT, in partnership with (CFES) [Comité français pour l'éducation à la santé] the French Centre for Health Education, (today INPES, [Institut national de prévention et d'éducation à la santé] the National Institute for Prevention and Health Education), OFDT [Observatoire français des drogues et des toxicomanies] the French Observatory of Drugs and Drug Addiction, DATIS and Toxibase; this site centralises information from various available sources. Its objective is to make all scientifically validated information on all psychoactive substances, licit or illicit, accessible to the public. It is the first public service site for drugs and drug addiction in France. It is organised in sections aimed at the general public and professionals with totally free access. It offers useful information and an area for exchanges: "Your questions, your answers" (presented by DATIS, national social telephone line).

From 2000 to 20001, a noticeable progression in the annual number of connections is noted – from 23 290 to 69 064 for the general public sections; from 18 000 to 23 978 for the professional sections – including the annual number of individual visitors (from 123 861 to 220 154 a year). This situation could be linked to an improved knowledge of the site by the general public and professionals, its referencing in the number of search engines[16] and the repetition of communication campaigns and actions used since 1999.

Although a qualitative *ad hoc* study is not available, the usefulness of the site seems to be largely recognised today. The ability to ask questions with total confidentiality associated with the scientific legitimacy of the information providers contributes to the recognition and credibility of the public publisher. In an audit ordered by the state and issued to a cabinet of independent experts the site was listed as one of the best ten French public sites[17].

10. Reduction of drug related harm

The policy of risk and damage reduction (RRD) is a crucial guide which is clearly a priority in French policy during 1999-2001. It advocates the extension of the RRD approach to all behaviours, in particular, with regard to the use of drugs in party locations. This approach aims to reduce dangerous consumption amongst young people in party, musical, cultural or sporting situations and also the consequences (particularly in terms of road safety). This new context, to which a new group relates, has just been added to those

[16] In the absence of available data concerning the average referencing of the site in the main search engines, the initial results of a study in progress showed the excellent referencing of the site under the title: MILDT – information, prevention against licit, illicit drugs and medicaments – and a selection of keywords.

17 Evaluation of the state services' internet sites carried out in November 2001 by a cabinet of independent experts, under the direction of the DIRE (Interministerial Delegation for State Reform). The criteria used were the following: organisation of information; visual and ergonomic quality, interactivity with the populations concerned (customised question/answer services), quality of the directory, diversity of the subscription propositions

already understood by the RRD, aimed at more marginalised active drug users.

10.1. Description of interventions

a) RRD in the party scene aimed at young people

The means by which the national authorities (Interministerial Mission for the Fight Against Drugs and Drug Addiction-MILDT and the General Health Department-DGS) boost these measures are the national associations network and the departmental prevention programmes (PDP).

- **Associations network**[18] The annual DGS contribution to the health prevention actions in recreational "rave" settings from decentralised state credits (chapter 47-15, article 40) increases to 457 K€ (annual average 1999-2002), an amount attributed, with the support of the DDASS (Departmental Management for Health and Social Action), to three or four (according to the years) main national “network head” associations. It is a matter of relatively stable financing, conventions established successively from one year to the next since 1997, the year in which “Rave” missions were born within large associations encouraged by the new measures adopted in the Circular[19] from 23 May 1997. With regard to the MILDT, a limited number of structures[20] (between three and six according to the year) are subsidised from the credits in Chapter 47-16, Art. 20 (employment and solidarity budget) with a total average amount of approximately 224 K€ a year (annual average 1999-2002). It is noted that the largest number of conventions signed by the MILDT occurred in 2001, the year of consolidation of efforts achieved over the three-year period: with financing rising between 2000 and 2002 from 195 K€ to 221 K€ reaching 256 K€ in 2001.
- **PDPs (Departmental Prevention Programmes)**: These actions are implemented at the local level which makes it difficult to estimate the credits actually mobilised. It is possible nevertheless to evaluate [21] the consideration of this dimension according to the activity report of the Drugs and Dependence Department Managers (CPDD) [Chefs départementaux des drogues et des dépendances] [22] : in 2001, 40% of French departments (response rate: 71%) would have implemented informative, preventive and/or first aid actions at party locations. Throughout the territory 165 manifestations were counted for which health protection interventions were made, which represents on average, six actions per department. With regard to the approximate number of people potentially affected by these actions, only two out of ten CPDDs responded. According to them, almost 90 000 young people

18 This data is limited to the national contribution to the main associations "network head", it does not take local financing into account (DRASS and DDASS) for local associations intervening in the party environment.

[19] Circular No. 97-366 DGS/SP3 relating to the monitoring of a health and prevention presence at techno rave events.

[20] It is possible to finance directly with decentralised credits (signposted) at the national level, regular interventions such as the Festival des Vieilles Charrues (Finistère) but this is not very frequent.

[21] Departmental project manager’s activity report in 2001, operated by the OFDT.

[22] The CPDD are in charge of giving impetus to the interministerial policy and to ensure the consistency of preventive actions at the local level.

were subject to these actions organised within the framework of the drug prevention programme throughout 2001.

b) RRD aimed at more marginalised drug users

During the period 1999-2001, the priority was to create and reinforce the RRD provisions (distributors of injection equipment[23], syringe exchange programmes (fixed or mobile), boutiques[24](fixed or mobile) and Sleep-ins[25]) and also to facilitate the acceptability of the risk reduction programme by the neighbourhood thanks to social mediation programmes (pilot project in the 18th district of Paris, extended to the 10th and 13th districts in the cities of Montpellier and Marseille).

- A clear increase in these credits granted for the creation and reinforcement of RRD[26] provisions is observed: from 11 M€ in 1998 increasing to 12 M€ in 1999, to 13.5 M€ in 2000, rising to 14 M€ in 2001.
- With regard to creating structures throughout the last three years, the increase concerned automatic dispensers and PES: a total of 77 **automatic dispensers** were installed (the total number thus increased from 150 to 227; 30 new **PES** were created (the number of PES thus increased from 88 to 118); the number of **boutiques** increased from 32 in 1999 to 42 (2 in 1999, 2 in 2000 and 6 in 2001). In 2001 four **sleep-ins** were counted, two of which were newly established in the period examined (in the cities of Lille and Paris).
- Concerning the **geographical coverage** of the RRD provisions, in the mainland each region has at least one of these structures and taken as a whole it may be said that the provisions cover a large part of the territory (87 departments covered). However, disparities do exist: in the DOM (French Overseas Departments), only the Union has a boutique. Furthermore, thirteen departments are in need of one, ten of which are in the rural environment and three others in the urban environment. An increase in the number of PES in pharmacies in this rural environment is noted, which seems to meet the population's requirements.
- The **pilot project in the 18th district of Paris** was implemented in 1999 with the aim of contributing to the social dialogue established between the neighbourhood, the drug users and the numerous risk reduction structures located in this district. The evaluation made[27] on this programme at the end of the first stage of experimentation shows the importance and the nature of the difficulties encountered by the parties in resolving conflicts between the neighbourhood and the structures. In fact the project did not succeed in furthering the social mediation at the district level. This objective proved to be too ambitious with regard to the particular conception of the programme. It was there, however, from time to time when a conflict emerged but did not have the areas of concertation envisaged by the institutional representatives.

[23] Automatic dispensers in the public thoroughfare supplying prevention kits for intravenous drug users (IDUs).

[24] The contact places are places of first reception for the most at-risk drug users offering syringe programme services, equipment support, nursing care, counselling and social welfare and/or legal services.

[25] They offer emergency overnight accommodation to drug users in potential danger.

[26] Distributors, boutiques, syringe exchange programmes (PES).

[27] Evaluation of the risk reduction system and social mediation in the 18th district of Paris, OFDT/ACT Consultants (to appear).

10.2. Standards and evaluations

Throughout the last three years (1999-2001), the evaluations piloted by the OFDT on "experimental" RRD programmes are as follows:

- Evaluation of the "methadone" bus in Paris (December 2000);
- Evaluation of the pilot project in the 18th district of Paris (September 2002).

The mobile facility "**Doctors of the World Paris methadone bus**" for the care of drug addicts substituting methadone, implemented in January 1998, constitutes one of the first French experiences on this subject. The OFDT was consulted[28] in 1999 for the purpose of establishing an evaluation in this institutional context of the research and experimentation of new social health provisions. This evaluation made by the IREP and the INSERM concerned on the one hand the provision's activities and users (effectiveness of the implementation) and on the other, the changes produced (effectiveness of the results) in terms of access to the social health network (role of capture/release), the effects on consumption practices and on the health and social rehabilitation of dependent people (report available at www.drogues.gouv).

At the authorities'[29] request, the OFDT piloted the evaluation on the "**Experimental programme for risk reduction and social mediation in the 18th district of Paris**". This evaluation conducted by ACT Consultants enabled the assessment of the effectiveness of the programme in relation to its initial objectives and the extent of the effectiveness of the facility with regard to users and the neighbourhood (realisation of discussions and surveys). One of the final objectives of this evaluation is to define the main recommendations for improvements in the operation and, if appropriate, to extend this type of operation to other agglomerations (report follows).

In addition to the surveys and studies involving users using the structures dedicated to the RRD, it is important to mention:

- the **1998 survey**[30] **on the social characteristics**, consumption behaviour and risks reported by **drug users attending the PES**;
- the **2001 survey**[31] **of the TREND sites** concerning drug users using the **"low threshold" structures** (PES, boutiques).

Any monitoring system implemented for drug users attending the facilities dedicated exclusively to the RRD. Furthermore we can mention the SIAMOIS system of the InVS which tracks the sales of sterile syringes on a national level and also the November survey (years 1997 and 1999) relating to the prevalence of HIV and hepatitis amongst IDUs (intravenous drug users) attending the specialised care centres for drug addicts, the hospitals and some social structures.

[28] MILDT, DGS, DDASS-Paris.

[29] MILDT, DGS, DDASS-Paris.

[30] InVS-INSERM-OFDT report "Social characteristics, consumption and risks amongst drug users attending PES in France", Emmanueilli, F. Lert, and M. Valenciano., November 1999.

[31] OFDT TREND report "Emerging phenomena linked to drugs in 2001 », June 2002.

11. Treatment

11.1 "Drug-free" treatment and health care at national level

It is the final objective of the authorities involved to assure the early indication and global[32] care of people with addictive behaviour towards one or more products, with the intention of uniting the structures and professionals in the field while assessing the exchange of practices (operation within the network) and the reinforcement of operation and liaison within the care structures. This system includes the structures financed by the DGS (General Health Department) in the fight against drug use: the CSST or "specialist care centres for drug addicts" (with or without accommodation), the "liaison and care teams" and the "town-hospital networks" within hospitals.

- **CSST (Specialist Care Centres for Drug Addicts)**: Their mission is to ensure health and social welfare care and social and educational care including assistance in integration and rehabilitation. More precisely the CSST must guarantee the reception, guidance and education of addicted persons and their families, withdrawal treatment and also support when this is achieved in the hospital environment, substitution (methadone and buprenorphine) and finally, support in the family environment. With regard to **developments**, the credits provided in Chapter 47-15/40[33] increase to 111 M€ in 2001, an increase of 1% on the previous year. An increase of 16% in the capacity of specialised facilities is observed over the three-year period, with the number of specialised centres increasing from 466 in 1998 to 541 in 2001. Between 1999 and 2001 almost a dozen centres were de-registered (9 CSST exactly, 4 in 2000 and 5 in 2001). The revision of the CSST's therapeutic projects anticipated by the policy note[34]from November 1998 enabled regional and national departmental redeployments, forming part of the reorganisation work in the offer of care supplied by the DDASS with the DGS's support, to establish the local requirements more effectively. Regarding the coverage of centres prescribing substitution treatments, it is noted that the number of departments with non-prescribing centres was reduced by half, decreasing from 13 in 1998 to 7 in 2001. In spite of this "step forward", the accessibility of first subscription[35] methadone is far from being assured. In addition to the seven departments without prescribing centres there are eight departments without the specialised structure. In the 2001 total, access to first prescription methadone remained inaccessible in the 15 French departments without prescribing centres.
- **Liaison and care teams in hospitals**: this concerns multidisciplinary teams that have received specific training; its composition is defined according to the patients' requirements as seen by the hospital

[32] In other words, to offer a social welfare and health response in cases of abuse and/or dependence on psychoactive substances.

[33] Operational costs of CSST, methadone purchase and also financing of the methadone bus, sleep-ins and rehabilitation workshops.

[34] DGS policy note from 5 November 1998 relating to the revision of the therapeutic projects of the CSST.

[35] Since 1994 (date methadone effectively came into force), initiation in methadone-based treatment is only possible in CSST (possibility of follow-up in urban medical practices). From 30 January 2002 doctors practising in health establishments (hospital structures) and also able to suggest first prescription.

structure. Their main missions are to form and support the hospital care teams (emergencies and services treating pathologies associated with addiction), to create care protocols and to develop links with care facilities enabling medical psycho-social monitoring. With regard to their recent **development,** since their creation in 1996, they were reinforced between 1999 and 2001: specific credits (globally provided) have been allocated to regional hospital agencies (ARH) at the approximate amount of 5.8 M€ for 2000, 7.6 M€ in 2001 and 5.9 M€ in 2002. The number has practically doubled increasing from 128 in 1999 to 252 in 2000/2001. Some teams have joined together: the teams offering combined guidance for "alcohol, drug and tobacco addiction" representing 19% of the whole. Those oriented towards "alcohol and drug addiction" are in second place (15%), followed by the "alcohol and drug addiction" teams (6%). Only one team oriented towards "drug and tobacco addiction" was recorded.

- **Town-hospital networks**: they were created in 1996 and their mission is to mobilise resources over a given area ensuring the liaison between professionals working in hospital services and general practitioners. Currently there are approximately 96 town-hospital networks in existence, 67 of which are for "drug addiction" and 29 for "alcohol addiction". **Development**: Their number has been constant since the hospital reform[36] of 1996. Regarding the state credits for the "town" section, financing is renewed annually by the ministry at an approximate amount of 23 000 € on average. As far as the health insurance credits for the hospital section are concerned, it is not possible to say how much the financing increases per network (globally provided).

11.2. Substitution and maintenance programmes

The interministerial plan of 1999 renews support for the development of a substitution policy 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:

[36] Note 59 of "Drugs and dependences" 2001

Statutory framework for substitution treatments in France in 2002

Methods	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 Specialist Care Centre for Drug Addicts in hospital environment since 30 January 2002 then possibility of supervision in urban medical practice First prescription in prison environment possible continuation of treatment in prison environment (initiation of treatment in hospital environment 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 and in hospital environment 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 at the Specialist Care Centre for Drug Addicts or at the hospital
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

Since the decree of 20 September 1999, regarding the application of the regulations controlling narcotics in certain medicaments based on buprenorphine[iii], 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[iv], sets the maximum duration of prescription for this medicament at 7 to 14 days, but the maximum issue in pharmacies at 7 days.

In order to make methadone more accessible and for the benefit of people who do not attend specialised care centres, the health authorities have

adopted the Circular[37] from 30 January 2002. It enables the prescription of methadone by doctors practising in health establishments within the framework of the initialisation of substitution treatments for drug addicts mainly dependent on opiates. The objective of this circular is also to diversify the locations and situations in which substitution treatment is undertaken within the framework of appropriate medical psycho-social supervision.

11.3. Aftercare and re-integration

In France the aftercare and re-socialisation programmes are mainly integrated in a specialised facility. More precisely it concerns **specialised centres with collective accommodation**, also called residential therapeutic centres. In these centres the drug users are taken care of from a medical psycho-social and socioeducational perspective by a multidisciplinary team (doctors, psychiatrists, nurses, psychologists, teachers, and social workers). The objective of this care is to restore the personal equilibrium and social integration of residents. Almost all of the centres with accommodation are managed by associations.

These centres also organise group activities outside of the centre and support for external courses of action. This social care also includes the involvement of the family or immediate circle of residents.

These therapeutic centres initially included a stage of withdrawal in which the patient attempted to use no products or medicaments at all. This approach was modified by the introduction of substitution treatments and the concentration on social order problems. The therapeutic centres have been encouraged, in conformance with the decree of June 1992(v) and the guidance note from November 1998(vi), to review their therapeutic projects and redefine their activities: the relaxing of their reception and residency conditions, collaboration with the local medical team for the care of patients, improved consideration of the social and professional requirements of patients.

In 2001, 46 centres were counted. Four centres were de-registered between 1999 and 2000. The reception capacity of these centres has therefore been reduced by 19%, decreasing from 679 places in 1998 to 569 places in 2001. At the same time the accommodation offered has been diversified.

The specialised care centres for outpatient drug addicts or those with accommodation can manage the temporary therapeutic accommodation networks, transitional or emergency accommodation structures or family reception networks.

The **therapeutic accommodation networks**, 86 of them in 2001, aim to enable drug users to rediscover their autonomy. Today they must be reserved for people with huge health or social difficulties. These structures must also help to reinforce the emergency and transitional accommodation capacity and the method of care to enable the user to take a "break" to stabilise the withdrawal or substitution treatment and benefit from stable accommodation. This type of accommodation also receives drug users leaving prison or those taking advantage of an alternative measure to imprisonment. The therapeutic accommodation networks provide approximately 422 accommodation places.

[37] DHOS-DGS Circular No. 2002-57 from 30 January 2002 relating to the prescription of methadone by doctors practising in health establishments, in the framework of the initialisation of substitution treatment for drug addicts mainly dependent on opiates.

The **transitional or emergency accommodation structures** propose short stays which are flexible from one to four weeks according to the person's health and social requirements. Socioeducational and/or health support is also planned. This type of accommodation is specially reserved for people suffering from significant de-socialisation and also for those leaving prison or within the framework of an alternative measure to imprisonment. In 2001, 147 places were proposed by the 18 existing structures.

The **reception family networks** were introduced at the end of the 1970s. The stay in a reception family responds to various situations and intervenes at different points in the addicted person's progression. In 2001, 20 reception family networks are recorded. In 1999, they represent a resource consisting of 215 families and 348 users were therefore received. The type of beneficiaries (single, with children, in withdrawal, undergoing substitution, under the law, etc.) and the length of stays (from a weekend to 9 months) are varied. Reception into the family is oriented towards the autonomy being regained and may be a step towards the professional rehabilitation of drug addicts. It enables the renewal of a "normal" life rhythm by confronting the people received with tasks and schedules and standing within a non-institutional framework. At the same time the therapeutic monitoring of the drug addicted person is ensured by the CSST attached to the reception family.

According to the General Health Department's figures, the total capacity of the specialised collective accommodation facilities for 2001 is approximately 1250 places.

12. Interventions in the Criminal Justice System

On 1 January 2002, France accounted for 185 prisons which received 47,473 people. Several surveys have been carried out in order to estimate the proportion of drug addicts in detention. The oldest survey carried out by the prison administration's research service (Kensey and Cirba, 1989) goes back to 1986: this estimated the proportion of drug addicts amongst those entering prison at 10.7%. The most recent one, carried out about twelve years later in 1997 calculated on the basis of a sample representing 75,825 people entering prison that about 60% of prisoners posed a problem connected with alcohol and/or drug consumption and required appropriate care[38]. However, the prevalence may reach higher proportions in some establishments located in areas heavily affected by drug addiction. Faced with this exponential increase, the care system within the prison environment tried to adapt.

12.1. Assistance to drug users in prisons

The prevention against the use of drugs in prisons is centred in the first place around the drug entry test in these establishments. A note from the Ministry of Justice from 18 February 1997 relating to the legal police checks at visits in the visiting room, within the framework of the fight against the entry of narcotic products in prisons, encourages visitors and prisoners to be informed of these measures. Disciplinary sanctions can be taken and judicial punishment applied against prisoners caught in the act of using illicit substances.

[38] DGS/SESI survey from May 1999 conducted on 75 825 entrants ("The health of prison entrants in 1997").

The care in prisons for drug addicts is regulated by the DGS/DM Circular No. 96-259 from 3 April 1996. The regional hospital medical psychological services and the health care personnel must according to the regulations distribute information on the damaging effects of drug use and on the necessity of using clean injection equipment. The offer of care for drug addicts made by the psychiatry sectors must be diversified and equivalent to that which is received externally, that is, the integration of all dependence phenomena and the continuation of substitution treatments initiated before imprisonment. The prescription of buprenorphine (Subutex®) or methadone can be continued or initiated in detention since the 1996 Circulars. Methadone can only be initiated in establishments with a Specialist Care Centre for Drug Addicts (CSST).

Beyond these general provisions, currently amongst the 185 existing prisons, few are developing a care facility specially adapted to drug addicts. In 16 large prisons there are Specialist Care Centres for Drug Addicts (their personnel mainly consisting of psychologists and specialist teachers, sometimes nurses but never doctors) and in 7 prisons there are units for prisoners who are to be released (UPS) [unités pour sortants] which look after drug addicts who are approaching their release date. This latter facility, evaluated in 2000, will be referred to as *infra*. Moreover, outpatient alcohol treatment centres have been introduced in 3 prisons.

Nevertheless, all prisoners on their arrival in prison, are offered a medical consultation in the outpatient consultation and care units, with in particular, screening for tuberculosis, voluntary and confidential screening for HIV and, more recently for hepatitis C, including a vaccination against hepatitis B. The regional medico-psychological services are responsible for psychological and psychiatric care in 26 prisons whilst the outpatient consultation and care units are responsible for somatic care.

In effect the statutory texts assign the co-ordination of the care of people showing addictive behaviour to psychiatrists for the medico-psychological and socioeducational sector, the establishment of the liaison with external structures with a view to ensuring intermediaries and to assist rehabilitation after release and epidemiological collection. The difficulty is attached to the multiplicity of specialised services which intervene in the care for addiction in prisons (UCSA, SMPR, psychiatry sectors, branches, SPIP, management and supervision personnel, external health and social partners) and which currently result in the dispersal of interventions. Furthermore if prisoners do not report their dependence problem and do not formulate a request to the health and prison services, the dependence is not always discovered by the intervening services in detention, whether they are health, socioeducational or monitoring services: reinforced co-ordination could lead to better recording.

In this context the interministerial recommendations have been addressed to the different services concerned in order that they may put in place co-ordinated organisation and better care for prisoners showing a dependence to licit or illicit psychoactive substances or who abuse these substances. An interministerial Health/Justice work group for the reduction in the transmission of the infectious diseases HIV and hepatitis in the prison environment completed its work in December 2000. Its mission consisted of creating an objective report on the exposure of prisoners to the risks of transmission of HIV and hepatitis via blood or sexual intercourse (significance of at-risk behaviour, incidence of different viruses), to assess the effectiveness and efficiency of the prevention measures implemented and to propose a risk

reduction strategy adapted to the situation and the prison context. The report submitted revealed the *within walls* consumption risks and made various propositions to reinforce the risk reduction policy in prisons[39], in terms of supplying injection equipment. Thus, the **interministerial letter** of 9 August 2001[(vii)] laid down the guidelines regarding the improvement of the reception into medical and social care of prisoners exhibiting a dependence to licit substances (notably, alcohol) or illicit substances or having an abusive consumption. It aims to improve the organisation of local intervention methods, associating all of the parties concerned within a clearly established project and with a named person in charge.
The objectives of this reorganisation are as follows:

- systematic detection of all situations of abuse and/or dependence, whatever the psychoactive substance;
- proposal for a reception into care adapted to the needs of the prisoner;
- develop prevention, especially for the risks associated with substance use;
- encourage penalty adjustments;
- 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 envisaged that a project group will be charged with drawing up and applying the new protocols for care in each 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 out. These will aim to support, in the months following their signature, the local processes of reorganisation of care for imprisoned drug users including the development of the co-ordination of services requested for intervention, both within prisons as well as outside of them.

Furthermore the care system for drug users in prison has seen preliminary changes: it has seen on the one hand, the arrival of numerous professionals outside of the prison administration and non-governmental organisations within the establishments; and on the other, it has been reformed by the law dated 18 January 1994 which transfers the social and health responsibility for prisoners to the public hospital service, in order to ensure that they receive the quality of care from which the general population benefits.

12.2. Alternatives to prison for drug-dependent offenders

The alternative measures to imprisonment applying to those subjects who are recognised as guilty and posing a drug usage problem are suspended sentences and probation which obligate the person charged to seek treatment, under the supervision of the review judge, under sentence of imprisonment. The sentence is registered in the national police record of the person charged. The review judge can also decide to defer sentencing and impose probation. The sentencing decision is then suspended for a period defined by probation during which the person charged is obligated to undergo health treatment. On

39 Source : annual report of the prison authorities 2000.

expiry the sentence pronounced takes into consideration the good will of the person under the law.

At the review judge's instigation, the user being pursued can volunteer themselves to carry out work in the public's interest. This involves unpaid tasks carried out by a group and representing from 40 to 240 hours. The amount of work carried out in the general public's interest for infringements of the drug law has decreased slightly in past years, decreasing from 561 measures in 1998 to 511 in 1999 and to 504 in 2000. These alternative punishments are mainly used for sentences for illicit usage or for possession and purchase of drugs: approximately 200 annual punishments are pronounced for these two main charges.

The monitoring of these alternative punishments is recorded by the Prison Service for Integration and Probation (SPIP). The SPIP identifies at the local level and under the supervision of the review judge, the social, medical and other structures which enable the application of the obligatory care pronounced which is substituted for imprisonment.

Finally, the preparation of prison drug users for rehabilitation on release which may assume a health and social dimension, also constitutes one of the points in the 1990 governmental programme, reaffirmed in the 1999 interministerial plan. Since 1997, the care facilities for addictive behaviour in prisons have been finalised by the pre-release units (UPS), a preparation facility on collective release for dischargeable imprisoned persons who pose a dependence problem. Initiated in 1992 through Fresnes prison's "intermediate release area", seven other pre-release units have since been created in the prisons in Lile, Lyon, Strasbourg, Marseille, Metz, Nice and in Fresnes's women's prison. In practical terms, the pre-release units are special units which concern prisoners showing dependence problems, generally at least one month before their release. They benefit from group activities (sports, theatre, others), work support courses and administrative measures (accommodation, others). These units focus on the group dynamic to make the "subjects" work on their self-esteem, respect their bodies and others. The pre-release units' management and direction are assured by a Specialist Care Centre for Drug Addicts in the prison.

Annually the courses involve from 100 to 200 people a year, this variation being explained by the variations in the number of participants and the frequency of courses: for the 7 sites, approximately 4-5 courses are organised each year with 4-6 prisoners to each course. Following the organisational difficulties illustrated by the evaluation of the facility implemented in 1999, in particular at the "recruitment" level of beneficiary prisoners, the central guardianship administrations redefined a more flexible framework of implementation for pre-release units at the end of 2001.

12.3. Evaluation and training

The initial and continuous culture of training development within the health community has been progressively established in France under the encouragement of the National agency for the accreditation and establishment of care (ANAES). The care system reform in prisons in 1994 has also contributed to promoting the more significant implementation of medical evaluation in prisons.

If the risk reduction policy implemented in prisons since 1996[40] , is proof of the collective realisation amongst prison personnel of the necessity for such care, the results of this awareness are very progressive. A survey carried out by the DGS and the DHOS indicates that in March 1998, the rate of disruption in substitution treatments in prisons remained significant: 19% in 1999 compared to 21% in 1998. The situation is more positive for prisoners benefiting from methadone treatments on entry with disruptions at 10% compared to 21% for buprenorphine. Access to substitution treatments still remains insufficient and uncertain in prisons. In effect, the survey carried out by the ministry of health in November 1999 on the medical services in 159 establishments, recorded one million people (1.653) under substitution treatment in French prisons (with 85% on Subutex™), approximately 3.3% of the prison population (2.8% for Subutex™), even though some studies estimate the number of drug users in prisons as 30%.

The prescription of Subutex™ in the prison environment today still arouses strong **resistance from certain medical personnel**, linked to the risk of abuse or *within walls* trafficking. Other intervening agents in prisons defend the feasibility of these treatments and their interests representing a vast range of indications and objectives concerning risk reduction and preparation for release[42]. In fact this absence of consensus has given rise to very differing practices[43].

As the general conclusion of the DGS-DHOS study indicates, it appears that **important partnership efforts need to be made**. The corollary studies establish that when the collaboration between the partners involved is effective (pharmacies, UCSA, SMPR), and substitution treatments fall within the global consideration on care for drug-addicted prisoners, progress is noted as much in terms of risk reduction as for research carried out on patients in prisons[44]. This conclusion is reinforced by the evaluation of the pre-release units led in 2000[45] which indicates that intravenous drug users who have benefited from substitution treatment before imprisonment are less likely to reoffend.

The interest in and the necessity for the continuation of substitution treatments has been further recognised and reinforced throughout the three-year period by a major advancement. In Law No. 2002-73 from 17 January 2002 for social modernisation[46], an amendment allowing the financing and prescription of medicaments during police custody (substitution medicaments in particular) was passed.

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[40] A General Health Department Circular in 1996, recognised the right of users to be able to undergo a high dosage buprenorphine or methadone-based treatment and opens up the possibility of substitution treatment prescription in French prisons. First prescription was authorised later, in the individual establishments with CSSTs.

[41] Survey on substitution treatments in prisons, I.TORTAY (DHOS)-H.MORFINI (DGS), November 1999.

42 Cf. Touzeau and Laurans, 1997 ; Brahmy, 1999.

43 For example, the SMPR in Marseille adopted an "all methadone" policy, while that of Fleury-Mérogis had an active list of 300 prisoners taking Subutex™, in 1999 it was a third of all substituting prisoners in France, with Fleury only representing 7.3% of the whole prison population (Brahmy, 1999).

44 Extract from an article by Betty Brahmy, psychiatrist of the Fleury SMPR, 1999

45 Johanne PRUDHOMME, Marc-Karim BEN DIANE, Michel ROTILY, first part of the evaluation of pre-release units (UPS), survey amongst professionals and prisoners, OFDT, March 2001.

46 LAW No. 2002-73 from 17 January 2002.

The prison personnel were informed and trained within the framework of mixed health and legal modules in drug addiction in general and in risk reduction. The APMMP (Association for the Promotion of Medicine in Prisons) created an internet site[47] in 1999 aimed at all the intervening parties in the environment inaccessible and accessible to prisoners.
In the pursuit of this partnership development objective, the MILDT finances associations helping to encourage the debate and reconciliations. Therefore the national association for the intervention against drug addiction (ANIT)[48]furthers exchanges and the consideration of the prevention of drug addiction by organising meetings and symposiums and representing the French intervening parties at international assemblies. It carries out important work for prisons through the specialist care centres for drug addicts.
Furthermore following the work on the consideration conducted in 1999 by the MILDT with the different ministries to draft an **interministerial specification on personnel training**, a one-day training module on the uses and public policies aimed at prison personnel was created[49]. It will have finalised the currently existing actions and developed for all the parties a common knowledge base on the products, uses and public policies, on the validated database[50].

13. Quality Assurance

To improve the quality of the care system, the three-year plan 1999-2001 emphasised the necessity of drafting diagnostic (early tracing) and care protocols (indications of different chemotherapies, and also educational and psychotherapeutic techniques) for harmful usage and dependence. Within this framework it is important to examine the activity of the National agency for the accreditation and establishment of care (ANAES) which has actively contributed to the implementation of quality measures in the area of health and also to the initiatives aimed towards implementing pre-established questionnaires for professionals in the area of addictions.

- **Methodological guides and ANAES recommendations:** Since 1998 the ANAES has organised four "Consensus conferences" on the subject: on withdrawal methods amongst drug addicts dependent on opiates (April 1998); on the cessation of tobacco consumption (October 1998); on methods of support for those dependent on alcohol following withdrawal (March 2001) – the sponsorship of the Ministry delegated for health and the MILDT illustrates their support in the organisation of the conference; on treatments for hepatitis C (February 2002). Amongst the "recommendations for clinical practice", it is necessary to mention the report from January 2001 on the screening methods for hepatitis C and at-risk populations. Furthermore, the ANAES has contributed to the creation of evaluation protocols with its work over the care network reviewing the existing one and defining a methodological framework (November 2001 available on request). All of the ANAES publications are available on line and are downloadable (www.anaes.fr). To facilitate the distribution of conclusions and recommendations of the jury, in specialised reviews in particular, there is a summarised

47 http://www.medecine-penitentiaire.com/

48 Joint financing MILDT-DGS, established by a multi-annual convention 1999-2000-2001 in the amount of 76.224 €.

49 This module has also been developed for police, police and customs officials.

50 Source: activity report from the prison authorities 2000.

consensus conference text. According to the Health Barometer[51] of general practitioners 98/99, less than a quarter of GPs were aware of the text submitted from the last consensus conference on tobacco withdrawal at the end of 1998. Amongst these, more than half found the conclusions interesting. Two out of ten admitted to "*not remembering or knowing about it*". Those doctors who were part of a network were more often aware of the text (28% vs. 21%).

- **Use of pre-established questionnaires** (recording tools): Beyond the methodological guides and consensus conference recommendations distributed by the ANAES, the three-year plan intended to support any other initiative aimed at building know-how and promoting this knowledge amongst the large number of medical or paramedic professionals. In this framework it is necessary to promote considerations regarding the recording tools for abusive behaviours and dependences on psychoactive substances, at the request of the MILDT and the health authorities (DGS and DHOS) with the assistance of several French and foreign experts. The final result has been the "low-level discussion[52] ", created from validated diagnostic discussions which enable the exploration of problems connected to substance usage (street "drugs", abused medicaments, alcohol). The objective of this systematic discussion is to differentiate between the pathological methods of usage (abuse and dependence) which do not arise from the same type of care, and to systematically study the consumption of substances that are less well known than the opiates (heroine and morphine), in particular the psycho-stimulants, the treatment of which is not as well documented, but which must be taken into consideration for the patient's long term future. It is also necessary to discuss the work of Professor Reynaud[53] on the harmful usage of psychoactive substances: identification of at-risk users, recording tools, behaviour control. Although these are the only two recorded experiences, it is not ruled out that other similar initiatives may be additionally developed. The evaluation[54] made by CEMKA-EVAL on "the projects for the reconciliation of specialised structures" enabled the professionals questioned to be confronted with this question. The effective use of recording tools appears not to be very widespread. A certain number of professionals do not consider these models to be very useful. According to them they use up necessary time for discussion helping to build trust in the patient/doctor relationship. As a result the medical and paramedic personnel would not be predisposed to use them for fear of making their reception "impersonal" and compromising the trust between doctor and patient. Furthermore, the evaluation on the reconciliation has not succeeded in identifying the recording tool in the customary practice of professionals questioned. The health barometer

[51] General practitioners' health barometer 98/99, CFES

[52] MINIGRADE support for the abuse and dependence on substances, MILDT-DHOS-DGS

[53] Harmful use of psychoactive substances: identification of at-risk usage, recording tools, behaviour to adhere to, Reynaud, Documentation Française 2002.

[54] Evaluation of the reconciliatory experiences of specialised structures CCAA-CSST for global care, OFDT/CEMKA-EVAL (to appear)

report[55] on general practitioners 98/99 confirms this observation: of the doctors questioned 6.2% use with their consultants pre-established questionnaires in support of consultations relating to tobacco. These tools are most frequently used by general practitioners who implement few actions. This practice seems to attract practitioners in the north of France more (22.9% vs. 15.6%), those in towns with 100,000 to 200,000 inhabitants and the Ile-de-France (respectively 30.6% and 27.6%).

[55] General practitioners' health barometer 98/99, CFES

PART 4 KEY ISSUES

14. Demand reduction expenditures on drugs

The expenditure laid out in relation to the whole illicit drug issue is traditionally divided into three categories: expenditure for prevention; expenditure for health; expenditure for drug repression. The question to be asked therefore, when we study the sensible expenditure having an impact on the demand for illicit drugs, is to understand if these different categories of expenditure are involved or in other words to identify the expenditure which by nature effectively enables a reduction in the demand for drugs.

On this note, it appears indisputable that the expenditure for prevention is exclusively dedicated to the reduction in the demand for drugs, since the objective of prevention, via information, is to encourage potential users not to become real users, while on the other side prevention attempts to urge real users to give up using drug products by informing them for example, about the dangers of these.

As far as the expenditure for health is concerned, it can not be considered as expenditure intended to reduce the demand for drugs, except in cases where the expenditure aims to help real users give up drug use. Such is the case when treatment programmes are implemented which aim to substitute drug consumption with certain products such as Subutex® or methadone, with the eventual objective being the complete cessation in the use of this type of product.

Finally the issue of expenditure for drug repression may appear more problematic. Indeed in France repression is aimed just as much at the offer of drugs as well as at the demand for them. Nevertheless, the objective of repressing the offer is to limit the access of users to illicit products and as a result leads to a reduction in demand by the absence of the offer. It is in this sense that it is estimated that the whole of the expenditure for repression has a negative impact on the demand for drugs.

It appears, however, that this type of distinction (expenditure for prevention, health and repression) is not always easy to implement. At first sight, it appears indeed that some administrations, for example, possess more of a repressive character and use expenditure in this sense (law, police, police force, customs) while the other administrations have missions to implement health and social treatment and prevention. In reality this type of division proves to be rather problematic and in the sense of the sharing between the repressive administrations and the others it must be remembered that the legal, police and police force administrations devote a proportion, sometimes a significant one, of their activities to prevention.

On the other hand it appears to be simpler to present the expenditure by administration, taking into account the existing budgetary framework (the state budget) and the lack of consistency between the different ministries. Thus at the national level, out of the total expenditure relating to the state budget, it proves not only to be easier to identify that which is directly dedicated to drug issues by ministry, without having to ask for example, if this or that expenditure is considered more so as expenditure for prevention or repression, but it is also clearly obvious that all expenditure relating to drug issues laid out in the framework of the state budget is intended to reduce the demand for drugs.

However, besides the expenditure allocated at the national level, i.e. the state budget, a certain amount of expenditure aimed at reducing the demand for drugs is allocated at the regional, departmental and local level, whether it is by

public authorities or by private associations. Since France is a State which is strongly focused on this type of issue, it does not mean that the local communities do not have an active role in the treatment of drug problems. Unfortunately the multiplication of hierarchical levels and the division of responsibilities makes the efforts to put forward any evaluation on the expenditure implemented at these levels, extremely difficult, indeed even impossible at the moment. Therefore only an estimate of the public expenditure on top of the state budget can be put forward, with this expenditure constituting without a doubt, the largest proportion of financial resources mobilised for the purpose of having a negative effect on the consumption of drugs.

14.1 – Concepts and definitions

The concepts and definitions are those generally used in national accounting.

14.2 – Financial mechanisms, responsibilities and accountability

All of the data presented below originates from the state budget.

14.3 – Expenditure at national level

All of the data presented below may be considered as being allocated completely to the reduction in the demand for drugs. It is presented by administration, although we will start with the treatment using Subutex® and its cost.

14.3.1 - Subutex® and its cost

According to Kopp, Rumeau-Pichon and Le Pen[56] ,Subutex®, introduced to the market in France in 1996 is a high-dosage form of buprenorphine which is a partial agonist of morphine receptors. This in fact is theoretically an opiate substitution product with no risk of respiratory depression owing to its ceiling effect. The authorisation for placing products on the market (AMM) defines it as a "*substitute treatment for major pharma-codependences on opiates, within the framework of medical, social and psychological care*". The methods for the product's prescription and delivery have been set by the French Agency of Medicaments and appear on the certified copy of the authorisation for its placement on the market. It is available in sublingual tablet form with buprenorphine dosages of 0.4 mg, 2 mg and 8 mg.

The SIAMOIS[57] indicators estimate that 14,000 to 18,000 patients per month were taken into care from June 1996 and almost 40,000 patients per month in June 1997. The calculation of these figures is based on the assumption that one 30-day treatment (at a dosage of 8 mg) is entirely purchased and consumed by the same person. It appears, however, that the reality may be less rigid: the hypothesis of 50,000 to 80,000 individuals consuming Subutex®

[56] Kopp, Rumeau-Pichon and Le Pen, The financial stakes of substitution treatments (in col.), Revue d'Epidémiologie et de Santé Publique (Epidemiological and Health Review), June 2002, No. 48.

[57] The SIAMOIS (Information System for the Accessibility to Sterile Injection Equipment) system, managed by the National Public Health Network, enables the collection of information relating to the sale of products in pharmacies purchased by drug users. It was put in place in January 1996 within the framework of France's risk repression policy.

seems more likely. The revenue court's report estimates that the number of drug addicts treated with Subutex® at approximately 42,000 on 13 December 1997, compared to 24,000 a year later.

With regard to the cost of treatment, a project is available which was carried out by the Centre for Economic and Sociological Research and Management [58](CRESGE), at the request of the Schering-Plough Laboratory, the results of which have been included in the recent report from the revenue court[59]. According to this study carried out amongst a panel of prescribing doctors, the cost for medical care using Subutex® [60] was estimated at 2,332.47 Euros per person per year.

Therefore based on the hypothesis of 40,000 people undergoing Subutex® substitution treatment, an approximate calculation of the monthly cost can be made. The direct medical cost globally would therefore amount to 91.47 million euros.

14.3.2 – Expenditure of public administrations

The division made for the expenditure for the administrations (mainly the ministries) is based on presentation by administration, this system being easier to adopt, taking into account the budgetary framework and the lack of consistency between the different ministries, but also the sharing between the repressive administration and the others whilst remembering that the legal, police and police force administrations devote a proportion, sometimes a significant one, of their activities to prevention.

A – The Ministry of Justice

The first expenditure group is linked to the activities of magistrates at different stages of the penal process and in the operation of magistrates' courts. This expenditure mainly consists of personnel costs (magistrates, clerks and legal employees), the costs for the operation of courts of law (building maintenance, information technology, etc.), legal costs and legal aid. This expenditure is allocated in the budget under the heading ***Judicial services***. The second expenditure category is linked to the imprisonment of charged and convicted persons. This is the expenditure for the ***Prison authorities***. Finally there is the expenditure allocated to the ***Legal protection services for young people*** relating to minors.

With regard to the ***Judicial services***, Table 1 estimates the cost of magistrates allocated to drug-related offences (ILS). In total the cost of the activity of judges dedicated to ILS rises to 14.65 million euros.

[58] Paree, Allenet, Lebrun, Subutex® within the therapeutic care system for heroin addicts: cost environment and assessment of the medical cost, Centre for Economic, Sociological Research and Management (CRESGE), October 1997. The participants used the general practitioners' network database of the Epidemiological Observatory, Thalès, with 383 computerised general practitioners. All Subutex® prescriptions issued by these doctors were studied from October 1996 to March 1997 inclusively. In total, 1548 prescription including Subutex® were thus analysed, detailling the prescription methods, co-prescriptions, the associated diagnostics and the supplementary examinations. 378 patients were involved, mainly men (77 % of the sample), with an average age of 30 years.

[59] op. cit.

[60] Subutex® is available in boxes of 7 sublingual tablets with buprenorphine dosages of 0.4, 2 or 8 mg, retail price 4.30 euros (0.4 mg), 9.92 euros (2 mg) and 26.94 euros (8 mg).

Cost of the activity of judges dedicated to ILS (million euros)

Type of magistrate	**Number of magistrates working on ILS**	ILS cost
Court of appeal magistrates	31.5	2.69
Court magistrates	24.9	1.67
Public prosecution magistrates	61.0	4.11
Examining magistrates	61.0	4.08
Review judges	30.0	2.00
Juvenile judges	1.6	0.11
Total	210.0	14.65

Two other categories of personnel to be taken into account in the judicial services are clerks and other official employees. In total, 327.25 clerks and legal employees devote the whole of their activity to ILS, representing in budgetary terms, 9.49 million euros.

However, it is advisable to add the cost for official employees appointed to the appeal courts. 64 clerks and supplementary legal employees allocated to ILS, representing in budgetary terms 1.86 million euros.

In total the cost for clerks and legal employees working on ILS represents 11.35 million euros.

Besides the different categories of personnel counted above, the judicial services include other expenditure. Table 2 details all the costs to be taken into account for judicial services.

Miscellaneous expenses for judicial services allocated to ILS *(in million euros)*

Type of cost	Expenditure
Ch 34-05 Information technology and telephony expenditure	0.48
Ch 34-90 Transfer expenditure	0.28
Ch 37-11 Criminal, correction and police justice expenditure	4.76
Ch 37-12 Legal aid	5.96
Ch 37-92 Legal operation	
- Art. 40 Appeal court	0.86
- Art. 51 Large scale courts (Métropole et DOM)	2.76
Ch 46-01 Subventions et interventions diverses	
- Art. 21 Private or public bodies contributing to judicial control	0.14
Total	**15.24**

Therefore the other costs for judicial services for ILS increase to 15.24 million euros.

In total when the personnel costs and other costs are added, the total cost of judicial services attributable to illicit drugs comes to 41.24 million euros.

With regard to the ***Prison authorities*** the number of prisoners held for ILS increased to 11816 people on 1 May 1995, while the total number of prisoners was 51325 at the start of 1995. Consequently the proportion of individuals imprisoned on account of ILS related to 23.02% of the total prison population. Therefore with a budgetary expenditure of 873.22 million euros for the prison authorities, the cost of detention of persons imprisoned for ILS represented 201.03 million euros.

With regard to the management of the ***Legal protection services for young people*** (PJJ), two groups of the public are affected by these actions: at-risk

minors (Law from 4 June 1970) and offending minors. The care for these two categories of minors depends on a public and a voluntary sector. Within this framework the expenditure of the PJJ has increased to approximately 0.32 million euros, of which 43% is distributed to the voluntary sector and 57% to the public sector.

More than 30000 minors have been monitored in the public sector, of which approximately 14000 are offending minors. More than 100000 minors are monitored within the framework of the voluntary sector, of which only 373 are offending minors. Unfortunately the PJJ does not supply information which helps to establish the number of minors whose care could be linked to their drug addiction or their implication in other ILS. The only statistical information available relates to 4376 minors implicated in ILS in 1994, representing approximately 4% of the total of minors implicated. On the other hand, in 1993, 866 minors sentenced on account of ILS were counted out of a total of 30714 minors sentenced. Out of these 866 sentences, 353 are educational measures which generally convert to simple admonishment, the other 515 sentences convert to imprisonment, fines or alternative sentences. In these conditions it proves to be extremely difficult to determine the cost of the PJJ services attributable to drugs. The only thing that can be mentioned, for instance is the worrying trend in the increasing number of “ILS” minors.

B- Customs

There is no specialist “narcotics” service in existence, but Customs estimates the approximate number of agents devoting all of their activity to the fight against drugs at 500. With the average budgetary cost for positions rising in 1995 to approximately 24086.94 euros, it is possible to estimate the minimum expenditure for personnel at 12.04 million euros, representing 500 agents allocated full-time to the fight against drug trafficking (a proportion of DNRED agents, surveillance levels that reinforce the DNRED agents and dog handlers specialised in narcotics).

On their part, the operational costs (outside of personnel) of customs represented 108.39 million euros in 1995. By dividing this amount in proportion to the number of agents, the operational costs per agent rises to 5411.94 euros. Therefore, additional to the operational costs are approximately 2.71 million euros, relating to 500 agents engaged in the fight against drug trafficking.

Besides these 500 people, are all the uninformed customs officers who assist in the fight against the trafficking of drugs. Based on hypothesis, it is considered that approximately 25% of the activity of uniformed customs officers is dedicated to the fight against the trafficking in narcotics. The total number in this category of personnel consists of approximately 9000 people, with 2250 customs officers allocated full time to narcotics. Therefore the personnel costs are estimated at 54.20 million euros and the operational costs relating to these 2250 agents at 12.19 million euros. Therefore the total cost for these 2250 customs officers increases to 66.39 million euros, to which the previously calculated cost of 500 customs officers, specialised in the fight against narcotics, is added.

C – Police force

The expenditure on the police force relating to ILS, originates on the one hand, from repressive activity exercised within the framework of ***criminal investigation missions*** and, on the other, from the preventive activity exercised within the framework of ***public security missions***. Finally, ***other***

expenditure which is directly identifiable will be added (anti-drug training officers, designated by the abbreviation FRAD, dog handlers etc.).

Regarding the ***criminal investigation missions***, the police force handles almost a third of crimes and offences committed in France each year, but there is no specialised service in narcotics in existence. There is a means of measuring the activity of service activity by type of mission and it emerges that in 1995, 27.345 million police hours were allocated to the "criminal investigation" mission, which represents 30% of total activity and 38% of activity relating to missions. According to the police force's statistics, the persons implicated in ILS represent 7.4% of the total implications by the police force and those imprisoned for ILS, 11.8% of the total imprisoned by the police force. The final statistic relates to the number of implicated persons, that is, 7.4% of criminal investigation mission activity is allocated to persons infringing the drug law. The police force therefore allocates 2,023,530 police hours to drug-related offences. The cost per police hour (combining personnel costs and other operational costs) increases to 34.43 euros, the overall cost of criminal investigation missions allocated to drug-related offences is therefore in the region of 47.51 million euros.

With regard to the ***general public security missions***, these bring together the surveillance activities exercised by the police services and also the regulation of road safety and the presence of police at "raves". Based on hypothesis, the drug-related offence part of the general public security mission represents 3%. With this mission taking up 23.7 million police hours, the total cost of the police's general public security missions allocated to drug-related offences is 16.69 million euros.

Other expenditure attributable to drug-related offences increases to 5.83 million euros. This includes in the first place, the FRAD (anti-drug trainers), representing 40000 working hours at a cost of 0.95 million euros. Then there are 120 additional people in various sectors, who devote themselves entirely to the fight against narcotics (dog handlers, etc.), at a cost estimated at 4.88 million euros.

D – The Police

Out of the national police force's entire personnel, 2000 active service officers devote their whole activity to the fight against drug trafficking. This concerns the officials of OCRTIS (Central Office for the Repression of Illicit Drug Trafficking), the criminal investigation services and the urban and departmental security departments. Also called upon to regularly intervene in the drugs domain, are approximately 260 officials belonging to the BRI (Research and Intervention Brigades) or to the BREC (Brigades for Repression, Investigation and Co-ordination), representing a proportion of activity estimated at 15 to 20% there are 45 officials giving an average figure of 17.5%. It is still necessary to add to this total a 5 to 10% proportion of administrative officials, representing 150 officials, with an average figure of 7.5%. In total therefore there are 2195 police officers devoting the whole of their time to the fight against drugs. Based on an average budgetary cost of 29727.56 euros, the corresponding expenditure increases to 65.25 million euros, adding to this the operational expenditure representing 15% of the total budget, which amounts to 11.51 million euros for the 2195 officers.

Still to be taken into account is the expenditure for 82600 public security officials relating to their activity allocated to the fight against drug trafficking. According to a CESDIP (Centre of sociological research on the law and penal

institutions) study, public security officials devoted 70% of their time to penal tasks. Therefore there are 57820 public security officials who devote their full time to legal action. This legal proportion itself is divided up into an identical amount of repressive and preventive activities, with 28910 officials devoting their full time to the repressive proportion and the same number of officials for the preventive proportion. Finally, the repressive activity allocated to drug-related offences increases to 12% (proportion of people implicated for drug-related offences out of the total of implications by the national police force),[61] while the proportion of activity for drug-related offences is 3%, the same as for the police force. Therefore, the number of officials increases to 3469 for the repression of drug-related offences and to 867 for the prevention of drug-related offences. In total there are 4336 public security officials devoting their full time to drug-related offences. Since the annual budgetary cost increases to 21885.58 euros per public security official, the total budgetary cost rises to 94.90 million euros and with the addition of operational costs rising respectively to 13.40 million euros for the repressive aspect of drug-related offences and to 3.35 million euros for the preventive aspect of drug-related offences.

E – The Ministry of Social, Health and Urban Affairs

An investigation into the expenditure of this ministry is directed towards the area of treatment and prevention. These issues are dealt with, in the area of health treatment, by the ***General Health Department*** (DGS), in the area of social treatment and prevention, by the ***Department of Social Affairs*** and the ***Interministerial Delegation for Urban Affairs*** (DIV). The ministry's direct expenditure for personnel is restricted to tasks of coordination and escalation to the ***Departmental and Regional Directorates for Health and Social Action*** (DDASS and DRASS). Nevertheless, it should be noted that the whole of this expenditure does not come into the reduction in the demand for drugs.

With regard to the ***General Health Department*** (DGS), its expenditure is listed in Chapter 47-15 of the budget of the ministry of social, health and urban affairs, under the title "programmes and mechanisms in the fight against drug addiction", excluding Articles 50 and 60 which relate to the DAS. The amount of the credits passed for 1995 increases to more than 92.08 million euros.

Nine tenths of these credits are found in Article 40 *"Structure of the fight against drug addiction*: *decentralised actions*". These credits are used mainly to subsidise the specialist centres for the treatment of drug addiction, exclusively for the area of health, not including the "prevention and studies" and "research" aspects. At the end of 1995, 163 treatment centres were counted (it is necessary to add to these 26 with permanent reception) and 51 aftercare centres with accommodation benefiting from these subsidies. The credits in Article 40 also enable the financing of drug addiction branches in penal establishments and town/hospital networks. The expenditure allocated in Article 40 increases to 82.98 million euros.

The second item, in order of importance, in Chapter 47-15 corresponds to Article 10 under the title "*Reimbursement for the health care of drug addicts*", which lists the amount of 9.01 million euros for 1995".

It is finally necessary to add the expenditure relating to the implementation of mandatory treatment rising to 1.65 million euros.

[61] Out of caution we based this on an assumption of 12%, while public security's proportion of penal activity allocated to ILS is between 12 and 25%.

On the one hand, a whole range of expenditure does not come into the reduction in the demand for drugs. Such is the case for expenditure for prevention in relation to AIDS and intended for drug users, estimated, according to the AIDS Division of the DGS, at 6.10 million euros (listed in Article 20 "*The fight against AIDS*: *decentralised actions*" of Chapter 47-18). It is a matter of credits relating to syringe exchange programmes, the creation of "boutiques" for drug users, the installation of urban containers, etc. On the other hand there are the subsidies (Article 10 "*The fight against AIDS*: *national actions*") to some associations acting in the area of drug addiction (Green Cross and Red Ribbon, SAFE, IREP) which do not represent more than 0.15 million euros. However, at the national level, the communication actions specifically targeting drug addicts would not have passed the embryonic stage in 1995, and represent no more than 0.15 million euros. Finally we exclude the expenditure, that is, the credits allocated to accommodation actions (6.84 million euros) and to the support of everyday life (5.06 million euros). Applying the rate of 25% (proportion of drug users treated for HIV infection in hospitals), additional expenditure of 2.97 million francs is reached.

With regard to the ***Department of Social Services*** (DAS), these preventive actions carried out on the national level as well as the local level, are financed by the credits listed in Chapter 47-15, Articles 50 and 60, and have increased to 2.13 million euros. From their side, the MILDT (Interministerial Mission for the Fight Against Drugs and Drug Addiction) credits have risen to 2.47 million euros.[62] Financed within this framework are the "counselling centres", some training actions, "sleep-ins", etc. In fact included in the overall expenditure some of these have an influence on the demand for drugs, although others simply concern the social treatment of a drug problem. Unfortunately we are not able to separate these amounts into the different types of expenditure.

3.35 million euros were allocated to the ***Interministerial Delegation for Urban Affairs*** (DIV) in 1995 for the prevention of drug addiction. The distribution of these credits can be achieved within the framework of the community or departmental councils for the prevention of delinquency or through urban contracts. State finance must increase in principal by at least 50%. It is the case, however, that in some disadvantaged regions, this percentage may be higher. The average multiplier effect would be between 2 and 3, that is, 3.35 million euros expended by the state could generate approximately between 6.71 and 10.06 million euros in expenditure on behalf of regions, departments and towns. In total, therefore, there would be an amount of between 10.06 and 13.42 million euros expended within the framework of the town policy and allocated to the prevention of drug addiction. This omits, however, the whole area of local financing, which it is impossible to establish accurately. In fact, the fight against drug addiction would be an important concern for town councils and one of the better handled priorities. Local financing therefore should be relatively significant.

Finally, with regard to the ***Departmental and Regional Directorates for Health and Social Action*** (DDASS and DRASS), it is necessary to calculate an equivalent amount of time fully dedicated to drug addiction per department, involving about a hundred people. The average budgetary cost for social welfare and social workers is approximately 24849.17 euros. Consequently, the **total cost for the DDASS and DRASS is 2.48 million euros**.

[62] The 2.47 million euros of MILDT credits are interministerial credits.

F – The Ministry of National Education, Higher Education and Research

For the ministry of national education, higher education and research, two areas need to be studied: the activity developed by **National education**, on the one hand, and aspects relating to **research** on the other.

The **ministry of national education** and the ministry for youth and sport both have the common specificity of mainly practising in the primary prevention sector involving young people. In both cases, identification of the measures taken, other than the MILDT credits is particularly difficult. This relates first of all, to the definition itself of a preventive action, for which it is impossible to say where it starts and where it ends. Finally the only preventive actions against drug addiction which can be measured are those that essentially appear as such in the interministerial credits regarding national education, youth and sport.

The ministry for national education created the “Social Environment Committees" (CES) in 1990, which were an instrument in the development of the prevention of at-risk behaviour in schools. The decision was taken in close collaboration with the ex General Department for the Fight against Drugs and Drug Addiction, which illustrates in spite of everything, the central position occupied by the fight against drug addiction. In 1995 there were 1691 CES, representing 20% of establishments. The ministry only contributed to the financing from its funds an amount of 0.30 million euros in 1995.

In each academy there is a pilot group consisting of 5 people (1 doctor, 1 nurse, 1 social worker, 1 school headmaster, 1 inspector). However, it is unfortunately impossible to determine the proportion of activity each of these people allocate to the pilot group. Furthermore, 3 people are available at the departmental level, but here again it is not possible to determine the proportion of their activity relating to drug issues. Finally, it is also necessary in each CES to count the head of the establishment, as well as a team with a variable composition.

The ministry's other expenditure is allocated to training, on the one hand for projects requiring the ministry's approval and on the other within the framework of academic training programmes. Unfortunately, the amount of expenditure from their funds, represented by this is not known.

Therefore with all these uncertainties, only 0.30 million euros is thus attributed to national education for the prevention of drug addiction.

With regard to the activity of the **ministry of research**, there is still difficulty in defining the field of drug addiction. Nevertheless, there are approximately 50 permanent researchers, to which it is necessary to add about forty ITA personnel, amounting to 90 people generating an expense (salary costs and operational credits included) of 5.75 million euros. However, the criteria of these two bodies for including or not including a researcher in the field of drug addiction are not known. It is thus necessary to note that the natural trend with these bodies is more so to minimise the amount of credits and researchers.

In fact a quick check of the number of researchers operating in the area of neurobiology and psychology is already approaching a figure of about fifty people. It is then necessary to take into account “clinical” research in the areas of psychiatry and psychology and the research of social sciences. A check based on the files of the GDR “psychotropics, politics and society" research teams enabled the calculation of about twenty researchers undertaking work focusing on drugs in 1995, and a single ITA post (ETP). It is also necessary to include the expenditure of approximately 0.27 million euros relating generally

to holiday payments. There would in total therefore be about 50 researchers in the neurobiology, psychobiology and clinical research domain, to which about forty ITA (ETP) should be added, which is 90 people in all at an average annual cost (expenses included) of 48783.69 euros. If 10% is added for operating costs, the expenditure for this category of researchers amounts to 4.83 million euros. Then 21 people are calculated for social sciences, amounting to an increased average salary cost (minus ITA) of 54881.65 euros. Calculating 10% for operating costs and holiday payments, the total expenditure increases to 1.52 million euros in 1995. Consequently the total expenditure for research is estimated at a minimum of 6.35 million euros.

G – The Ministry for Youth and Sport

As for the national education, the means committed to the prevention policy of the Ministry of Youth and Sport are not globally identifiable, the financing of the actions have been decentralised in a general procedure that does not allow for the registering of the prevention as such. More generally, apparently none of the government programmes may be considered as exclusively centred on the prevention of drug addiction.

In this way, the costs for the people-resources on which drug addiction rests, the policies for the prevention of drug addiction may only be identified at a local level. There are 104 of these people (1 individual by department and by region), and devotes between a third and two thirds of their activities to the drug addiction domain. By taking one part of drug addiction activity averaging at 50%, there are 52 people who are entirely devoted to the drug addiction problem. In this way, with an average budgetary employment cost of 25800,62 euros, the Minister for Youth and Sports allots, a minimum of 1.34 million euros to the drug addiction problem.

H- The Minisitry of Foreign Affairs

The voluntary contributions of the minister to the PNUCID programmes (United nations Programme for International Drug Control) and the financing of certain co-operation actions may be considered as bound to the policies for the fight against drug addiction and drug trafficking. In 1995, the voluntary contributions to the PNUCID have risen to 1.07 million euros.

Certain co-operation actions including a “narcotic” section that remains however difficult to estimate. The government has made hundreds of attempts but finished by abandoning this due to the difficulty in obtaining information from the players on the field. However, according to the spokesperson for the Minister of Foreign Affairs, the expenses for the fight against drugs included in the programmes of co-operation must not exceed the amount contributed to PNUCID.

In total, this is approximately 2.13 million euros that the Minister of Foreign Affairs allots to the drug problem (excluding interministerial funds, in other words 7 million of the contribution to PNUCID and 7 million of expenses in the cop-operation programmes).

I-The Ministry of the Cooperation

The actions for the fight against drugs makes up a section of programmes for the fight against large trafficking and the programmes of general co-operation with regards to the police and the police force.

For West Africa, over three years, including 1995, the authorisation of programmes rose to 18.45 million euros for the co-operation as regards to the

police, and is at 11.59 million euros for the police force. The « narcotic » part of these programmes are evaluated at 20% for the police funds and 0% for the police force funds. In this way during 1995, 3.69 million euros would have been allotted to the fight against drug trafficking in the name of intervention funding (structuring of services, equipment, training).

On the other hand, we must also take into account the expenses linked to the presence of a corresponding “narcotic” in each of the 12 countries of West Africa. The cost being estimated at 53357.76 euros yearly and by person, the total cost for the 12 correspondents rises to 0.64 million euros. Therefore, in total there is 4.33 million euros of “narcotic” funds for West Africa.

The government action also extends to Central Africa and to The Caribbean Islands. This latter area does not seem to have benefited from the identifiable funds of their actual budget. On the other hand, for Central Africa, the amount of the funds for the actual budget may be roughly estimated at half of the funds allotted to West Africa, in other words approximately 2.16 million euros.

J-Cooperation of France to the EU drug budget

The European Union budget allotted to the fight against drugs has risen to 27.94 million euros in 1995, of which 13.3 million is for the Union’s internal programmes and 14.59 for actions in Southern countries on one hand, and Eastern Countries and Central Europe on the other hand.

France’s portion in the total budget of the European Union was 17% in 1995. So, the French contribution to the European programmes for the fight against drugs has risen to 4.75 million euros. However, we have noticed that the amounts allotted to the Union Interior cooperation with regards to the justice department and the police are not evaluated here, it is difficult to pinpoint the specific part allotted to the fight against drug addiction in these funds.

14.4 – Expenditure of specialised drug centres

No information available

14.5 - Conclusions

Table 3 relates to the expenses made at a central level by the group of administration who allotted a part of their resources to the drug question. In total, 803.71 million euros was spent to attempt giving a negative attitude to drugs.

The justice department alone represents 30.14% of these expenses, followed by the police (23.44% in total). Only these two administrations represent almost 53.59% of the total expenditure, the only prison administration represents a quarter of these expenses.

By adding to the expenditure of the police, and other “repressive” administrations (customs and police force), we obtained an expenditure amount of 339.58 million euros, in other words 42.25%. In total, these expenses amount to 581.85 million euros, in other words 72.40%, the total expenditure, that were made by the “repressive” administrations (the justice department, police, customs and police force) but we must remember that the justice department, the police and the police force administrations devote a very important part of their activities to drug prevention.

The third item, by order of importance, is represented by a social administration (Department of Social Affairs) with 12.69%.

Type of expenditure	Expenses
Subutex®	*91,47*
Public Administration expenditure	*712,24*
Department of Justice	*242,27*
including : -judicial departments	41,24
Prison Administration	201,03
Judicial Department for the protection of youth	NA
B-Customs	*81,14*
including : -personnel	66,24
-- running expenses	14,90
C- Police force	*70,03*
including : -- Judicial police missions	47,51
- general public security missions	16,69
- other expenses	5,83
D-Police	*188,41*
including : -personnel	160,15
-- running expenses	28,26
E- Social, health and Urban Affairs	*101,99*
including : -DGS (General Health Department)	94,03
including : -chapter 47-15	92,08
-therapeutic injunction	1,65
-chapter 47-18, article 10	0,15
- communication actions for drug addicts	0,15
- DAS (Department of Social Services)	2,13
-DIV	3,35
-DDASS and DRASS	2,48
F- National Education, higher education, research	6,65
including : - National Education	0,30
- Research	6,35
including : -personnel	5,79
-- running expenses	0,56
G- Youth and Sport	1,34
H- Foreign Affairs	2,13
including : - PNUCID (United Nations Programme for International Drug Control)	1,07
- Cooperation Actions	1,07
I- Cooperation	6,49
including : - West Africa cooperation	4,33
Central Africa Cooperation	2,16
J- France's Cooperation to the EU budget for drugs	4,75
K- Work, employment, and professional training	0,12
L – MILDT	*6,92*
Public expenditure at a local level	*NA*
Expenditure of associations privately financed	*NA*
Total	*803,71*

Syntheses of imputable expenses used for drugs (in million euros)-1995

The other administration expenses are on the whole quite marginal, since each one represents less than 1% in total expenditure.

Obviously this data only includes the expenditure of central administrations, no data was available for the expenditure of the players at a decentralised level (regions, departments, communes). This limits the representation of the work, even if we could estimate on the drug question, the State represents the main source of expenditure. It appears that a study of expenditure at a local level made up one of the main reflections conducted at a French level to have a global vision of the amounts at stake concerning the problems in reducing the drug demand.

Concerning a global estimation of theses expenses, it sometimes proves quite difficult to distinguish with precision which of these expenses have a negative action on the reduction of the drug demand, and those that have no impact at all. For example, in the case of the Department of Social Affairs, Health and Town certain funds are accounted for, when we didn't know if these had had a real impact on the drug demand. In this way, for the Department of Social

Affairs [*Direction de l'action sociale*] (DAS) a group of diverse funding is accounted for including the financing of "help-lines" training action, "sleep-in", etc. If the personnel training has caused a negative approach to the drug demand, the other expenses could be considered as a simple social treatment of the problems generated by drugs, without knowing if these expenses had any effect on the drug demand.

Be that as it may, it however appears that the large majority of the expenses described here have had a negative impact on the drug demand, the amount of these expenses could give rise to a discussion being relatively marginal**.**

14.6-Methodological information

a- Limits in the available data

The limits in the available data essentially comes from three aspects. Firstly, the available numbers date back to 1995 and after this date no study has been conducted. Consequently, it could prove interesting to update the numbers of 1995. If during the period 1995-2002, there does not seem to be large differences, in budgetary terms, that have been made, it seems, on the other hand, that the actual budgetary adjustment could change the prospect of the expenses described here.

The second point that should be indicated on the data projected here rests on the fact that no data is available for the expenses made by the players at a decentralised level (regions, departments, communes). This limits the representation of the work, even if we could estimate on the drug question, the State represents the main source of expenditure.

Finally, even if we have an explicit reserved hypothesis to calculate the expenses presented in this work, we have to admit that, in certain cases, it sometimes proves quite difficult to precisely distinguish the expenses that have had a negative action on the reduction of the drug demand, with those that have had no impact.

b- Main studies and research

The main studies and research on the expenditure domain concerning the drug problems in France are those that have been used to produce this article. Two sources seem nevertheless more complete on these questions. The first rests on the description of public expenditure with regards to drugs and was produced in 1998 (Kopp P. et Palle C., 1998). The second, conducted in 2000, drafting the social costs of legal (alcohol and tabacco) and illicit drugs in France (Kopp P. et Fenoglio P., 2000). The main information sources on these questions are given in the heading "Bibliographic References" below.

c- Bibliographic References

Kopp P. et Fenoglio P. (2000), Le coût social des drogues licites (alcool et tabac) et illicites en France, OFDT/ARMI, Paris, 277 pages.

Kopp P. et Palle C. (1998), Vers l'analyse du coût des drogues des drogues illégales : un essai de mesure du coût de la politique publique de la drogue et quelques réflexion sur la mesure des autres coûts, OFDT/ARMI, Paris, 80 pages.

Kopp, Rumeau-Pichon et Le Pen, Les enjeux financiers des traitements de substitution (en col.), Revue d'Epidémiologie et de Santé Publique, juin 2002, n° 48.

OFDT (2002), Drogues et Dépendances : indicateurs et tendances 2002, OFDT, Paris**,** 368 pages**.**

15. Drug and alcohol use among young people aged 12-18

Adolescence is an age that often corresponds to the beginning of the drinking period, it is also important to observe this age group behaviour. For precaution reasons, the under 15 year olds are rarely interrogated with very delicate questions, under which illicit drugs fall. However, there is some available information on the 12-14 year old group, but it is sometimes subjected to protection because survey protocols may consider it to be unsuitable.

15.1 Prevalence, trends and patterns of use

Three types of surveys allows for the observation of adolescent drug consumption **:**

- The first survey took place at the high school, where the pupils fill in an anonymous questionnaire themselves. This was the case of the survey conducted in 1993 (Choquet et Ledoux, 1994), in 1997 (Ballion, 1998), in 1998 (de Peretti et Leselbaum, 1998), in 1999 (ESPAD Inserm-OFDT-MENRT) and in 2000 (Ballion, 2001). The majority of the young people interrogated were between 15 and 19 years old.
- The second one took place during the Call to Preparation for Defense Day [*Journée d'Appel de Préparation à la Défense*](JAPD) dedicated to military service in France (replaces military service), where girls participate in the same manner as the boys. The context and the population interrogated differed therefore: in the survey in a school environment, it lacked absentees and youngsters who did not attend school. Nevertheless the results obtained by these two methods of surveys are shown to be very close. 18 year old young people are interrogated, but this survey poses retrospective questions that helps obtain information on the initiation of these products that often begins between ages 11 and 17.
- The third survey was conducted by telephone at the parents homes of 12 – 19 year olds, (Baudier et al., 1998) or in a group interview made up equally with adults (Gulibert et al., 2001). The results are not detailed here (see 15.4)

The most recent data is from the Annual Enquiry (ESCAPAD) produced in 2001 by the OFDT (French Observatory of Drugs and Drug Addiction)**.**

Frequency of alcohol and other drug use in 18 year olds, in 2001, according to sex

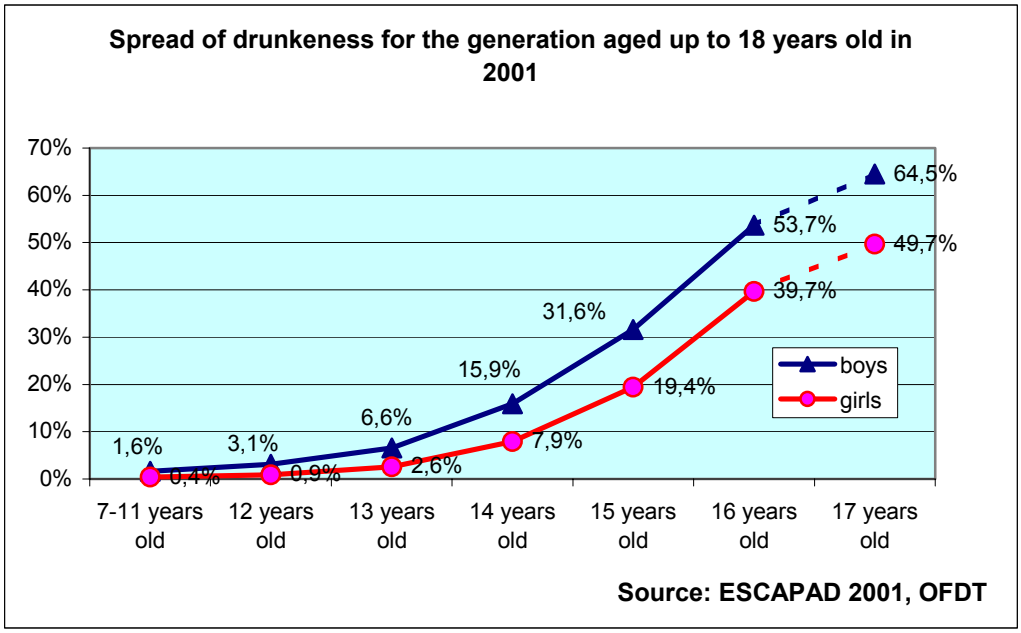
	during life		during the year		during the month	
	boys	girls	boys	girls	boys	girls
alcohol	93,3 %	91,9 %	nd	nd	73,6 %	80,3 %
cannabis	55,7 %	45,2 %	50,0 %	37,5 %	39,2 %	23,6 %
Psychotropic medication	12,4 %	31,1 %	8,6 %	25,2 %	3,9 %	14,9 %
hallucinogenic mushrooms	6,9 %	2,5 %	5,2 %	1,5 %	1,4 %	0,3 %
poppers	5,7 %	3,4 %	4,2 %	2,1 %	1,6 %	0,7 %
Inhalants	5,8 %	3,7 %	2,1 %	1,3 %	0,7 %	0,4 %
ecstacy	5,0 %	2,7 %	3,9 %	2,1 %	2,2 %	1,1 %
amphetamines	2,5 %	1,2 %	1,8 %	0,8 %	1,0 %	0,3 %
LSD	2,3 %	1,3 %	1,6 %	0,8 %	0,8 %	0,3 %
cocaine	2,5 %	1,3 %	2,0 %	0,9 %	1,0 %	0,4 %
heroin	1,0 %	0,8 %	0,6 %	0,4 %	0,2 %	0,2 %
crack	1,0 %	0,6 %	0,5 %	0,2 %	0,3 %	0,2 %

Source : ESCAPAD 2001, OFDT.

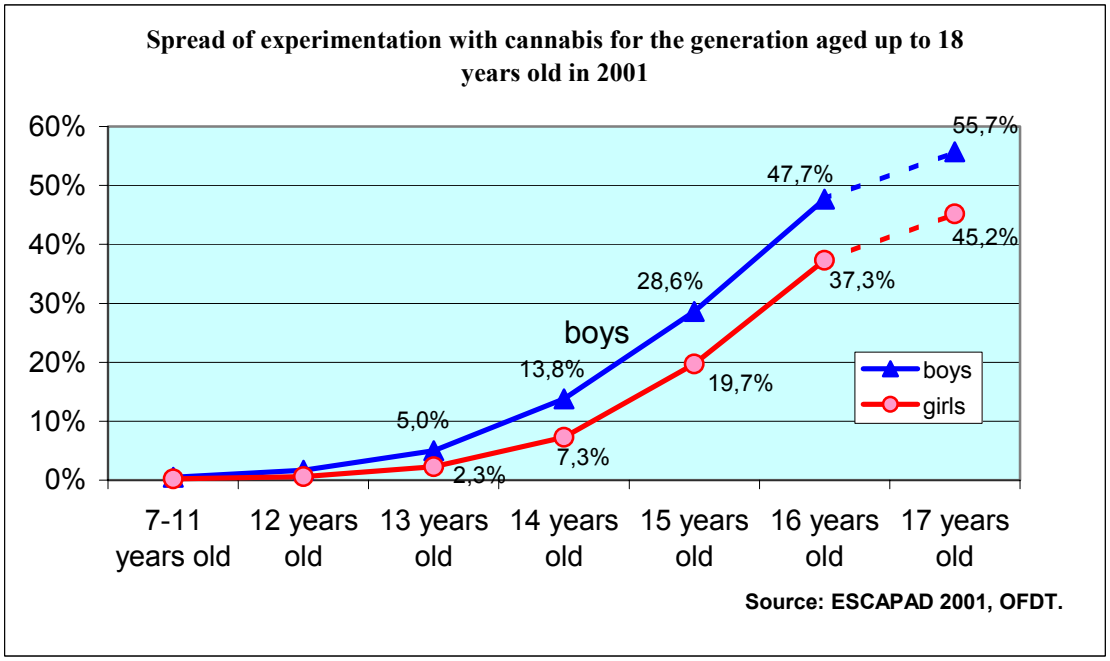
At 18, after tobacco, alcohol, cannabis and psychotropic medication, hallucinogenic mushrooms, poppers, inhalants and ecstasy are the products that are experienced with more that amphetamines, LSD and cocaine. These experiments are always more frequents with the boys, except for tobacco and psychotropic medication. For the boys, the experimenting surpasses 5% of five products : Cannabis, hallucinogenic mushrooms, poppers, ecstasy and inhalants.

During the last 12 months cannabis use concerns more than a third of the girls (37.5%) and one boy in two (50.0). The use during the last month concerns 23.6% girls and 39.2% boys. The boys who declare to have smoked cannabis more than 10 times during the last months (regular use) are almost 3 times more numerous. 19.7% against 6.9% of girls.

In ESCAPAD 2001, retrospective questions were also asked which could enable them to have information on the age when these products were first used. This question was not asked about alcohol (because quite often the memory is fuzzy and happened a long time ago) but being drunk did reveal that it was effective. The average age for experimentation is placed at age 15.2 years for boys, and age 15.6 years for girls. It is easy to retrospectively retrace the diffusion curve of intoxication. It then appears that the experimentation diffusion of intoxication seems to have an almost exponential growth up until the age of 16. The gap between the two sexes grows as soon as the habits stop being immaterial, and seems to rise with age: 4 points difference at 13 years, 8 points at 14 years, 12 points at 15 years, 14 points at 16 years and 15 points at 17 years.



On average, boys have experimented with this product at the age of 15.2, and at age 15.5 for the girls, the experiments are concentrated between 15-16. As with the experiments of intoxication, the diffusion curve of cannabis can be retrospectively retraced for the 18 year olds questioned in 2001. The experimenting with cannabis clearly rises for both sexes from the age of 14. The difference between the girls and boys grows from the age of 12 to 15 and then stabilises around the 10 points in the boys favour.



The other products are summed up on the following table :

Average age for experimenting with the group of psychoactive products (in years)

	Experimentation boys	Experimentation girls
Tobacco	13,6 (n = 2 705)*	13.8 (n = 6,886)*
Inhalants	14.2 (n = 157)*	14.4 (n = 273)*
Regular tobacco	14.9 (n = 1,490)*	14.8 (n = 3,544)*
Psychotropic medication	15.1 (n = 360)*	15.5 (n = 2,488)*
Cannabis	15.2 (n = 1,926)*	15.5 (n = 3,855)*
Intoxication	15.2 (n = 2,250)*	15.6 (n = 4,283)*
Crack	16.0 (n = 21)*	15.6 (n = 23)*
Heroin	16.2 (n = 20)*	16.0 (n = 45)*
Hallucinogenic mushrooms	16.2 (n = 213)*	16.1 (n = 182)*
Poppers	16.2 (n = 168)*	16.1 (n = 259)*
Cocaine	16.3 (n = 70)*	16.1 (n = 86)*
Amphetamines	16.3 (n = 67)*	16.0 (n = 74)*
Ecstasy	16.4 (n = 152)*	16.4 (n = 203)*
LSD	16.4 (n = 60)*	16.2 (n = 80)*

* The number of people who answered the question is shown between the brackets

Source ESCAPAD 2001, OFDT

The ESPAD-France investigation was done in 1999 in a school environment by INSERM, in partnership with the OFDT and the Department of National Education. The reason for this is to broaden it's presentation to the 14-18 year old age group.

Regardless of age or product, drug experimenting rises with age and always more so for the boys than the girls. In the 14 to 18 year old age group, cannabis experimentation increases from 14% to 59% of the boys, and 8% to 43% for the girls. With regards to the other drugs, the level of experimenting is always less than 5% for the inhalants, (glue, solvents…) and in a lesser light, hallucinogenic mushrooms (older boys).

Illicit Drugs: Lifetime Prevalence according to age and sex

boys	age 14	age 15	age 16	age 17	age 18
Cannabis	13,8 %	25,4 %	38,0 %	47,3 %	58,9 %
Inhalants	12,7 %	12,1 %	12,3 %	12,5 %	12,7 %
amphetamines	3,6 %	2,8 %	2,9 %	2,8 %	3,1 %
LSD or hallucinogens	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 (psilocybin)	2,1 %	2,1 %	4,2 %	6,2 %	7,4 %
girls	age 14	age 15	age 16	age 17	age 18
Cannabis	8,0 %	18,9 %	31,6 %	38,1 %	42,8 %
Inhalants	10,3 %	10,6 %	8,9 %	8,5 %	8,0 %
amphetamines	1,2 %	1,7 %	1,8 %	1,9 %	1,2 %
LSD or hallucinogens	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 (psilocybin)	0,6 %	1,5 %	2,1 %	2,3 %	3,1 %

Source ESPAD-{}- 1999, INSERM-OFDT-MENRT.

The statistics in 1999 can be compared with those of the 1993 INSERM study done on school pupils in the group aged 14 – 18

For cannabis, growth is quite clear, with usage by age group doubling from one study to the next (from 15% to 33%). If this growth is further analyzed by age and sex, it appears particularly strong at 18, at which age in 1999, 59% of boys and 43% of girls acknowledged having tried cannabis, against only 34% et 17% in 1993. For other psychoactive substances, the weakness of the observed trend makes comparisons less meaningful. However, the level of experimentation appears overall to have risen between the two studies, particularly for inhalants. Upon closer inspection, it seems that the growth is largely attributable to younger boys**.**

Illicit Drug use by age for those 14-18 years old, 1993-1999

PRODUCT	INSERM 93 (n = 6518)	ESPAD 99 (n = 9657)
Cannibis	14,6 %	33,1 %
Cocaine	1,1 %	1,6 %
Heroin	0,8 %	1,1 %
LSD or Hallucinogens	1,7 %	3,6 %
Amphetemines	2,3 %	2,2 %
Inhalants	6,0 %	10,7 %

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

The measurement of usage at levels higher than experimentation is difficult for cannabis and inhalants. For other substances, repeat consumption is rare, inasmuch as the majority of those that have tried one of these products do not do so again. In 1993, at age 18, 15% of boys had consumed cannabis 10 times or more over the course of their lives. In 1999, this rate was achieved by the age of 16 (19%) and by age 18, 35% had tried the drug. For girls, the incidence of consumption is lower, but the trend is similar, i.e., in 1993 by the age of 18, 6% of girls had tried cannabis 10 times or more, with the rate in 1999 having been reached by the age of 15 (6%) and reaching 22% by the age of 18. The widespread usage is therefore not limited to simple experimentation.

However, in the case of inhalants, the growth is far more subtle, in particular for girls. At the age of 18 in 1999, 5.4% of boys and 3.5% of girls had taken inhalants at least three times in their lives, compared with 2.5% and 2.3%, respectively, in 1993**.**

Cannabis and inhalants : use by sex and age 1993-1999

boys	Age 14	Age 15	Age 16	Age 17	Age 18
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, three time or more	4,8 %	5,2 %	5,5 %	5,8 %	5,4 %
girls	Age 14	Age 15	Age 16	Age 17	Age 18
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, three time or more	3,7 %	4,8 %	2,7 %	3,1 %	3,5 %

Source : INSERM 93, ESPAD 99.

Outings and use of psychoactive substances

In light of the multivariate analysis conducted on the 2001 ESCAPAD data, the link between youth's "outings" and psychoactive substances could be studied. Six profiles were defined based on six types of "outings".

A first group, known as "**infrequent outings**", groups approximately half of the informants (45.9%). These young people go out little insofar as concerts and sporting events are concerned. For this group, the most frequent event is a visit to a discotheque, attended by 60% of the group over the course of the year.

The next set comprises four groups of approximately equal size:

"**Sporting events and discotheques**" – (12.6% of informants) the profile is primarily masculine (66.5% boys). These young people go to sporting events at least once a month each year and slightly more frequently than the rest of the sample to discotheques.

"**Rock**" – (11.6% of informants), these young people enjoy rock and hard rock concerts, having been at least once per year, and in many cases, attend once per month.

"Rap, reggae and discotheques" – (11.4% of informants) – this group shows a clear preference for rap or regae concerts which they attend typically at least once per month**.**

"**Other music**" – (12.7% of informants) – this group has the highest proportion of girls (70.7% girls) These young people usually go to funk, soul, R&B, vocalists, jazz and classical music**.**

Finally, the last group is know as "techno party and discotheques" – the profile of this group reveals young people who have attended at least one techno party in the preceding year and 80% of the group, have attended at least one per month. In addition, they have all been to a discotheque and about 80% of this group have been at least once per month**.**

Significant differences in consumption appear among the profiles. Nothing in the data demonstrate that consumption takes place during the outings, however, those who frequently attended musical events consumed psychoactive products more often than the others. It is worth noting that the relationship between musical event attendance and drug usage is higher for girls than for boys.

Young people who regularly attend rap or reggae concerts and those who frequently attend techno parties are the greatest number of daily and heavy smokers (more than 10 cigarettes per day). One should note however that young people in the "infrequent outing" profile are associated with a higher incidence of smoking than those in the "other" or "sporting events" categories. The regular use of alcohol et repeated drunkenness are found in "rap and reggae" and "techno party" groups, as well as among those who prefer rock and hard rock. The lowest incidence is among "infrequent outings".

Concerning the usage of illicit substances, at the age of 18 those who have attended the greatest number of musical events consume more frequently than the others. For cannabis, the profiles "rap reggae" and "techno party" are the most associated whether it is in connexion with repeated or regular use. Other illicit substances also reveal a higher level of consumption among the "techno party" profile but such consumption relates to a minority of young people. Within this group (5.9% of informants) less than one-quarter of them had consumed ecstasy over the course of the year. Taken in the context of the entire sample group, the incidence of ecstasy consumption reaches a level of less than 2%. With respect to cocaine, the proportion of consumers within the "techno group" is low as well, reaching only 9.4%, or less than 1% of the entire sample group of young people interviewed. After Ecstasy, the drug most frequently consumed by boys who attend techno parties is hallucinogenic mushrooms, and for girls, poppers.

Usage of psychoactive substances among 12 and 13 year-olds

In 1997, in the youth health barometer study (Baudier et al, 1998), questions regarding illicit drug consumption were not asked of adolescents aged 12 to 14. This precautionary action resulted from a pilot study done in 1997, during

which researchers found frequent reticence on the topic among the youngest respondents. The research team determined that this type of exchange, unaccompanied by any preventive counselling or any deeper discussion on the topic of illicit drugs, had a tendency to upset the least informed respondents, who typically, are the youngest**.**

In the study in 2000 however, researchers inquired about, but not about other illicit drugs. (Guilbert et al, 2002). By telephone, these young informants acknowledged very low usage (3.6% of boys and 3.7% of girls having already consumed cannabis.) However, solicitation to try cannabis was reported to be relatively higher, 9.9% for boys and 13.6% for girls (Beck, 2000) [Note: French text said "filles" for each percentage and is obviously wrong for one of them]. These incidence levels can be compared with the retrospective usage reported by 18 year olds questioned in the ESCAPAD 2001 study, as shown below.

Cannabis use by age amongst 12-14 year olds, beginning with acknowledgement of first use in 2001

	boys	girls
Age 12	1,7 %	0,6 %
Age 13	5,0 %	2,3 %
Age 14	13,8 %	7,3 %
Age 12-14	6,8 %	3,4 %

Memo : 13.8% of boys have smoked by the age of 15.

Source : ESCAPAD 2001, OFDT

In the Health Behaviour in School-aged Children Study study (HBSC), completed in 2002, 11-, 13- and 15-year-olds were questioned. This OMS study was done in France in 1994 (Baudier et al, 1997), and in 1998 (Navarro et al, 1999, and Godeau et al, 2000), but at the time it was not representative at a national level, having been conducted only in schools in Toulouse and Nancy. In this study, questions relative to illicit drug use were not asked of adolescents aged 11 and 13, although they were asked about alcohol and tobacco usage. The initial results of this study will be available in 2003.

15.2 Health and social consequences

Heath and social consequences of alcohol and drug usage are usually not very visible before the age of 18. In effect, users found within the health care system have a higher average age which corresponds to an outcome from cumulative usage or from a given point in the drug user's life. Users seen in public health clinics are somewhat younger, but average about 25. (DREES study, November 1999).

It is largely cannabis that triggers involvement of the national health system for adolescents and young adults. The percentage of individuals under 25 years old "pris en charge" for cannabis usage was 52% in 1999, but for heroin the rate was only 13% (DREES Study, November 1999) On the question of possible consequences from the use of cannabis on mental health, the collective expertise of INSERM has reached some conclusion based on available information: there appears to be a statistically significant relationship

between cannabis usage for one and various affective disorders and schizophrenia for another. The experts point out however, how difficult these relationships are to interpret and in fact prompt new questions. (INSERM, 2001). The debate can also be extended to by enlarging the range of issues to be interpreted connecting cannabis and mental health, which go beyond the pharmacologic effects of the drug and reach in to the sociologic dimension of usage, based on the findings of ESCAPAD 2001 (Peretti-Watel et al, 2002). Thus, insofar as the mental health of 18 year olds is concerned, if it appears to be poorer among cannabis users, this may be associated with other variables related to lifestyle and life experience of the adolescents, i.e., tobacco and alcohol usage, family context, violence encountered and intensity of socialization. When the all the relationships are considered together, the link previously observed between cannabis and mental health tends to disappear. This result would argue in favour of a sociological interpretation, one which attributes a key role to the lifestyle of the adolescent whose cannabis and psychological difficulties are only two facets that are indirectly linked.

15.3 Demand and harm reduction responses

See Chapter 9 – Prevention

15.4 Methodological information

The principal studies used were the following:

European School Survey on Alcohol and Other Drugs (ESPAD – France)

Conducted by the French Observatory of Drugs and Drug Addiction (l'*Observatoire Francais des Drogues et des Toxicomanies*, OFDT), under the scientific direction of Unit 472 of the National Institute of Health, Studies and Medical Research (*Institut National de la Santé, des Études et de la Recherche Médicale*, INSERM), whose objective was to measure the changes in consumption of psychotropic drugs among school children. This study is based on a periodic survey (every four years) conducted for the first time in France in 1999. 11870 from grade 8 (14 - 15 year olds) through school-leavers (age 18 or 19) responded to a self-administered questionnaire distributed in class by personnel from the scholastic health service. 300 schools were randomly selected, from which two classes were also randomly chosen. Therefore the results reflect the school-age population, 14- 19 ans.

Survey of Health and Behaviour on Call-Up and Preparation for Defence Day (*Enquête sur la Santé et les Comportements lors de l'Appel de Préparation A la Défense*, ESCAPAD)

Conducted by the OFDT, in partnership with the Central Direction of National Service (DGNS) this annual investigation consists of a questionnaire given to a group of young people attending the military call up. (One day). In other words 17000 individuals, men and women between 17 and 18 years old. The reason behind this was to get an idea on emerging tendencies in terms of products and to offer help to this particular population. The investigation conducted on the OFDT basis, obtained the opinion of the National Statistic Information Council (CNIS). It has the advantage of being able to question all the young French people, including those who work or not longer attend school; Since 2001, this has been extended to the DOM.

Youth Health Barometer 97/98

Conducted by the CFES using the system CATI Collective Assistance by telephone and computers that optimises the quality of data in the sense where it allows the holding of quality and offers to the interviewer appreciable ergonomics by automatic management of calls, appointments made, etc. This field began in November and December 1997, after a focus group of 4115 young people representing the 12-19 age group living in metropolitan France. This was obtained from randomly choosing numbers out of the national telephone directory and it included unlisted numbers. The interviewees were selected according to their birth date. An explanatory letter was sent out before the actual telephone call. The representative of the group was assured of dealing with the right age, sex, residential area and type of housing. The health barometer collects information relative to the behaviour, knowledge and attitude of the adolescents with regards to health**.**

Health Barometer ; 12-75 age group

Conducted by the CFES in collaboration with other OFDT partners for questions on alcohol, tobacco and illicit drug use, using the (CATI) system. The field began in November and December 1999, after a focus group of 13685 where 1847 were young people representing the 12-19 age group living in metropolitan France. This was obtained from randomly choosing numbers out of the national telephone directory and it included unlisted numbers. The interviewees were selected according to their birth date. An explanatory letter was sent out before the actual telephone call. The representative of the group was assured of dealing with the right age, sex, residential area and type of housing. The health barometer collects information relative to the behaviour, knowledge and attitude of the adolescents with regards to health**.**

The statement value on illegal behaviour is difficult to measure, particularly with adolescents, even if, with different types of questioning, the investigators are trained on certain sensitive subjects and understand how to put a young person at ease. The comparisons between the different investigations sometimes appears to be difficult to bring due to the fact that there are numerous methodological differences (different question formulas, drawing up of different questionnaires…)**.**

Between the different types of questioning, a difference carried on the probability of the individual being questions may be noted: The refusal to answer by the general population happens more often by telephone that by more direct interviews. There are a certain number of steps to be taken before beginning to collect the answers by telephone. Even if the refusal by the young people themselves is very weak, (3.3% individual and 0.9% that abandon the interview), the parents refusal (17.4%) is clearly more important. The problem is that we have no idea of the attitude of these young people who have not answered.

Like this, the main explanatory cause for the gap shown between the two investigations seems to be the retrieval of information. It is easier to admit to cannabis consumption by ticking an anonymous questionnaire than by answering over the telephone. Even when all precautions have been taken when drawing up a telephonic questionnaire to guarantee discretion (a simple yes or no answer) the young people are not comfortable with revealing their habits. If an interviewer notices that the interviewee was not alone when answering, it has been notices that the declaration of cannabis consumption is

on the whole very weak (17% at some stage during life, 14% during the year). Family definitely has an influence on the answers (Beck et Peretti-Watel, 2001).

Such a hypothesis could be brought closer to another result shown in the investigations done with young people relating to suicidal ideas or attempted suicide. (Baudier et al, 1998). We noticed, when comparing an INSERM survey of adolescents in 1993 at school, by auto-administered questionnaires, the rate of declarations was no as strong in the 1997 youth health barometer On the other hand, when it related to suicides resulting in hospitalisation, therefore official and the family have had to talk about it, the numbers were the same for both surveys. This confirms that there is a reluctance to admit to certain behaviour that is not known about at home, telephonically.

We have noticed that a telephone interview is situated in a particular context, linked to the family. The opposite being, that the young people have the opportunity to express themselves when answering the auto-administered questionnaire because at school they are with friends, putting them at ease because they are with people in the same position. Sometimes there is a reluctance to express inexperience if they have never used cannabis. Having said this, the answers on the questionnaire are more sincere, calm, and serious.

Bibliographie

BALLION R., Les conduites déviantes des lycéens, CADIS, Rapport OFDT, 1998, 243 p.
BALLION R., Conduites délictueuses et consommation de substances psychoactives des lycéens, Rapport à la Fondation MAIF et à l'Observatoire Français des Drogues et Toxicomanies, février 2001, 104 p.
BAUDIER F, DRESSEN C, ARENES J, (1997) Baromètre santé jeunes 1994, Editions du CFES,.
BAUDIER F., JANVRIN M.-P. et ARENES J., Baromètre santé jeunes 97, CFES, Paris, 1998, 328 p.
BECK F. (2000) « Usages de drogues illegales », *Baromètre santé 2000*, Les éditions du CFES, 4 p.
BECK F., PERETTI-WATEL P., CHOQUET M., HASSLER C., LEDOUX S. (2000), « Consommations de substances psychoactives chez les 14-18 ans scolarisés : premiers résultats de l'enquête ESPAD 1999 ; évolution 1993-1999 », Tendances, n°6.
BECK F., PERETTI-WATEL P. "Influence du mode de collecte sur les usages de drogues illicites déclarés par les 15-19 ans », Population, numéro spécial méthodologie d'enquête sur les sujets sensibles, 2001.
BECK F., LEGLEYE S., PERETTI-WATEL P. (2002) « Santé, mode de vie et usages de drogues à 18 ans : ESCAPAD 2001 », Rapport de recherche OFDT, 198 p.
CHOQUET Marie, LEDOUX Sylvie, 1994, Adolescents, enquête nationale, Paris, Les éditions INSERM, 346 p.
DE PERETTI Christine, LESELLBAUM Nelly, 1999, Les lycéens parisiens et les substances psychoactives : évolutions. Paris : OFDT, 170 p.
GODEAU E, NAVARRO F, DRESSEN C, MOURET G, JEUNIER B, (2000) Les années collèges, Editions du CFES, 114 p.
GUILBERT P., BAUDIER F., GAUTIER A. (dir.) *Baromètre santé 2000*. Vanves, Les éditions du CFES, 2001.
INSERM, Expertise collective : Cannabis, quels effets sur le comportement et la santé ?, Paris, INSERM, 2001a, 429 p.
NAVARRO F, GODEAU E, DRESSEN C, MOURET G, JEUNIER B, APTEL E, (1999) Les comportements de santé des jeunes, consommation de substances psychoactives, résultats préliminaires (enquête HBSC/OMS),

Bulletin Epidémiologique Hebdomadaire (BEH) n°48, novembre 1999, p 201-203.
OFDT, Drogues et Dépendances, Paris, 2002, 368 p.
PERETTI-WATEL (P.), LEGLEYE (S.), BECK (F.), « Santé mentale et usage de cannabis à la fin de l'adolescence : Une relation complexe qui déborde du cadre pharmacologique », *Médecine/Science,* 2002a, n°4, vol. 18, p 481-488.

16. Social exclusion and re-integration

16.1 Definition and concepts

a) definitions and concepts used in France

Poverty is a lack of income [63]. A precarious situation, more difficult to define, is the fragility of a situation [64]", and includes the notion of poverty : it can therefore only be measured with reference to the instability of situations and with the consideration of many angles. If the concept of insecurity could be defined, but not measured, this exclusion is very difficult to seed at the first attempt. All research work highlights '*Exclusion is not isolated by a type of "sanitary rope" which will be inserted into society, there is a continuum of situations, a group of positions where relations with the centre has more or less spread*". (ONPES 2001, p. 49)**.**

We generally attribute the origin of the term social exclusion to René Lenoir but Pangam (1996) observed that the notion was already present in the writings in the sixties. "The observers agree on one more point : *Impossibility to define the excluded with the help of a unique criteria*". Weinberg et Ruano-Borbalan (1993).

For the department of employment and solidarity, exclusion is defined as being a group of ruptured mechanisms on the symbolic plan. 'stigmas or negative attributes) and that of the social plan (different ruptures socially linked which incorporates men between them). Exclusion is at times a process, produced by a social cohesion by default, and a condition resulting in insertion default. (Department of employment and solidarity 2002a).

The concept of exclusion is characterised by 3 dimensions :

- the economic sphere : insecurity with regards to employment, chronic resources shortage

- the non-acknowledgement : lack of use of social, civil and political rights ;

- social relations : social and psychological destruction that the economic crisis and the non-rights situation breeds in the individual, the family and social groups.

Social exclusion is therefore spread, and is generally studied in interaction with the other two dimensions.

On the opposite side, insertion is a process that leads a person to find an acknowledged place in society. This can be done in several ways : professional insertion (contact with the work market), social insertion or global insertion (employment, health care, housing, culture, education).

In France, 300 000 people are affected by exclusion (0.4 to 0.5% of the total population, according to HCSP in 1998), 8 to 10% of the population is affected by poverty, (ONPE 2001) and probably 20 to 25% by insecurity (HCSP 1998).

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[63] According to the ONPES. Nevertheless poverty cannot be reduced to a single, monetary factor but also concerns other aspects of daily life: housing, health, education, work and family life. The line between poverty and serious poverty is defined by INSEE.

[64] A precarious situation is the absence of one or several securities, in particular employment, allowing people and families to meet their professional, family and social, obligations and to enjoy their fundamental rights" (Statement from the Economic and Social Council 11/02/1987 in a report by Wresinski J., 1987) ..

Problems put forth or discussed in the country affected by social exclusion/inclusion in relation with drugs.
The HCSP (1998) picks up at several stages in its report the existing interaction between the process of insecurity or exclusion and illicit drug consumption. The behaviour risk and the problematic consumption of drugs generally develops at the same time as the deterioration of a person's self-image and the impression of being socially useless. Depression, anxiety, alcohol and drug use problems increase depending on whether we are dealing with inhabitants of the Ile de France region, housed RMI (social/occupational integration minimum income) claimants or homeless people (Marpsat and Firdion 1998 according to a survey carried out in the Ile de France region by Viviane Kovess)

The report continues by citing the terms "exclusion", "violence", "delinquency" and "drug addiction" as the trait the most frequently associated with the suburbs.
In certain cases, however, and always in precarious areas, the presence of drugs may be a means of economically inserting through the intermediary of a microeconomic traffic, obtaining a status of a psychoeffective acknowledgement. (Jamoulle 2001).

However, notice should be taken that the accompanying risk and the problematic consumption are more spread in an underprivileged background and does not allow for determining if these are consequences of a precarious condition or a cause. Indeed, due to the French action plan against poverty and social exclusion (Department of Employment and Solidarity 2001), the use and consumption of illicit products was not subject to systematic study in this area. The information that we have concerns almost uniquely the consumption and drug traffic of the young people from other districts or the phenomena of alcoholism of the homeless.

In the 1970's, the almost exclusive usage by drug addicts in a specific system is based on the gratuities and the anonymous, and the consequences of this were the aspects of social negligence and kept in the same social exclusion. (Wieviorka 1999). With regards to the fight against the problems connected to drugs, France has in the space of 15 years taken an approach towards individual users recognising that this could be related to social exclusion. The vision of drug addicts as such the excluded could contribute to the implementing of "threshold" structures.

Groups identified as particularly vulnerable regarding the consumption of drugs :

The youth intermittent experimentation with drugs is connected to curiosity, peer pressure, and fashion, as much as the availability of the product and the opportunity to try it. (Hartnoll 2002).

Intense use of drugs, is, in itself, associated to individual and family background and the socio-economic underprivileged status. We also found that often a consumer has mental and delinquent problems.

Risk factors connected to the problematic consumption of drugs

- ✓ Individual characteristics - genetic, metabolism, personality
- ✓ Broken family – family dysfunctionning
- ✓ Weak socio-economic status/social dropout/unemployment
- ✓ Other social and psychological problems – school problems, low self esteem, depression
- ✓ Early use – particularly associated with other school problems
- ✓ Repeatedly exposed to the availability of the products – particularly in vulnerable groups knowing other risk factors
- ✓ Lack of clear and precise information on the health risks

Source : Hartnoll 2002.

From the factors listed in figure 1, a typology of the population most exposed can be done. If we keep the criteria linked to socio-economic situations and underprivileged families, the sub-population is easily recognised: Young people, unemployed, RMI beneficiaries, immigrants or foreigners, no stable address. These groups have been identified as particularly vulnerable in the exclusion process.

We also know that the imprisoned or ex-convict population and prostitutes have a higher level of consumption than the general population.

16.2 Drug use patterns and consequences observed among socially excluded population

It has proven difficult to find information on the illicit drug consumption of the socially excluded : The tendency towards alcohol and tobacco consumption, *a contrario*, is better known in France.

In a study conducted in Paris in 1996, of 838 homeless people, 16% declared to use or to be hooked on drugs for life and 10% in the year. During their whole life, 33.9% have a problem with substance use or are dependant. *L'Observatoire du Samu Social* (1998, 1999) gave out similar numbers : 21% of the people who frequent emergency shelters for nursing care (CHUSI) admitted to taking illicit substances or medication (26% in 1999). On the whole, including the general population, men in a precarious situation appeared more concerned by drug consumption than the women.

In the adult excluded population, the most widely consumed drugs are cocaine (22% in 1998 and 33% in 1999), cannabis (20% and 28% in 1999) and when two substances are associated, it is often cocaine or heroin. (OSS 1998, 1999). Some people declared to have taken Subutex® or methodin. (7% of these people frequent CHUSI).

When comparing the population in general, (ages 12-75) the prevalence to experiment with cocaine is 1.3% and 0.2% for occassional use. Cannabis is placed at the same level for the unstable and general population. (1 French person in 5 or 21% of the 12-75 age group have experimented, but only 7.6% had consumed during the last 12 months. (Beck 2000).
Young people who do not attend school or have no professional training are more at risk that school goers (HCSP 1998). When they are homeless or in an unstable position, consumption of psychoactive substances is more important to them than to other young people: 65% frequently consume cannabis or another illicit drug, yet the general 14-18 age group population experimentation with psychoactive products other than cannabis is less than 5%. (Beck *et al.* 2000).

Cannabis as an illicit substance plays a big part in the young homeless population, its repeated consumption concerns more than half of those questioned. (Amossé *et al.* 2001). This substance is found in the general population where half of the young people in the 14-18 age group declare to have tried it, nevertheless, repeated consumption of illicit substances other than cannabis is very high on the homeless list: (Beck *et al*. 2000). 65% repeatedly at least two illicit substances other than cannabis, 34% at least three.

16.3 Relationship between social exclusion and drug use

Indications of social exclusion in specific drug consumption populations in comparison with the general population

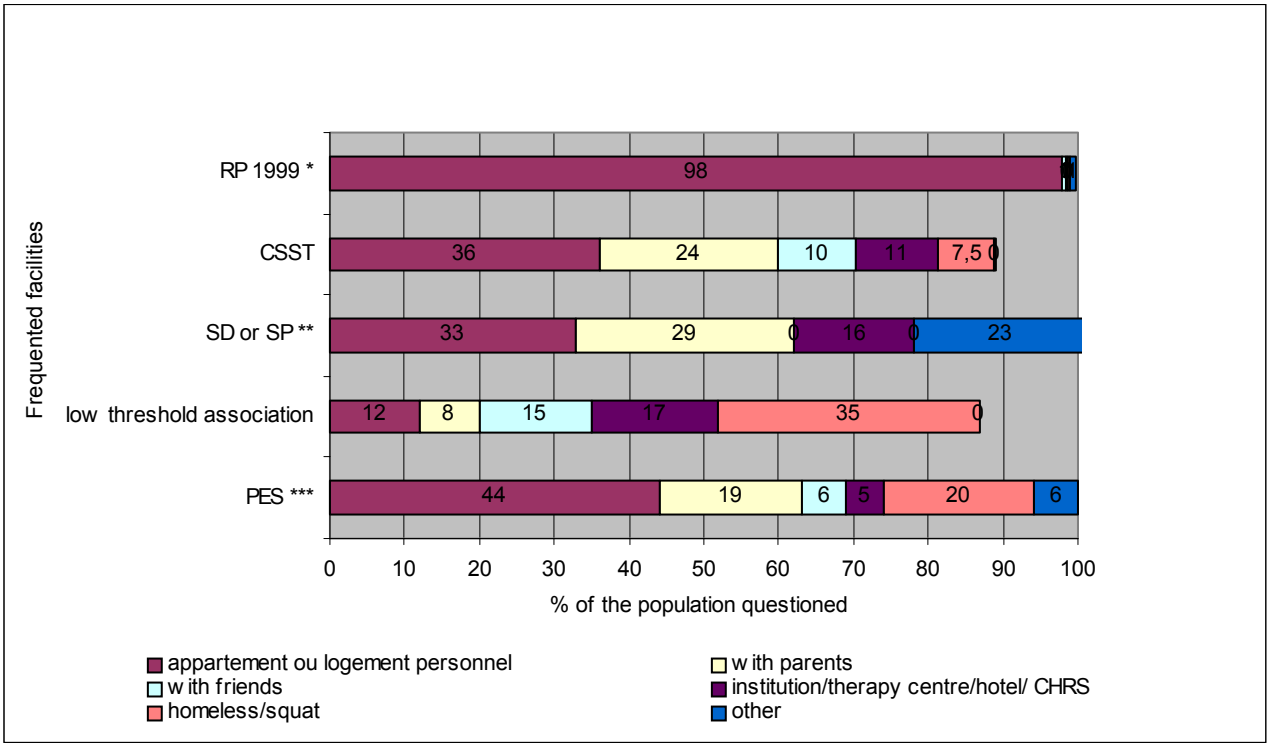
Several surveys conducted for the use of drugs in the lodging structures tell about their economic and social situation. (CEIP, DGS 1999, Facy 1999, IREP 1996, Tellier 2001). The survey methodologies are different (exhaustive or groups, survey place, time, date, structure and questionnaire) but the results boil down to the same. A population of drug users drop outs for whom the health and social conditions have deteriorated (AIDS and Hepatitis epidemics have largely contributed to this deterioration) and so the unstable situation of social exclusion accentuates over the years.

As an example, l'IREP (1996) observed between 1991-1992, a radicalisation of unstable situations: a growth of RMI beneficiaries, begging, sexual work, a change in the market – smaller doses for smaller prices, a phenomena of malnutrition in the "lower-threshold" structures.

The people frequenting the Specialised Drug Addict Treatment Centres (CSST) in 1999 are mainly unemployed. (62% in 1999 according to Tellier 2001). As a comparison the unemployed represent around 4% of the active French population. 31.4% of the cases looked after by the CSST have a revenue from work, 13% receive the DOLE, 33.4% receive the RMI or a handicap allocation (AAH) and 12% are looked after by a third party (DGS 1999), but most of them have medical aid cover. These numbers are much lower in the general population for the age group concerned: 3.3% of the population receive the RMI, 2.1% the AAH.

If almost 68% declare stable housing (independent or with the family), 23% have unstable housing and 7.5% are homeless (DGS 1999) (figure 2).

Comparison of the living conditions of drug users in relation the facilities that they frequent



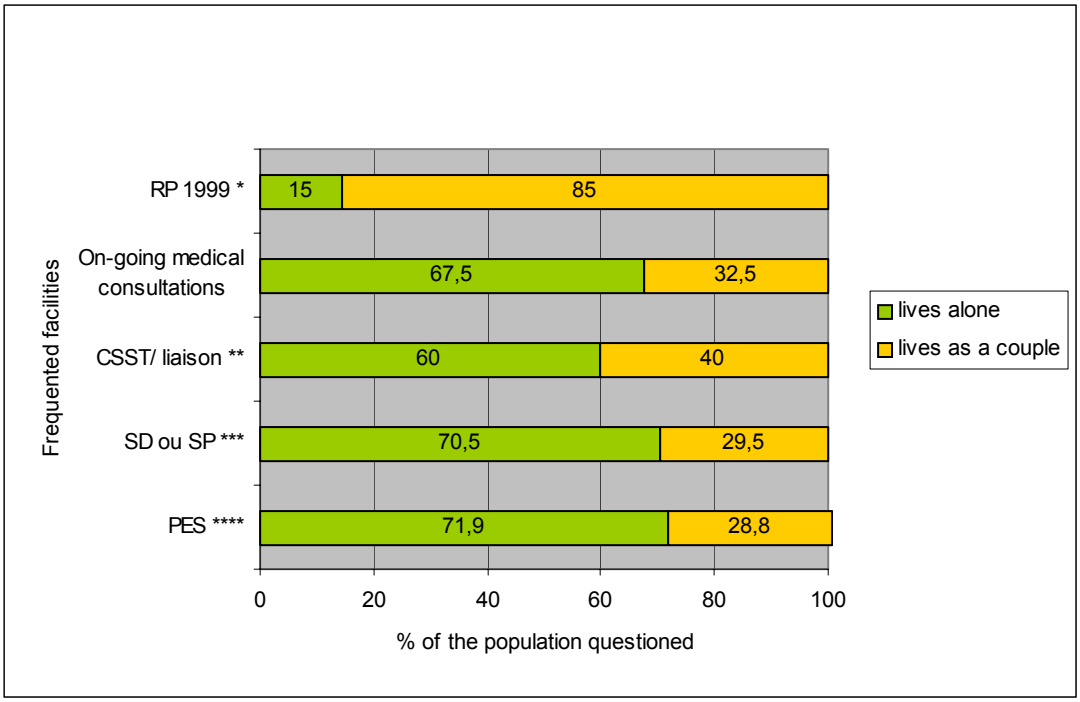
* RP 1999: Census conducted by INSEE in 1999 of the French population for the Ile-de-France region. The heading apartments or personal housing and parents home are put together.

** SD or SP corresponds to homeless or prevention centres (IREP 1996).

**** PES: Programme d'Echange de Seringues [Syringe Exchange Programme] (Emmanueli *et al.* 1999).

About 60% of the patients that are heroin users for more than 18 months treated in CSST are single (35% of the French population declared themselves as single in the 1999 census) less than 40% live together as a couple (figure 3). They rarely live alone (13%), their usual circle is a partner (36%), children (25%), parents (45%), family (29%) or friends (32%) (Facy 1999)

Comparison of the marital situations of drug users in relation to the facilities that they frequent



* RP 1999: Census of the French population in 1999 carried out by INSEE for the Ile de France region. The section named *alone* corresponds to households made up of one person only ; the section named *in a couple* corresponds to households made up of at least 2 people.

** CSST / liaison : data published by OPPIDUM programme (CSST/ liaison team and certain other structures) (CEIP 2000)

*** SD or SP corresponds to homeless and prevention structures (IREP 1996)

****PES: Programme d'Echange de Seringues [Syringe Exchange Programme] (Emmanueli *et al.* 1999).

The people found in so-called "low-level" group homes are generally more marginalized than those who frequent CSSTs (Bello *et al.* 2002, Emmanuelli *et al.* 1999, Espoir Goutte d'Or 2001, Le trait d'Union 2001, OFDT 2000). Most drug users are single, and about 30% live in conditions of "*extreme poverty*"; 50% come from risky living arrangements. Furthermore, 80-90% have no work-related income, and about 30% have no type of social security coverage. At least half, and perhaps more, of these people who frequent "low level" structures receive RMI or AAH: these allocations are potential resources that enable them to receive some type of social security coverage, but the their level of living conditions remains at-risk.

These users are turned into social outcastes because "dependency hinders the formation of social links" (Sida Parole): "psychiatric problems, lack of well-being, chronic instability, inability to form close-knit relationships, loss of any concept of time, and loss of intellectual abilities make their isolation even worse" (Le Trait d'Union). This marginalisation is confirmed by institutions offering treatment that underscore an increase in requests for material and social assistance, which are far more frequent than requests for health care-related assistance (Espoir Goutte d'Or 2001, IREP 1996).

Data published from research on social exclusion (as a risk or a consequence of drug use)

Numerous authors have shown that economic and social difficulties often result in an aggravation of the health, both physical and mental, and by the adoption of risk behaviour (Marpsat et Firdion 1998).

Consumer behaviour in fringe or homeless populations appears, for women as for men, to be strongly linked to the type of their accommodation: the amount of consumers of illicit substances is less in institutionalised, collective housing areas that in « independent » housing (Amossé *et al.* 2001).

10% to 20% of the homeless population is involved in drug use but the problems vary according to certain socio-demographic characteristics, essentially age, income level and the reason for the situation (Kovess et Mangin-Lazarus 1997). Drug use is more frequent amongst young people that have no income (30% of the homeless population of less than 30 years old are involved). These young people, a 1/3 of them fostered in their childhood or in serious conflict with their family have an unstable personality type (impulsive or limited). However, women use drugs much less than men (as in the general population) and people over 55 years old have practically no drug abuse problems.

A comparison has been carried out between homeless people staying in specialised alcohol abuse centres and other people (Facy *et al.* 2001): it showed that twice the amount of homeless people use drugs other than tobacco and alcohol (30% vs. 15%): heroin (3% vs. 1%), cannabis (8 % vs. 3 %) and multiple drugs (8 % vs. 1 %).

Paugam and Clemencon (2002) determined that amongst all the personal difficulties confronted at adult age by the people that go to shelters, centres and homes, 27% describe problems with alcohol, 17% answer problems with drugs, the answer most often given in the same category is problems with health (33%).

To study the workings of breakdowns and the insecurity process, people have been questioned about the difficulties that they encounter. Most often mentioned is a drop in resources or a loss of housing. Drug problems are in 11th position (14%): Drug use, therefore, does not seem to be the most important factor at the root of the breakdown process.

In homeless or unstable situation populations problems of illicit drug abuse are less frequent that the use of alcohol or tobacco. Therefore, we can see that « *the majority of illicit substances are used (heroin, cocaine, poppers, medicaments) and if the prevalence is not higher it is only a question of cost »* (Sida Parole, Laurent El Ghozi).

16.4 Political issues and reintegration programmes

Policies regarding social exclusion problems and their implications for responses to social exclusion

The blueprint law relating to the fight against exclusions, dated 29th July 1998, is a four-pronged approach (Ministry of Employment and Solidarity 2002b):

- to guarantee access to fundamental rights: the right to employment, housing and access to treatment, education, and knowledge;

- to prevent types of exclusion stemming from exclusive assistance logistics in order to make a shift toward prevention: excessive debt counselling and treatment, the keeping of housing arrangements, improving the subsistence means of the most destitute, enabling these groups to exercise their civic rights…;

- to deal with urgent social issues by increasing the effectiveness of responses to these issues. To do this, it has been deemed necessary to reinforce and extend existing social monitoring tools but also to co-ordinate emergency financial assistance mechanisms;

- to better co-ordinate collective actions, shifting from traditional administrative logistics to a sense of individual case management for each person.

Within this framework, the government has introduced three types of operations that enable it to fight, more specifically, against social inequalities with regard to health care. Universal Health Insurance Coverage (CMU in French) guarantees everyone social security health coverage and makes it easier for the most destitute to gain access to supplemental coverage. The second operation, consisting of regional prevention/treatment access programmes (PRAPS) aim to protect people who live in risky situations and who have experienced difficulties in accessing social and health services; this operation means that a specific treatment/prevention offer is being adapted to the needs of every region[65]. The third operation pertains to private and public health care establishments that take part in the public hospital system: ongoing treatment access (PASS) adapted to the needs of those who live in risky situations[66].
Within the context of the application of the law pertaining to the fight against exclusions, mechanisms that help guarantee access to rights, housing, and social reintegration for people in difficult circumstances have been greatly expanded. Drug users have directly benefited from these improvements, but no figures are available for this specific population.

Reintegration-oriented treatment elements found within services specialising in drug addiction

The French case management mechanism comprises a number of structures: CSST, outpatient treatment centres, centres with group housing, therapeutic apartment networks, transitional group homes, group homes for people in urgent circumstances, networks of foster families, treatment centres in penal institutions. Nevertheless, the "*group home/treatment mechanism has, for a long time, benefited from a psychological and medical approach, to the disadvantage of a social approach. It seems that the social and family-related problems of users need to be addressed […] Thus, this does not concern specific rehabilitation and re-integration tools that would be added onto those that already exist but would involve the better use of existing tools."* MILDT 1999 (p. 79 and following pages).

The same document (MILDT 1999) contains recommendations for better risk-reduction policies with regard to the most marginalised users:

- to reinforce and pursue the development of risk-reduction structures and related structures (shops, sleep-in centres, neighbourhood mobile teams,

[65] For the 26 regions, only 4 have given priority status to prevention and case management of dependencies.

[66] They offer treatment or palliative care, monitoring the ongoing nature of treatments following the admission of people in difficult circumstances or their housing and must be able to accommodate people in risky situations, both day and night.

syringe exchange programme [*programme d'échange de seringues,* PES], automatic syringe dispensers);

- to provide a framework for risk-reduction policies by creating specifications that will enable it to be integrated sufficiently within specialised treatment mechanisms and in more general structures that receive marginalised people;

- to define the role and status of former drug users working in risk-reduction structures.

Operations already undertaken since 1999 in the area of group housing, guidance, treatment, and reintegration comprise, notably[67] :

- the creation of 20 hospital liaison teams;

- the development of substitution treatments (improvement in terms of the accessibility and quality of case management)

- risk-reduction (10 shops, 2 "sleep-in", 18 PES, 72 automatic syringe dispensers, 4 neighbourhood mobile teams);

- treatments to drug users in prison;

- training in the area of tobacco withdrawal given to doctors.

As of this writing, 387 out of 1345 organisms (including the associations sector) specialised in drug addiction case management focus on re-integration/rehabilitation[68] (DATIS 2002). Amongst these structures, 40 offer legal assistance, 26 offer group housing, 38 structures offer work rehabilitation programmes, 26 permit one-night stays in hotels, and 354 provide social/educational follow-up services[69]. It must be noted that there are significant regional differences.

Finally, outside those programmes and types of operations established by the MILDT's three-year plan and the national plan for the fight against exclusions, operations may be carried out in the area of rehabilitation/re-integration by means of certain projects established at the community, departmental, or regional level: urban development programmes, large-scale urban development programmes (including the European URBAN project), local security contracts or re-integration programmes [*contrats locaux de sécurité,* CLS or *contrats locaux d'insertion,* CLI], local education contracts [*contrats éducatifs locaux*] (CEL), Health and Citizenship Education Committees [*comités d'éducation à la santé et à la citoyenneté*] (CESC), departmental re-integration programme [*programme départemental d'insertion*] (PDI), departmental prevention programmes [*programmes départementaux de prévention*] (PDP), regional health programmes [*programmes régionaux de santé*] (PRS)…

Programmes de réintégration spécifique concernant les anciens consommateurs de drogues

None

[67] As of 1st June 2002

[68] The other areas of operations may be the following: treatment, prevention and housing. These are not mutually exclusive. As a means of comparison, 690 structures offer treatment, 969 are involved in the area of prevention, 187 focus on therapeutic housing (an operation that does not exclude the others).

[69] There may be several re-integration operations per structure.

Results of the assessment

In 1999, the MILDT (1999) identified three populations for which case management should be built up and reinforced: parents who use drugs and these users' children, adolescents, and incarcerated populations.

For drug addiction and for exclusion, the processes are multidimensional, not only affecting the "excluded," but also a wide variety of population categories still within the bounds of social and institutional categories. At this moment, the latter have only been very slightly affected by risk reduction efforts or other policy-based operations in the fight against drugs.
(Joubert 2000).

16.5 Methodological information

limitations of available data

It must be noted that traditional statistics, including all information that is backed up by figures, have "trouble identifying populations in conditions of poverty and risk. These individuals, much more than others, tend to be ignored by general surveys that aim to describe structures pertaining to society at large and its evolution" (ONPES 2001 p. 43). Furthermore, as we have already seen, the idea of poverty-risk-exclusion does not amount to merely the financial aspect. Hard-to-assess factors of fragility or insecurity must also be taken into consideration. Only a multidimensional approach can allow all the dimensions of risk to be encompassed.
The socio-economic profiles of surveyed drug users have been used to allow us to compile this report. Indeed, there has been no more specific study or research carried out on this topic in France. The prejudices are thus hard to ignore: users outside the substitution programme (Subutex® or methadone) or outside PES are surveyed even less often; reports of operations of associations specialising in the area of drug addiction only allow for very limited analysis.

Main surveys and research

Surveys of excluded or homeless populations[70]: CFI-Pâque, dispositif 16-25 ans: jeunes en insertion (1994) ; Kovess and Mangin-Lazarus (1997); Facy *et al.* (2001) ; Amossé *et al.* (2001); Monitoring Centre for the Social and Medical Welfare of the Homeless (SAMU) in Paris (1998 and 1999); Paugam and Clemencon (2002).

Surveys of drug-addicted populations[71]: Tellier S. (2001 , also from 1987 to 1997 and 1999) ; IREP (1996); Facy (1999); Emmanueli *et al* (1999), DGS (1999), Bello *et al* (2002, also 2001 and 2000); Drug addiction evaluation and information centre (CEIP, OPPIDUM programme 1999 and 2000), OFDT (2000).

Bibliographic references

Amossé, T., Doussin, A., Firdion, J-M., Marpsat, M., Rochereau, T. (2001). Vie et santé des jeunes sans domicile ou en situation précaire. Enquête INED, Paris et petite couronne, février-mars 1998, Série Résultats, Biblio n°1355. CREDES, Paris.

Beck F. (2000). Usages de drogues illicites, *In* : Baromètre santé premiers résultats 2000. CFES, Paris.

[70] This only lists the surveys that provide information on drug consumption within the surveyed population.

[71] This only lists the surveys that provide information on socio-economic status and degrees of exclusion of the surveyed population.

Beck, F., Peretti-Watel, P., Choquet, M., Hasseler, C., Ledoux, S. (2000). Consommation de substances psychoactives chez les 14-18 ans scolarisés : premiers résultats de l'enquête ESPAD 1999 ; évolutions 1993-1999. Tendances ,6, 6 p.

Bello, P-Y., Toufik, A., Gandilhon, M. (2002). Tendances récentes : rapport TREND. OFDT, Paris. Forthcoming.

DATIS (2002). Répertoire des structures spécialisées. May be viewed online.

Direction Générale des Services (General Directorship of services) (1999). Report of operations of CSSTs. DGS, Paris.

DRESS (2000). Annuaire des statistiques sanitaires et sociales 1999 édition 2000, Collection of studies and statistics. La Documentation française, Paris.

Emmanuelli, J., Lert, F., and Valenciano M. (1999). Caractéristiques sociales, consommations et risques chez les usagers de drogues fréquentant les programmes d'échange de seringue en France, étude n°18. OFDT, INSERM U88, InVS, Paris

Espoir Goutte d'Or (2001). Report of operations 2001. Paris

Facy, F. (1999). Toxicomanes et prescription de méthadone. EDK, Paris.

Facy, F., Dally, S., Rabaud, M. (2001). Alcoolisme et précarité, *In* : précarisation et risque de santé, Joubert M., Chauvin P., Facy F., Ringa V. (ed), pp. 350-363. INSERM, Paris.

Haut Comité de la Santé Publique (Senior Committee for Public Health) (1998). La progression de la précarité en France et ses effets sur la santé. Rapport de février 1998. Edition ENSP, Paris.

Hartnoll, R. (2002). Mesurer la prévalence et l'incidence de la consommation de drogues. Objectif Drogues, 3, 4 p.

Institute for Research on the Epidemiology of Drug Dependency (ed.) (1996). Etude multicentrique sur les attitudes et les comportements des toxicomanes face au risque de contamination par le VIH et les virus de l'hépatite. Rapport de synthèse. IREP, Paris.

Jamoulle, P. (2001). Enquête de terrain auprès des professionnels. Psychotropes, 7, (3-4), 11-29.

Joubert, M. (2000). Usage de drogue, sida et exclusion sociale en France. Transcriptase, (86), 5-8.

Kovess, V. and Mangin-Lazarus, C. (1997). La santé mentale des sans abris à Paris : résultats d'une enquête épidémiologique. La revue française de psychiatrie et de psychologie médicale, (9), 17-23.

Kovess, V. and Mangin-Lazarus, C. (2000). Troubles psychiatriques et utilisation des soins chez les sans abris à Paris : abus et dépendance à l'alcool et aux drogues. Alcoologie et Addictologie, 22, (2), 121-129.

Le Trait d'Union (The Link), (2001). Balance Sheet of Operations 2001. Paris.

Marpsat, M. and Firdion J-M. (1998). Une typologie de l'utilisation des services et du mode d'hébergement. Société contemporaine, (30), 111-140.

MILDT (ed.) (1999). Plan triennal de lutte contre la drogue et de prévention des dépendances 1999-2000-2001. MILDT, Paris.

Ministry of Employment and Solidarity (2001). Plan national d'action français contre la pauvreté et l'exclusion sociale. La Documentation française, Paris.

Ministry of Employment and Solidarity (2002a). Les mots de l'action sociale. May be viewed online: www.santé.gouv.fr.

Ministry of Employment and Solidarity (2002b). Présentation du programme et de la loi de prévention et de lutte contre les exclusions. May be viewed online: www.santé.gouv.fr.

Observatoire de la pauvreté et de l'exclusion sociale (Monitoring Centre for Poverty and Social Exclusion) (2001). 2000 Report. La Documentation française, Paris.

Observatoire Français des drogues et des toxicomanies (French Monitoring Centre for Drugs and Drug Addictions) (ed.) (2000). Evaluation du dispositif Bus Méthadone Paris. OFDT, Paris.

Observatoire du Samu social de Paris (Monitoring Centre for the Social and Medical Welfare of the Homeless (SAMU) in Paris) (ed.) (1998). Conduites addictives, substitution et grande exclusion, enquête sur 275 personnes. OSS de Paris, Paris.

Observatoire du Samu social de Paris (Monitoring Centre for the Social and Medical Welfare of the Homeless (SAMU) in Paris) (ed.) (1999). Conduites addictives, substitution et grande exclusion, enquête sur 275 personnes. OSS de Paris, Paris.

Paugam, S. (1996). L'exclusion : l'état des savoirs, Collection textes à l'appui. La Découverte, Paris.

Paugam, S. et Clemencon, M. (2002). Détresse et ruptures sociales: Résultats de l'enquête OSC/Fnars "personnes en détresse ", Synthèse. OSC, Paris.

Tellier, S. (2001). Prise en charge des toxicomanes dans les structures sanitaires et sociales, novembre 1999, Collection of Statistics, memorandum n°19. DRESS / Ministry of Employment and Solidarity, Paris.

Weinberg, A. and Ruano-Borbalan, J.-C. (1993). Comprendre l'exclusion. Sciences Humaines, 28, 12-15.

Wieviorka, S. (1999). Les toxicomanes dans la cité. Avis et rapport du Conseil Economique et Social. Les éditions des Journaux Officiels, Paris.

References

Bibliography

Angel P., Richard D., Valleur M., (2001), Essais sur la santé de la consommation de cannabis, Paris, INSERM (Institut national de la santé et de la recherche médicale), 2001, Coll. Expertise collective, Toxicomanies, Paris, Masson, 2000, 276 p.

Beck F., Peretti-Watel P. Choquet M., Hassler C., Ledoux S., (2000), Consommations de substances psychoactives chez les 14-18 ans scolarisés : premiers résultats de l'enquête - ESPAD 1999; évolution 1993-1999, Tendances, n°6, Paris, OFDT, 6 p.

Beck F., Legleye S., Peretti-Wattel P., (2000), Santé, mode de vie et usages de drogues à 18 ans : ESCAPAD 2001, Paris, OFDT, 198 p.

Beck F., Legleye S., Peretti-Watel P., (2002 – à paraître), Penser les drogues : Représentations des produits et opinions sur les politiques publiques - EROPP 2002, Paris, OFDT

Bello P., Toufik A., Gandilhon M., Giraudon I., (2002), Phénomènes émergents liés aux drogues en 2001, Rapport TREND, juin 2002, Paris, OFDT, 296 p.

Bergeron H., (1999), L'état et la toxicomanie : histoire d'une singularité française, (Coll. Sociologies). Paris, PUF, 370 p.

Bless R., Korf D., Riper H., Diemel S., (1997), Improving the comparability of general population surveys on drug use in the european union, Final report, commissioned by EMCDDA

Caballero F., Bisiou Y., (2000) Droit de la drogue. 2e édition, Paris, Dalloz, 827 p.

CFES, CNAMTS (Caisse nationale d'assurance maladie), (2000) Baromètre Santé. Premiers résultats 2000. Enquête auprès des 12-75 ans, Vanves/Paris, CFES, 17 brochures thématiques.

Direction générale de la santé/OFDT, Rapports d'activité « type » des CSST, chiffres non publiés

Duprey D., Kokoreff M., (2000) Les mondes de la drogue : usages et trafics dans les quartiers, Paris, Odile Jacob, 393 p.

Faugeron C. (dir.), (1999) Les drogues en France : politiques, marchés, usages, Genève, Georg, 279 p.

INSERM (Institut national de la santé et de la recherche médicale), (1998), Des données biologiques et cliniques aux contextes d'usage, Paris, Coll. Expertise collective, 345 p.

Kopp P., Fenoglio P., (2000) Le coût social des drogues licites (alcool et tabac) et illicites en France, Paris, OFDT/ARMI, 277 p.

MILDT (Interministerial Mission for the Fight Against Drugs and Drug Addiction), (2000), Plan triennal de lutte contre la drogue et de prévention des dépendances 1999-2000-2001, Paris, Documentation française, 226 p.

MILDT (Interministerial Mission for the Fight Against Drugs and Drug Addiction),Savoir plus. Risquer moins. Drogues et dépendances, le livre d'information, Paris, MILDT, 146 p.

OCRTIS (Central Office for Illicit Drug Traffic Control), (2002 - forthcoming), Usage et trafic de stupéfiants. Statistiques 2000, Paris, ministère de l'Intérieur

OFDT (French Monitoring Centre for Drugs and Drug Addiction), (2002), Drogues et toxicomanies : indicateurs et tendances, Paris, OFDT, 368 p.

OGD (Geopolitical Drug Dispatch), (2000), La géopolitique mondiale des drogues 1998/1999, Paris, OGD, 262 p. (www.ogd.org).

Parquet P.-J., (1997), Pour une politique de prévention en matière de comportements de consommation de substances psychoactives, Vanves, CFES, 107 p.

Reynayd M., Parquet P.J., Lagrue G., (2000), Les pratiques addictives : usage, usage nocif et dépendance aux substances psychoactives. Rapport au Directeur général de la Santé, Paris, Odile Jacob, 273 p. (Alcoologie)

Roques B., (1999) La dangerosité des drogues : rapport au secrétariat d'État à la Santé, Paris, Odile Jacob/Documentation française, 318 p.

Tellier S., (2001) La prise en charge des toxicomanes dans les structures sanitaires et sociales — novembre 1999, Paris, DREES, 47 p. 5 (Document de travail n°19)

Data bases

APPRE : database regarding preventive operations, available on CD-Rom (OFDT)
ILIAD : database regarding local indicators, available on CD-Rom (OFDT)
SINTES : database regarding the composition of designer drug samples collected within the framework of the TREND observing system, available on CD Rom (OFDT)

Annex

Drug monitoring systems and sources of information

Tools used for observation

All sources of information used in the report may be classified into larger categories; it is possible to describe their specific properties and limitations insofar as they are able to describe the phenomenon. First, however, two general comments should be made.

The mobilisation of available sources of information offers us a snapshot of the greater drug/dependency phenomenon. The representation that is thus obtained of a reality largely depends upon sources of information, as well as what they try and successfully manage to observe. The ambivalence of sources (indicator of the phenomenon and/or the development of an institution's operations) and the lack of data in certain areas are the main limitations that must be underscored. As they sometimes only supply us with partial elements of observation, they restrict the scope of perspective that is desired. For example, it is difficult to address the health consequences stemming from the use of all wide categories of drugs on the same level.

The focus on populations of drug users, inherent to this type of exercise, must not enable us to forget that these individuals are subgroups of the general population and that certain trends can only be the mere reflection of wider trends identified in the entire population.

General population surveys

These surveys rely on respondents' declarations. This type of research aims to measure the behaviour, attitudes, or options of the general population, or a part thereof, with regard to the usage of products. The method that is used consists of questions asked to a representative sample of these groups. The advantage of these surveys is that they yield a direct measurement of the phenomenon, and notably how widespread it is, within the entire population, as well as a reliable measurement of the evolution of said phenomenon. It is, however, difficult to use these surveys to identify relatively rare behaviour. The results offer an image of declared consumption, which is not necessarily identical to actual consumption.

Registries

National statistics stemming from compulsory declarations (death, AIDS, etc.) also enable us to estimate, at least in part, the use of harmful substances from the perspective of some types of harm that ensue from their abuse.

Administrative statistics

Administrative statistics and some studies target a particular population, as defined by the institution that is operating in this area (for example, health/people who seek treatments, justices/incarcerated individuals), offer a partial vision of the phenomenon of drug use, as perceived from a particular perspective. By definition, the "hidden" population, not observed by the institution, evades these statistics.

These sources of information are particularly valuable for the analysis of general trends due to their durability, regularity, and availability. Using them, however, can nevertheless be a tricky task, and their limitations must be taken into consideration. The indicators that are thus produced are "indirect indicators," and their inertia, which is an inherent part of their production process, generally does not enable us to explain recent trends in the phenomenon. Furthermore, these sources of information pose specific

problems: limitations on the theoretical field, reliability, and possible duplication of counting…

Qualitative studies

Individual studies concern population subgroups that are directly affected by usage of the products but are not institutionally selected. Ethnographic research is an example of such studies. In addition to being able to describe forms of usage and behaviour, this type of approach enables us to tackle the "hidden" part of the phenomenon: individuals that are not perceived by any institution. These individual studies describe types of behaviour qualitatively but do not enable us to measure their scope.

System used to monitor emerging phenomena

In 1999, OFDT set up a specific system used to monitor emerging phenomena (TREND). On one hand, this tool concerns a network of "watchdog" observers focusing on "urban space" (marginalised drug users with problems) and "festive space" (drug users who frequent nightclubs or "techno" gatherings/raves). On the other hand, this system uses a designer drug collection analysis system. This system, at the crossroads of the various methods described above, is distinguished by the subject of observation on which the tool focuses: emerging phenomena. Ruling out resorting to statistical methods, the information given by this system is mainly qualitative: field observation whose cross-validation and analysis enable us to guarantee the presence of trends that are seen in observations supplied through surveys and lasting statistics.

Information/documentation system

Toxibase, national network of documentation on drugs

Toxibase ("1901 law" association, essentially funded by the State) is a national network led by field professionals who work in the area of drug addiction and comprise, for some since 1986, a wealth of documents on this subject.

The nine Toxibase documentation centres are open to an extensive public: decision-makers, professionals, and individuals. Their operations at the local or regional level render them resource hubs for information regarding addictive behaviour. Their area of authority extends to all addictions-linked to psychoactive and other (games, Internet, etc.) substances-and to multiple drug use.

The Toxibase bibliographic database currently holds some 25,000 references for works, articles, reports, theses, congress proceedings or brochures, in both French and English. Toxibase publishes a quarterly documentary review-entirely revised in 2001-that notably includes topical files that have been compiled by specialists and document entries. The network also has a database of articles (with bibliographic references) that pertain to this subject in the national and regional daily and weekly press. Furthermore, in order to address the most pressing needs, Toxibase publishes a series of practical sheets.

Finally, for the past few years, Toxibase has been collecting and storing specialist prevention tools related to psychoactive substances and primary prevention. The database describes approximately 300 French-language tools, as well as an index and a descriptive summary for the purpose of identification.

Drug /dependencies information centres

In 1999, the first seven drug/dependencies information and resource centres [*centres d'information et de ressources sur la drogue et les dépendances*] (CIRDD) were created in the context of the Three-Year Plan. In 2000, there were already 26 of these centres, with around ten at the regional or interdepartmental level. Often formed using existing resources, most CIRDDs are directed 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 organisations should increase even more in 2001, as the goal of the Three-Year Plan is the implementation of 40 CIRDDs that cover the entire country.

Their purpose is to supply technical support to key institutional players and professionals in the departments for the implementation of local operations, notably those pertaining to prevention, education, and treatment. As of this writing, the CIRDDs are most committed to their documentation/information-collecting duties and to giving support to "drug and dependence" project managers, especially for the development of a departmental prevention programme. A few CIRDDs are already monitoring tools and operations implemented locally or are serving in an advisory position in the development of relevant projects.

List of tables, Graphs and Maps used in the text

List of Abbreviations used in the text

ACSF	Analysis of sexual behaviours in the French population
AFSSAPS	French Health Products Safety Agency (formerly the Medication Agency)
AHI	Reception and Housing Scheme
AMM	Marketing authorisation
ANPA	National Alcoholism Prevention Association
ANPE	National Employment Agency
ANRS	National AIDS Research Agency
APPRE	Prevention Operations and Programmes – collection
CADIS	Sociological Operations and Analysis Centre
CANAM	National State Health Insurance Office
CCAA	Outpatient Alcoholism Treatment Centres
CDIT	Tobacco Documentation/Information Centre
CDO	Departmental agreement on objectives in health/justice
CDPA	Departmental Alcoholism Prevention Committees
CEIP	Drug Dependency Information/Evaluation Centres
CEL	Local educational contract
CESAME	Centre for Research on Psychotropic Drugs, Mental Health, and Society
CESC	Health and Citizenship Educational Committees
CFES	French Committee for Health Education
CHAA	Centres for Food Safety and Alcoholism Treatment
CHU	University Hospital Centre
CHG	General Hospital Centre
CIM 10	World Health Organisation International Medication Classification, 10th revision
CIRDD	Drug/dependencies Resource and Information Centres
CLS	Local safety contract
CNAMTS	National State Health Insurance Office for Salaried Workers
CNRS	National Scientific Research Centre
CODES	Departmental Health Education Committee
CREDES	Centre for Research, Study, and Documentation on Health Economics
CRES	Regional Health Education Committee
CRIPS	Regional AIDS Information and Prevention Centre
CRPS	Regional Health Policy Committees
CSST	Specialised drug addiction treatment centres
DATIS	Drug/Alcohol/Tobacco Information Service
DCPJ	Central Office for the Criminal Investigation Department
DCSSA	Central Office for the Army Health Department
DDASS	Departmental Health and Social Welfare Office
DDJS	Department al Youth and Sport Office
DESCO	Academic Information Office
DGDDI	General Customs/Indirect Duties Department
DGLDT	General Delegation for the Fight Against Drugs and Drug Addiction

DGS	General Health Department
DH	Hospitals Department
DPJJ	Youth Legal Protection Department
DRJS	Regional Youth and Sport Department
DREES	Statistics, Evaluation, Studies, and Research Department
DSM	Diagnostic and Statistical Manual of Mental Disorders.
EPCV	Ongoing Household Living Conditions Survey
EROPP	Survey on Representations, Opinions, and Perceptions Regarding Psychotropic Drugs
ESCAPAD	Survey on Health and Consumption on Call-Up and Preparation for Defence Day
ESPAD	European School Survey Project on Alcohol and other Drugs
FNAILS	File of Police Questioning for the Use of Narcotics
FRAD	Anti-drug shift trainers
HBSC	Health Behaviour in School-aged Children
HCSP	Senior Committee for Public Health
IHESI	Institute for Advanced Studies on Inland Security
INPES	National Institute for Health Education and Prevention
INRA	National Institute for Agronomic Research
INRETS	National Institute for Research and Studies on Transport and Security
INRP	National Educational Research Institute
INSEE	National Institute for Statistics and Economic Studies
INSERM	National Institute for Health and Medical Research
INTERPOL	International criminal police organisation
IREB	Institute for Scientific Research on Beverages
IREP	Institute for Research on the Epidemiology of Drug Dependency
MDMA	Methylenedioxymetamphetamine (Ecstasy)
MENRT	National Research and Technology Education Ministry
MILAD	Mission for the Fight Against Drugs
MILDT	Interministerial Mission for the Fight Against Drugs and Drug Addiction
MNCPC	National Mission for Controlling Chemical Precursors
OCRGDF	Central Office for Eliminating Serious Financial Crimes
OCRTIS	Central Office for the Repression of Drug-related Offences
OEDT	European Monitoring Centre for Drugs and Drug Addiction
OFDT	French Observatory of Drugs and Drug Addiction
OFT	French Tobacco Prevention Office
OMS (WHO)	World Health Organisation
ONISR	National Interministerial Monitoring Centre for Road Safety
ONPES	National Monitoring Centre for Poverty and Social Exclusion
ORS	Regional Health Observatory
OSS	Monitoring Centre for the Social and Medical Welfare of the Homeless (SAMU)
PACA	Provence-Alpes-Côte d'Azur

PDI	Departmental Housing programmes
PFAD	Anti-drug trainer/police officer
PHRC	Hospital clinical research programme
PRAPS	Prevention/treatment access programme for people at risk
PRS	Regional Health Programmes
RMI	Minimum benefits paid to those with no other source of income
SINTES	National poison/substance identification system
SMPR	Regional hospital medical/psychological services
SROS	Regional health organisation guidelines
TIG	General interest work
TRAFCIN	Processing of Information and Action Against Clandestine Financial Circuits
TREND	Recent trends and new drugs
UCSA	Outpatient treatment/consultation unit
UNODCCP	United Nations Office for Drug Control and Crime Prevention
VHC	Hepatitis C Virus, HCV