



OBSERVATOIRE
FRANÇAIS DES
DROGUES ET DES
TOXICOMANIES

**2006 NATIONAL REPORT (2005 data) TO THE EMCDDA
by the Reitox National Focal Point**

FRANCE
**New Development, Trends and in-depth information on
selected issues**

FRENCH VERSION

REITOX

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CONTENTS.

- SECTION A: NEW TRENDS AND DEVELOPMENTS 7**
- 1. National Policy and context 7
 - 1.1 Legal context 8
 - 1.2 Institutional framework, strategy and policy 8
 - 1.3 Budget and Public Spending 9
 - 1.4 Social and Cultural Context 10
- 2. Drug Use 12
 - 2.1 Drug use in the General Population 13
 - 2.2 Drug use among young people and school pupils 18
 - 2.3 Drug use within specific groups 20
 - 2.4 Attitudes to drugs and drug-users 21
- 3. Prevention 22
 - 3.1 Universal prevention 24
 - 3.2 Selective Prevention 27
- 4. Problem Use 28
 - 4.1 Prevalence and estimated incidence 29
 - 4.2 Profile of people receiving treatment 29
- 5. Treatment 34
 - 5.1 System 36
 - 5.2 "Drug free treatment" 36
 - 5.3 Medical treatments (detoxification, substitution) 36
- 6. Health consequences 38
 - 6.1 Drug-related mortality 40
 - 6.2 Infectious diseases linked to drug use 42
 - 6.3 Psychiatric comorbidities 44
 - 6.4 Other comorbidities linked to drug use 44
- 7. Responses to health problems 45
 - 7.1 Prevention of drug-related mortality 46
 - 7.2 Prevention and treatment of infectious diseases linked to drug use 46
 - 7.3 Interventions linked to psychiatric comorbidities 46
 - 7.4 Other interventions targeting post-use sanitation 46
- 8. Social Consequences 47
 - 8.1 Social Exclusion 49
 - 8.2 Crime and drug-related offences 49
 - 8.3 Use in Jail 56
 - 8.4 Social cost 56
- 9. Responding to social problems 57
 - 9.1 Social Integration 59
 - 9.2 Prevention of drug-related crime 59
- 10. The market and supply 60
 - 10.1 Availability and supply 62
 - 10.2 Seizures 64
 - 10.3 Price and purity 66
- SECTION B: SELECTED ISSUES. 68**
- 11. Drug use among young adolescents 68
- 12. Cocaine and Crack Use: prevalence, risks and responses 77
- 13. Drugs and driving 90

SECTION C: BIBLIOGRAPHY AND ANNEXES..... 100
14. Bibliography..... 100
15. Annexes. 109

SUMMARY

2005 did not bring any real changes in direction on drug policy. Apart from a possible revision of the 1970 law which is the basis for the fight against drug use and drug trafficking, the only major event was the attempt to classify Subutex® as a narcotic. This measure was aimed at fighting misuse and the black market, but it was unpopular with health professionals, and was ultimately not adopted.

The publication of the results of the SAM (*Stupefiants et Accidents Mortels: Narcotics and Fatal Accidents*) survey was much featured by the media. All the road accidents in urban France between October 2001 and September 2003 resulting in at least one fatality were analysed to measure the effects of cannabis and alcohol consumption on drivers. It showed that, all other things being equal, cannabis use multiplies the risk of fatal accident by 1.8. Alcohol consumption multiplies it to a much greater extent, by 8, and by almost 15 when the two substances are mixed (see *Selected Issue* on drugs at the wheel).

The TREND observatory showed growth in cocaine consumption, which, thanks to lower average prices, has breached its traditional boundaries (higher socio-economic classes) to break into new markets (students, young professionals, creative circles). Heroin has become more visible, especially on the party and techno scenes. Finally, methadone's role in substitution treatment has increased, although without shifting BHD® from its dominant position.

Records of treatment requests at mobile CSSTs (drug addiction treatment centres) kept by RECAP (*Recueil commun sur les addictions et les prises en charge*, i.e. Data Retrieving for Drug Treatment Demands) give an idea of the principal characteristics of people undergoing specialised treatment for problems linked to drug use. The majority of CSST patients in 2005 were male (80%) and young (60% under 30 years old). Cannabis use was at the origin of nearly half the requests for treatment (48%). Cannabis is behind the majority of treatments in CSSTs, especially where specialised consultants are involved (67%), and this is because specialised consultancies for cannabis users were created in the majority of CSSTs in 2004. Problems linked to heroin and cocaine are the second and third most common, being at the origin of 31% and 6% of consultations respectively.

Summary of 'Selected Issues'.

Drug use and related problems among very young people

For legal and/ or technical reasons, it is difficult to measure drug use among young adolescents. Launching a number of surveys across the general population is one possible response to this shortcoming. Following the example of older adolescents, tobacco, alcohol and cannabis are the products most commonly mentioned by under 15s, while the use of other drugs remains minimal. Differentiation by gender occurs very early on ([link to text](#)).

Cocaine and crack- situation and responses

Although present in France since the beginning of the 20th Century, cocaine is unique in that its use is limited, and confined to specific social categories- affluent artistic circles. However, consumption has increased significantly from the 1990s, and the drug is becoming more and more easily accessible. At the same time, crack use has become more widespread, but its use is restricted to a more marginalized population in urban areas. These disparities are reflected by different methods of treatment, by staff not always adequately informed ([link to text](#)).

Drugs and Driving

The results of the SAM (Drugs and fatal accidents) study, which covered all road accidents in France between 2001 and 2003 that resulted in one or more fatalities, were published in 2005. Among other interesting results, it emerged that cannabis use multiplies the risk of a fatal accident by 1.8 all other things equal; alcohol consumption multiplies it by nearly 8, and mixing the two substances by almost 15 ([link to text](#)).

SECTION A: NEW TRENDS AND DEVELOPMENTS.

1. National Policy and context.

National Policy: an Overview

Legal context: The 1970 French law on narcotics constitutes the legal framework for French policy in the fight against drugs. It embodies three principal objectives in civil law.

-Severe penalisation of trafficking

- promoting a total ban of narcotics use on principal, with therapy offered as an alternative to stopping altogether;

- ensuring care is free of charge and guaranteeing anonymity for users seeking treatment;

The five-year public health law 2004-2008, adopted in August 2004, introduced the policy of Risk Reduction for drug users into the public health code. Risk Reduction is thus a State initiative.

The list of drugs covered by the 1970 French law on narcotics (the list of substances classed as narcotics having been fixed by decree, 22 February 1990) is regularly updated to include substances newly recognised as dangerous in orders from the Health Minister, proposed by the Director General of the French Agency for ensuring safety of pharmaceuticals (AFSSAPS)¹.

Institutional context: The inter-ministerial Mission to fight drugs and drug addiction (MILDT) is the organ responsible for preparing the report for the 'Permanent Inter-ministerial Committee to fight Drugs and Drug Addiction' and for ensuring the proper implementation of any decisions made there.

The current Chair of the MILDT was appointed in October 2002. A five-year action plan to counter illicit drugs, tobacco and alcohol (2004-2008) was adopted in July 2004 (OFDT2004a, MILDT 2004).

Budget and Public Spending: Most spending in the fight against drugs is funded by the Ministry of Health's accounts and those of the MILDT. Spending on specialised care centres for drug addicts is covered by health insurance management bodies.

Social and Cultural Context: the vast majority of the population still supports the existing measures of the risk reduction policy (substitution therapy, free distribution of syringes) and is largely still committed to anti-narcotics measures (against authorising the use of cannabis and heroin under certain conditions, opposed to the sale of cannabis (Beck et al., 2003)). In the case of the use of illicit drugs under careful supervision, for medical purposes, half declare themselves in favour of heroin use, while three quarters support prescription of cannabis for certain serious conditions. In 2002 there were more people in favour of legalising the sale of cannabis than in 1999, but they were still in a minority (24% in favour compared to 17% in 1999).

¹Appendices I and II of the list of drugs classified as narcotics correspond to tables I and IV of the 1961 International Narcotics Convention. Appendix III includes the substances from Tables I and II and some substances for tables III and IV from the International Psychotropic Drugs Convention, 1971. Appendix IV consists of psychoactive drugs not internationally classified, and certain of their forerunners.

1.1 Legal context

Modification of the list of drugs classified as narcotics:

In 2005, a new decree² added various substances to Appendix IV that could be components of *Ayahuasca*: *Banisteriopsis caapi*, *Peganum harmala*, *Psychotria viridis*, *Diplopterys cabrerana*, *Mimosa hostilis*, *Banisteriopsis rusbyana*, harmine, harmaline, tetrahydroharmine (THH), harmol, harmalol.

Prompted by the MILDT, BHD was re-classified as a narcotic, resulting in much stricter controls on its prescription. This was an interim measure presented as a means of combating the black market and the inappropriate use of substitute drugs, and in August 2006, BHD regained its former status.

Reference to Risk Reduction legislation:

Decree no. 2005-347 of 14 April 2005 (NOR: SANP0521129D) established a national point of reference for risk reduction legislation aimed at drug users. It thus fulfils the requirements of the public health code. It set up CAARUDs (walk-in supervision centres to reduce risks for drug users) and adds that these 'along with other measures, contribute to the risk reduction policy'.

The frame of reference consolidates the aims of risk reduction activity and intervention methods within French legislation, along with different activities that could be run by institutions (distribution of material and of information on the risks). It also specifies materials that can be used for prevention, and Stresses the importance of providing information on the risks of drug use, whilst respecting the idea of 'not showing drugs in a favourable light'. It highlights the importance of health warnings and lists possible locations for intervention for prevention. The same frame of reference prohibits testing (see section 3.1).

Strengthening cooperation to fight narcotics trafficking in the Caribbean region:

Law no. 2005-1276 of October 13 2005 (NOR: MAEX0400204L) strengthens cooperation, with the aim of intercepting illicit air and sea trafficking of narcotics and psychotropic drugs in the Caribbean region.

1.2 Institutional framework, strategy and policy

Circular on the judicial response to drug use

The circular sent out to the prosecutors by the Ministry of Justice on April 8 2005³ aims to improve and harmonise the judiciary's response to narcotics use, by passing on the guidelines set out in the government plan to fight illicit drugs, tobacco and alcohol (2004-2008).

This text reaffirms the guidelines set out in the Ministry of Justice circular of June 17 1999 concerning criminal law policy in practice, which called for a response 'tailored' to drug users. The guidelines set a limit on criminal court appearances and incarcerations in 'exceptional' cases, and favour alternatives to trial and imprisonment, especially those including some sort

² Decree of 20/04/2005 (NOR: SANP 0521544A) modifying the decree of 22/02/1990, which fixed the list of substances classed as narcotics, and those that make up 'Ayahuasca' –J.O. 03/05/2005

³ CRIM 051G4-08042005; NOR JUS D 05-300561 C

of health component (compulsory treatment, court order to attend a health and/ or social institution, compulsory care).

The 2005 circular also advocates a graded penal response, which would be both 'systematic' and 'more user-friendly', whilst still moving towards harmonising practice between prosecutors and courts across the country.

The circular is innovative in that it calls for a crackdown on offences inciting narcotics use. In the text, the concept of 'inciting narcotics use' is rigidly defined, and specific activities and behaviour are targeted:

- 'hemp reception centres where cannabis seeds are sold for home production';
- 'sale of clothes or jewellery decorated with a cannabis leaf motif';
- 'circulation of works or magazine articles which glorify narcotics'
- 'sale of materials or accessories accompanied by instructions for narcotics dosage'

The circular also recommends vigilance in the face of offences linked to raves and to obtaining high dosage Buprenorphine (Subutex®) for misuse.

Lastly, the circular encourages regularising customs transaction limits in conventions between the customs service and the Public Prosecution Service. The circular sets out the most commonly used limits as an example for the department of public prosecution and the customs service, allowing for modification according to local specificities. The minimum ranges are 20-50g of cannabis resin, 30-100g of grass, 1-5g of heroin, 1-5g of cocaine and 1-5 doses of designer drugs.

1.3 Budget and Public Spending

The organic law relating to the Finance Laws of August 1 2001 (LOLF) fundamentally reforms management of the State. This law came into effect in stages and has been applicable to the whole of French administration since January 1 2006.

The general State budget is now divided between 34 missions, 133 programmes and almost 580 agencies, while previously it was defined per Ministry.

There is now a 'drugs and drug addiction' programme (within the health mission) under the jurisdiction of the Chair of the MILDT. To take action and for widespread implementation of this programme, the MILDT will rely on three operators: the public interest groups (GIPs) DATIS, OFDT and CIFAD (Inter-ministerial group for anti-drugs training). It also has a budget of 38 million Euros, divided into three sections:

- Inter-ministerial coordination in the areas of prevention, health and prohibition (67%⁴);
- Trial of new partner schemes in prevention, care and application of the law (32%);
- International cooperation (1%).

For this reason, chapter 47-11 of the Finance Act 2003, relating to 'public health programmes, prevention schemes and promotion of health' was removed from the 2004 Finance Act and the different articles were transferred to chapter 39-01 'public health and prevention programmes' under the trial of the new organic law.

Inter-ministerial action against drug addiction (MILDT budget) continued to be financed through the intermediary chapter 47-16.

⁴ Indicators from the draft finance law 2005.

Table 1. Specific allocations to inter-ministerial action in the fight against drug addiction voted in the Finance Laws and executed 2002-2004.

Specific allocations voted in the initial Finance Law	2002	2003	2004	2005
Chapter 47-16 : Inter-ministerial action against drug addiction	45.58	40.05	38.04	38.00
Executed Budget				
47-16 Article 10 (allocations transferred to ministries)	5.69	6.39	3.90	2.7
47-16 Article 20 (Decentralised allocations for intervention)	14.15	15.11	10.35	11.8
47-16 Article 30 (Decentralised allocations for prevention progs., CDO, CIRDD)	21.47	16.01	19.50	17.9
Total⁽¹⁾	41.31	37.51	33.75	32.4

(1) Differences between allocated credits and the executed budget are principally due to budgetary freezes over the course of the year

Sources: MILDT; Special Treasury accounts ('greens'), Ministry of the Economy, Finance and Industry.

The structure of the MILDT budget since 2005 is essentially organised around inter-ministerial coordination in three areas (prevention, care, applying the law and the fight against trafficking). Consequently it is impossible to identify each individual area within the budget.

For the year 2005, coordination is allocated 23.5 million Euros and research is allocated 4.1 million. In terms of specific action, prevention in the broadest sense (from health education to crime prevention) is allocated 2.3 million Euros ; application of the law and fighting trafficking : 2.4 million and health care 0.15 million.

1.4 Social and Cultural Context

As in the previous period, cannabis is the illicit drug uppermost in public debate.

The issue of cannabis and driving which was the subject of heated debate at the end of 2005, before the results of the SAM (drugs and fatal road accidents) study were published. On October 3 2005, the first conclusions of the study appeared in the daily *Libération* and in *Agence France-Presse*. On December 2, the subject was brought up again when an article on the epidemiological aspect of the study was published in the *British Medical Journal*. 'Cannabis increases risk at the wheel, but much less than alcohol' ran the AFP headline. The same theme hit the headlines again in May 2006 when the inter-ministerial Mission to fight drugs and drug addiction and the inter-ministerial delegation for road safety launched a publicity campaign on the subject. For a month, the campaign hammered out: 'Cannabis causes 230 road deaths per year' and 'Cannabis + alcohol= 15x greater risk of fatal accident'.

Still on the subject of cannabis, early 2006 saw the press taking an interest in the toxicity of cannabis smoke, with the appearance of a study and test results in the magazine *60 million consumers*. The April issue was headed: '3 joints= 1 packet of cigarettes', while other newspapers latched onto the information, like *Le Figaro* (March 28) for whom it seemed that 'cannabis smoke is more toxic than that of cigarettes'.

Lastly, on the 30th anniversary of the call to legalise cannabis, launched in June 1976 by *Libération*, and in a pre-electoral year, several newspapers returned to the status of the drug in France: consumption, and possible developments. On June 16, *Le Monde* noted that 'its proponents struggle to make it an electoral issue', and *Libération* (June 17) emphasised the fact that 'France is still one of the most repressive European counties'. Some weeks later

(July 28), *Le Monde*, in an article entitled 'Cannabis, weapon of prohibition' highlights the public authorities' focus on that illicit substance.

Although far more marginal in terms of consumption, another substance, methamphetamine, raised press interest in the 2005-06 period. After the accounts of three crystal meth users were printed in *Libération*, August 19 2005, successive articles were published in *Courrier International*, *L'Express*, *Paris Match*, *Le Nouvel Observateur* and *Le Figaro* on this drug which is common in the United States and in Asia, and on its possible arrival on a grand scale in France. Concern over methamphetamine is also regularly expressed in the audio-visual media, notably on the TF1 television news (the largest in terms of audience) on January 15 2006.

The debate surrounding the chance to classify Subutex® (a substitution drug for heroin) as a narcotic also regularly took up newspaper column space. One of *Libération's* first features, on June 2006, raised the possibility of classification at the request of the Minister of the Interior. As the year unfolded several articles related the often antagonist positions of the different specialists and decision-makers, until *Le Monde*, on July 15 2006, finally revealed that 'Subutex should not be classed as a narcotic'.

Also worth mentioning is the significant number of articles on cocaine consumption throughout this period. The *Parisien* ran two features on the subject on March 5 and July 30, centred on the habits of showbusiness stars and their brushes with the law. On April 10, *Le Figaro* led with the story 'Cocaine: consumption and rising risks'. On April 13, *Le Monde* ran a double-page spread on 'Cocaine day-to-day'.

Lastly, among newspaper features, those on drug use at work stand out via the numerous comments provoked by the appearance of a work on the subject : 'Double life: Drugs and Work'. (cf. the book review of 'The Drug Taboo' in *Le Monde*, March 21, 2006). On another level, several magazines (*Paris Match*, *Le Nouvel Observateur*, *Elle*) hit on the increased use of psychotropic medicines in the most privileged areas of the capital, following the results of a survey of young people by ESCAPAD Paris.

2. Drug Use

Drug Use: An Overview

Four levels are generally used to measure the scale of consumption. These levels were established on the basis of international indicators

- Experimentation: having used the drug at least once in a lifetime
- Occasional use: consumption at least once a year
- Regular use: consumption at least 10 times in the last 30 days
- Daily use: consumption every day

In certain cases, recent use (consumption at least once in the last 30 days) is also used.

Use across the population In France several studies seek information on drug use:

-For the adult population: The Health Barometre (National Institute for Preventative Health Education –INPES- lasting four years. A study of the representations, opinions and perceptions of psychotropic drugs (EROPP, carried out every three years by the OFDT) [epidemiological table no. 1].

- For the school-age population: European School survey Project on Alcohol and other Drugs (ESPAD), carried out every four years (INSERM-OFTD) [epidemiological table no.2].

- For young people: Annual study of health and behaviour on the call-up and preparation for defence day (ESCAPAD): a survey of 17-19 year olds carried out by the OFDT. This study particularly focuses on young people who have dropped out of the school system prematurely [epidemiological table no. 30].

Cannabis is the most commonly used illicit substance in France, and its consumption has increased significantly over the past 10 years. In 2005, 3 in 10 adults aged 15-64 had already experimented with cannabis, while less than 1 in 10 used it occasionally or regularly (Beck and Cytrynowicz, 2006). Cannabis consumption affects all social classes, although certain distinguishing features stand out. Cannabis is consumed slightly more by students and school pupils (Beck et al., 2005a), single people (Beck et al., 2002), the unemployed. Among employed people, consumers are those in key-worker professions, and, to a lesser extent, manual workers (Legleye and Beck, 2004). However, differences between socioprofessional categories are largely relatively insignificant.

Less experimentation with illicit drugs other than cannabis was declared: for example, 12.4 million tried cannabis, 11 million tried cocaine, 900 000 tried ecstasy and 360 000 heroin. However, a slight increase in those aged 18-44 years who had experimented with cocaine (3.3% vs. 3.8%), hallucinogens (3.0% vs. 3.6%), and ecstasy between 2002 and 2005 shows these drugs are becoming more widely available. Levels of heroin experimentation have been stable for around a decade (Beck et al., 2006).

Whatever the drug, men in large urban centres are the greatest experimenters (Beck et al., 2002). Experimenters in illicit substances are often unemployed or on a low income, with cannabis users, generally more socially integrated, a notable exception.

At 17, after tobacco, alcohol, cannabis (53.2% of boys and 45.6% of girls) and psychotropic drugs, the substances most experimented with are poppers (5.5 %),

magic mushrooms (3.7 %), solvents and Ecstasy (3.5 %) and, to a lesser extent, cocaine (2.5 %), amphetamines (2.2 %) and LSD (1.1 %) (according to ESCAPAD 2005 (Beck, Legleye and Spilka, 2006)).

Use in specific groups: the most recent studies done on groups of sex workers (men and transgendered people, women) show that only a minority have made recent use of illicit drugs, apart from cannabis (Cagliero and Lagrange, 2004 ; Da Silva, 2003). However, drug use occurs more often in men and transgendered people (13% have recently used poppers, 11% ecstasy, 7% cocaine, 2% heroin) than in women (recent heroin use 5%).

Data for the homeless population is fragmented, however it is known that drugs are available for consumption. Users who live on the streets 'have intoxication habits that differ significantly from less marginalised addicts: lacking in money or routine, they consume what they can get their hands on that day [...]'(Solal and Schneider, 1996). The assessed prevalence of illicit substance consumption over the last few months varies from 10% to 21% or 30% depending on age, level of income, their reasons for drifting, and the shelter institutions attended (social Samu Observatory, Paris, 1999; Kovess and Mangin Lazrus, 1997; Amosse et al., 2001).

Although an epidemiological knowledge of drug addiction in the professional environment is held back by various types of obstacles (ethical, technical, financial, temporal, regulatory, cultural, practical), some assessment criteria are available. In 1995, a urine sample analysis of 1976 anonymous employees in the North Pas de Calais region showed that 17.5% of the workers had consumed at least one psychoactive substance: 40% of employees were in security positions (Fontaine, 2002b). For the majority of employed users, consumption is hidden from their colleagues. Work and consumption are separated as far as possible (Fontaine, 2002a).

Attitudes towards drugs and drug users: the EROPP study is the tool used to gauge French attitudes to drugs and drug users. This study serves to measure the level of information people believe they have on drugs, the substances that people are aware of as drugs, and the perceived danger of drugs. It also examines how drug addicts are represented in public opinion.

In 2002, 61% of the French population considered itself to be well-informed about drugs: slightly more than in 1999. In response to the question: 'What are the principal drugs that you know of, even if only by name?' the French named on average 3.8 drugs. The drug named most often is cannabis (82%), followed by cocaine (60%) heroin (48%) and then ecstasy (37%) (Beck et al., 2003).

The drug judged most dangerous in France is heroin, followed at a distance by ecstasy and cocaine, alcohol and tobacco, and finally cannabis (only 2% of those questioned judged cannabis to be the most dangerous drug). This classification varies little with age, gender or socioprofessional category. The perceived danger of cannabis varies according to age, gender, and most importantly, involvement with the drug (Beck et al., 2003).

2.1 Drug use in the General Population

Use by drug

The 2005 Health Barometre, a representative survey of the French population aged between 12 and 75, updates data from 2000.

Table 2. Assessment of consumers aged 15-64 per type of drug considered, in France in 2005 (%)

Drug	Experimentation	Consumption over the year
Alcohol	92.2	86.0
Tobacco	78.2	NA
Psychotropic drugs	35.7	18.5
Cannabis	30.6	8.6
Poppers	3.9	0.6
Magic mushrooms	2.7	0.3
Cocaine	2.6	0.6
Ecstasy	2.0	0.5
Inhaled drugs	1.7	0.2
LSD	1.5	0.1
Amphetamines	1.4	0.2
Heroin	0.8	0.1
Crack	0.3	0.1

NA: not available. Source: *Baromètre Santé 2005 INPES, interpreted by the OFDT.*

In 2005, 84.4% of 12-75 year olds declared that they had consumed alcohol over the course of the year, and this was over-represented in the male populace: 13.7% of French people admitted to daily consumption- 20.3% of men and 7.3% of women (Legleye et al., 2006). 8.4% said that they had never consumed alcohol in their lives and 15.2% had not drunk in the past twelve months. Lastly, 38.4% of those questioned had consumed alcohol at least once a week over the past twelve months.

Tobacco consumption continues to decrease, an ongoing phenomenon for almost forty years now (Wilquin 2006): from 33.1% of 12-75 year olds who declared themselves smokers in 2000, to 29.9% in 2005. Over the past few years, particular effort has been made to discourage young people: apart from the continued rise in the price of cigarettes, it is worth mentioning prohibition of the sale of tobacco to under 16s, although it is far from being implemented by all tobacconists. The proportion of smokers in the 12-15 age-group has passed from 14.4% in 2000 to 8.6% in 2005.

However, an increase in tobacco products other than manufactured cigarettes (cigars, and rolling tobacco in particular) has been remarked upon, and medium-term predictions (2010) chart a continuation of this trend (Beck et al., 2005). Smuggling is a developing phenomenon in border departments, and this minimises the impact of raising the price of a packet of cigarettes (Ben Lakhdar and Kopp 2006).

In 2005, 30.6% of 15-63 year olds had consumed cannabis at least once in their lifetime. Conversely, experimentation with other illicit substances remains particularly low (Beck and Cytrynowicz, 2006), and is principally the domain of young adults. Various available data confirms cannabis' position as the number one illicit drug consumed in France.

Tableau 3. Cannabis users, aged 15-64 (%), France 2005.

Consumption habits	Men	Women	Gender ratio
Experimenter	37.9	23.5	**
Consumer in the past year	12.0	5.4	**
Recent consumer	7.3	2.5	**
Regular consumer	4.3	1.3	**
Abstainer	62.1	76.9	

***: p<0.001. Source: Baromètre Santé 2005 INPES, interpreted by the OFDT.*

Compared to other illicit substances, consumption of cannabis in whatever form differs according to gender, perpetuating the trend of the past few years.

Almost 6 in 10 people aged 15-64 (58%) judge that they could easily obtain cannabis in 24 hours. This opinion is particularly shared by men aged 20-25 (79.2%, versus 61.3% in the rest of the population; $p < 0.001$). Less than 1 in 10 people (7.2%) were unable to answer the question, and this proportion increased with the age of those questioned, from 2% among 15-19 year olds to 14.3% among the over 55s ($p < 0.001$). This question has its limits when posed to people who have no desire to procure cannabis and who do not really accept the hypothetical situation put to them. Nonetheless, cannabis is seen as an accessible drug even in the oldest groups.

When questioned on their principal means of obtaining cannabis, almost 6 in 10 users within the last twelve months said that usually it was offered to them (58.7%), while just over a third (36.2%) said that they purchased it. Among consumers in the past year, home growing appears infrequently as the principal means of obtaining a supply (5.1%), shared equally between men and women (4.9% versus 5.6%). More women said they are usually given the cannabis that they consume (67.5% versus 54.5%; $p < 0.001$).

However, these proportions vary with frequency of use. Those who were given cannabis made up only 25% of regular users, with no distinction between the sexes, while 12% of regular users said they grew their own as their normal source of supply (15.8% of women versus 11% of men $p < 0.001$) and almost two thirds (59.1% of women, 64.1% of men $p < 0.01$) purchased their supply. The proportion of current consumers who normally purchase cannabis rises between 15-19 years and 26-34 years (34.2%-41.8%) and then falls (while 22.2% of 45-54 year olds said they were still purchasers, this was not the case for a single consumer in older groups). It is probably a sign of growing financial independence and greater involvement with cannabis, followed by a gradual loss of interest in the drug with use becoming more sporadic and more linked to specific people and circumstances.

Among people aged 15-64 who have already consumed cannabis, but not during the past 12 months, a clear majority (78.8%) give loss of interest as the principal reason for stopping. Other reasons came up much less frequently: the main ones were: not having like it the first time (4.2%); lack of opportunity (3.9%); health worries (3.9%); distaste for drugs in general (2.6%); not enjoying it any more (2.3%); feeling too old (1.9%); fear of dependency (1.4%) or simply that it did not fit in with their social circle (0.9%).

There was much greater variance between the motivations of those who had consumed the drug within the past year. The main reasons were: curiosity (21.9%); relaxation (19.9%); wanting to taste it (13.9%), to try it (11%). A second group of motivations can be distinguished relating to the socialising properties of cannabis: a desire to have fun (10.3%); to bond with friends (8.9%); to conform ('To be like everyone else' 8.4%); to be sociable. Notably, 7.2% said they were seeking pleasure, 2.7% wanted intoxication, 2.2% smoked to forget their problems, 1.6% to get high and 1.1% to get to sleep.

Cannabis use is therefore primarily motivated by hedonistic factors, and people stop consuming it out of apathy or lack of interest. Very few former consumers said they gave up because of problems relating to drug use.

Focus on problem use⁵

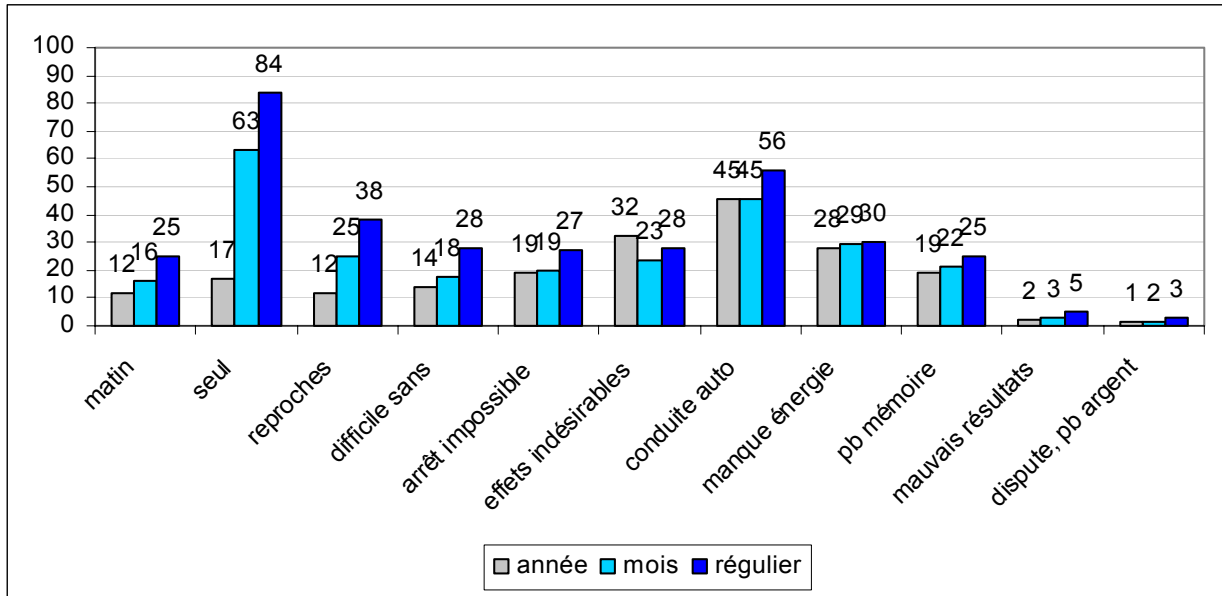
In the population aged 15-64, the behaviour patterns studied are relatively rare among cannabis smokers as a whole. The most frequent are undesirable effects such as dizziness, bad trips and paranoia, that around a third (32%) of consumers said they had experienced at least once over the period of the study, followed by lack of energy (28%), problems with memory (19%) and reproaches from friends and family (12%). Signs of dependency, such as difficulty passing a day without consuming, or inability to stop or reduce consumption are relatively frequent (14% and 19% respectively). On the other hand, more serious difficulties at work or in relationships are much rarer (2% for poor results or problems at school or at work, 1% for disputes and money troubles). Two other behaviour patterns were studied: consuming cannabis in the morning before going to class or to work and using it alone. These practices, which show a departure from the norm (use in social gatherings, typical of adolescents) rather than problem use, concern 12% and 17% of current users respectively.

On the whole, these behaviour patterns or problems tend to be declared more frequently in studies of more regular users. This is especially true of solitary cannabis use, which is relatively rare across the whole group of smokers over the year, but which is admitted by 84% of regular smokers. The one exception concerns undesirable effects. This paradox can apparently be explained by the selection of users: it is possible that those who are more at ease with the drug continue to consume while those who experience unpleasant effects quit. Lastly, risky behaviour seems particularly widespread: driving after smoking cannabis was admitted by almost half of those who had smoked in the past twelve months (45%) and by the majority of regular users (56%).

Note that it is rare for these behaviour patterns to be repeated : less than 5% of those who had smoked in the past year admitted to having experienced the above events often, with the exception of driving after having smoked cannabis (9.1%) and smoking cannabis alone (15.1%), which cannot be considered problem use, but simply a pattern of consumption. For example, only 3.2% of those who had smoked in the past year said that they often smoked in the morning before going to school or to work. The proportion of consumers who admitted to having often had poor results or problems at school or at work, or disputes or money problems caused by their cannabis use was particularly low (less than 0.7%).

⁵ The full version of the Cannabis Abuse Screening Test (CAST) creates an overview of cannabis consumption habits and the problems associated with them, over a twelve month period. This questionnaire is designed to provide a description of problem use of cannabis in studies of the general population. It is based on the principal criteria for determining abuse (and harmful use) as described in international nosography (DSM4 and CIM10), but it also addresses the social aspects of use. A clinical validation of this test is underway, which should evaluate its psychometric and locating qualities, compared to the standard psychiatric test. When complete, it should provide an estimation of the proportion of users who, bearing in mind their level of use and associated problems, should consider reducing consumption or giving up altogether⁵. For each question, the interviewee is asked to specify the frequency of certain events over the last twelve months: *never, once or twice, sometimes, often*. Specifically, the questions all make explicit reference to cannabis as the cause of events or problems targeted. They actually force the interviewee to recognize or not this causality. This is therefore about perceived effects. If it is possible to attribute bad school results to cannabis, or on the contrary to refuse to make the link between the two, the only cases that are viable are the ones where the interviewee recognizes the link.

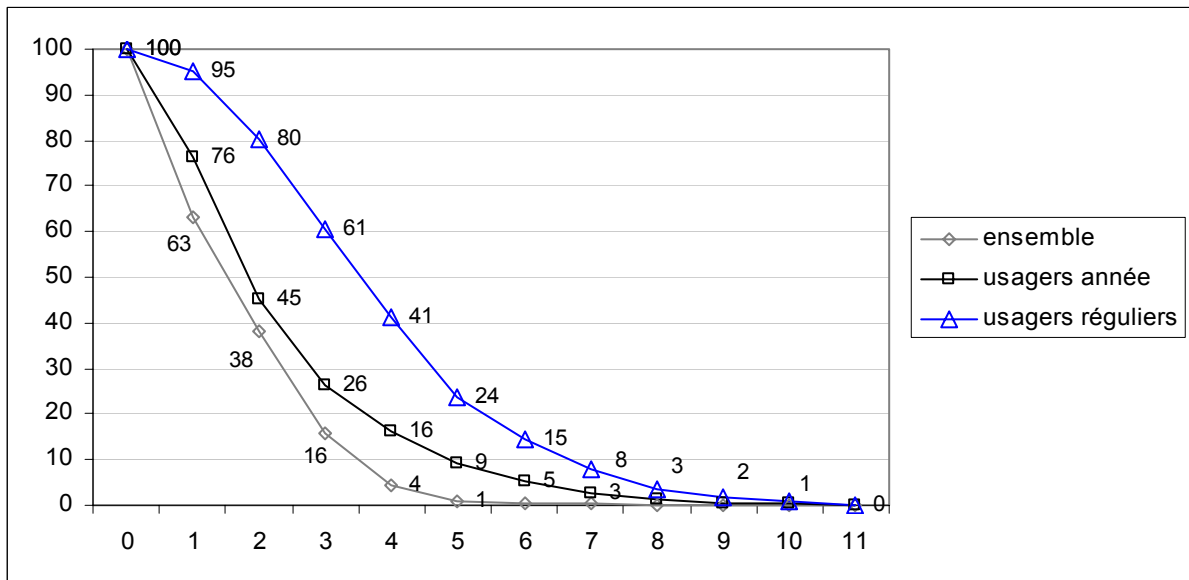
Figure 1. Patterns of use and associated problems among those who consumed cannabis over the past year (15-64 years old)



[morning/ alone/ reproaches/ difficult without/ impossible to stop/ unwanted effects/ driving/ lack of energy/ memory problems/ poor results/ arguments or problems with money... year/ month/ regular]

These behavioural patterns are far more common in men. If the positive responses to the 11 questions in the survey were added up (restricted to responses of at least 'sometimes' for the question of solitary use in the morning before going to work or to school), men would score an average 2, versus 1.5 for women ($p < 0.001$). The following shows the distribution of scores:

Figure 2. Population distribution according to CAST (drug addiction centre) score among 15-64 year olds, following the frequency of cannabis use (%)



[overall/ past year/ regular users]

Key: 76 % of those who had consumed cannabis in the past year obtained a score over than or equal to 1, which is 63% of all 15-64 year olds.

The optimum score for discerning individuals with a cannabis problem (cannabis abuse in the sense of the DSM IV) has not yet been determined. However, in order to simplify the study without turning to complex statistical methods, the relationship between score obtained and

patterns of use can be shown by taking the score 4 at random. Almost 16% of those who had used cannabis over the past year scored 4 or higher (4% of the age group, as shown on the graph). Frequency of use is closely linked to the CAST score: 16% of those who had used over the past year scored at least 4, as did 41% of regular users and 58% of daily users. The average score for those who had used over the past year was 1.8; 2.5 for those who had used in the past month, 3.3 among regular users, peaking at 4.1 among daily users. Unsurprisingly, a high CAST score went hand in hand with more frequent use, as well as a rise in the quantity last smoked. Consequently, among users with a score of at least four, 25% had smoked one joint or fewer at their last consumption, 40% had smoked 2 or 3 joints and 21.3% had smoked 5 or more. Corresponding figures for those with a lower score were 53.4%, 30.7% and 8.8%.

Beck, Legleye and de Peretti (2006) summarize the differences in alcohol-related practices and behavioural patterns according to gender. They explain that this differentiation is far from contemporary. In the nineteenth century, abstinence was encouraged in women as a means of stabilising and protecting the family group. In contrast, the masculine image became associated with alcohol consumption as a symbol of strength and virility, and initiation into this world became a rite of passage in itself. This rule is so strongly internalised that it continues to extremes, an example being a population subject to extreme circumstances, such as the homeless (Beck 200- see the specific clarification in 2.3). However, the reduction of inequalities between the sexes has led to a closer affinity in drinking habits over the last few years.

This reasoning can be extended to all psychoactive drugs. Differences in drug use according to gender reflect a gender biased process of education and socialisation, reverting to sexually distinct cultural and symbolic stereotypes. For boys, these are more permissive, and consequently they find themselves in a position which favours all kinds of experimentation.

Lastly, the matter of age: the earlier the age of initiation to a psychoactive product, the greater the likelihood that consumption will become regular. Beyond this simple statement hides a more complex reality concerning the links between frequency of use and dependency on the one hand, and psycho-social, especially familial, instability on the other (Beck 2006a: 192-195; see also the SQ 'drugs among very young people'), which leaves the individual vulnerable to early initiation.

2.2 Drug use among young people and school pupils

The 2005 study is the fifth national ESCAPAD survey (Study of health and behaviour on the call-up and preparation for defence day). It is based on the responses of 29 393 young people living in urban areas, aged 17 at the time of the study, and it gives an idea of developments in the five years preceding the study (Beck, Legleye, Spilka 2006). The first results highlight the following:

- Levels of experimentation in legal products seem to have been decreasing since 2003;
- Tobacco, alcohol, and to a lesser extent, cannabis, are the principal drugs consumed by 17 year olds, and use of other drugs appears to be very low.
- Differentiation according to gender is marked where experimentation with psychoactive substances is concerned.

Over the last thirty days, among the substances studied, alcohol was the product consumed most (around eight in ten young people), before tobacco (around four in ten). Fewer than 3 in 10 17 year olds had recently used Cannabis; 1 in 10 for psychotropic drugs.

Table 4. Use of psychoactive drugs, at 17 years old, over the course of a month

	last 30 days		
	girls	boys	total
Alcohol	75.4	82.0	78.8***
Tobacco	41.0	41.2	41.1
Cannabis	22.5	33.2	28.0***
Prescription drugs	11.8	3.7	7.7***
Ecstasy	1.0	1.7	1.4***
Poppers	1.1	1.6	1.4***
Magic	0.4	1.3	0.9***
Mushrooms	0.4	1.3	0.9***
Cocaine	0.7	1.2	0.9***
Amphetamines	0.6	1.0	0.8***
Solvents	0.6	0.7	0.6
LSD	0.3	0.4	0.4*
Heroin	0.2	0.3	0.2**
Crack	0.1	0.2	0.1*

Source: ESCAPAD 2005, OFDT.

*, **, *** chi-2 test significant respectively at a threshold of 0.05, 0.01, 0.001 for comparison of the sexes

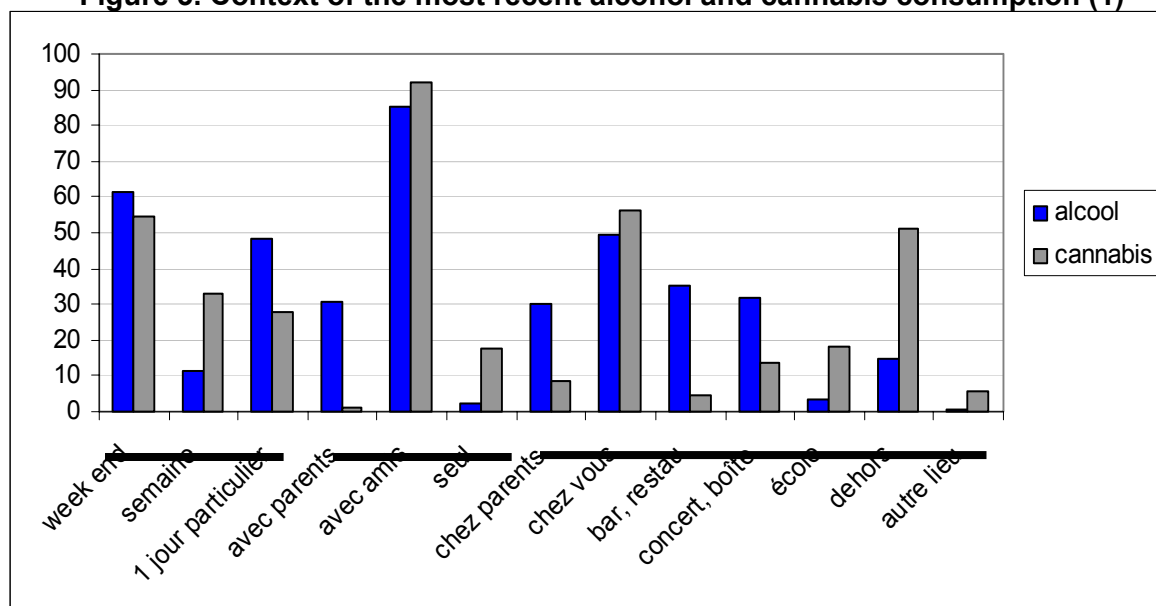
Between 2003 and 2004, the public authorities rigorously increased taxes on tobacco products (from 3.60€ at the end of 2002 to 5.00€ in 2006 for the most widely sold packet of cigarettes). However, few 17 year olds quit smoking in response to these price hikes: between 2003 and 2004 tobacco consumption diminished by 3% for the population concerned. The reduction in daily consumption seems to be due more to a fall in experimentation and in new consumers than to quitting.

Like alcohol consumption, inebriety and binge-drinking are masculine traits: the gender ratio is 1.3 for inebriety over a lifetime, 1.4 for inebriety over the year, and 2.9 for inebriety on a regular basis (at least ten times over the course of the year). At 17, young people primarily consume alcohol at the weekend, and usually at a particular event (a party, birthday or special occasion). The vast majority of this consumption takes place with friends, but a not insignificant proportion is with parents. Incidences of solitary consumption occur very rarely. When consumption takes place with parents, it is on a special occasion in 59% of cases, and when it occurs in the parental home, the parents are present in 82% of cases. Consumption in bars or clubs occurs much less frequently than consumption at home at this age. Lastly, a minority of young people say that the last time they consumed alcohol was at school, and in an open public place (in the street, in a park, etc.) for just over 15%.

Out of all the alcoholic drinks consumed over the past month, beers and premixes⁶ are the most popular, preferred by 57.1% and 48.1% of consumers, before spirits (42.6%), then champagnes and sparkling wines, cocktails, and wine, which finishes in sixth place (28.4%). The order of preference is similar for boys and girls, but distinguishable notably by their three first choices: beer, then spirits and premixes for boys; premixes, then champagne and beer for girls. Premixes figure strongly among these preferences, so careful attention must be paid to the use of these products, and the strategies used to market and promote them. In 1997 they had virtually disappeared, following the introduction of a specific tax, but they reappeared in 2002 thanks to a loophole in the regulations.

⁶ A mix of sugary soft drinks and spirits. Sometimes called 'alcopops', the majority are around 5-8% proof.

Figure 3. Context of the most recent alcohol and cannabis consumption (1)



(1) Percentages calculated for drinkers over the past month and smokers over the past month respectively.
 NB: for each product, the total percentages may be over 100 because more than one response was possible
 Source: ESCAPAD 2005, OFDT
 [weekend/ weekday/ a special occasion/ with parents/ with friends/ alone/ parental home/ home/ bar or restaurant/
 concert or club/ school/ outside/ other... alcohol/ cannabis]

Compared with alcohol, cannabis is much more often consumed during the week, on an ordinary day, and mostly with friends. It is consumed alone much more often than alcohol. Consumption takes place in different locations: consumption in the parental home and in commercial public places (bars, restaurants, clubs) is much rarer. 'In the car' is in the lead over other locations. A large proportion of consumers smoke where others can see them because they lack a place to smoke in private.

Among those who had smoked cannabis in the past year, more boys than girls said that they 'usually' purchased it (49.9% vs. 33.3%) or grew it (12.4% vs 4.5%). On the other hand, girls were more likely to be given cannabis (77.2% vs. 60.4%). The responses were not mutually exclusive: a consumer could vary their means of obtaining a supply according to the opportunities available. However, the proportions of growers and purchasers increase with frequency of use, while the number who are given it decreases. Consequently, 85.9% of daily smokers say that they usually purchase cannabis, regardless of gender; 31.4% grow it themselves, but 34.1% say they still obtain it free of charge, with young girls being the principal beneficiaries (45.0% vs. 29.9%). The order of methods of obtaining cannabis, alongside levels of use, is similar to that observed in the adult population.

2.3 Drug use within specific groups

Psychoactive drugs and the student population.

The data is from the 2000 *Baromètre Santé*, in which 645 of the sample group studied were students. While the public authorities have paid consistent attention to drug consumption among 18-25s for several years, there is little information on the use of psychoactive products in the student population. Compared to the rest of the population aged 18-25, students in higher education have a lower regular consumption of alcohol, but experiment more with inebriety; they use cannabis more widely, but consume less tobacco, and their consumption of psychotropic drugs is the same.

Students constitute a relatively homogeneous sub-group regarding their declarations of psychoactive drug use. Therefore the determining factor in consumption habits is the context of student life and not the level of study. Lastly, among students as among non-students, the differences between the two genders are significant in alcohol, cannabis and drug use. In this respect, the two sub-groups show characteristics similar to those of the general adult and adolescent populations.

The Homeless

In 2001, a study was carried out in France of a group of 4084 French people who frequented shelter hostels or received free hot meals in urban areas of more than 20 000 inhabitants. Within the health section were four questions relating to alcohol consumption⁷. Use of tobacco and illicit drugs was not addressed in the 2001 study of the homeless. Responses to the first question gave an overview of the current consumption of alcoholic beverages. The next three questions were inspired by the clinical test DETA⁸, supposed to raise drinkers' awareness of the risks of dependency on alcohol (Beck 2006). Contrary to certain received ideas, the results, when compared to those of studies on the general population, revealed that alcohol was predominantly consumed in moderation, in contrast with the heterogeneity of this population. The homeless declare themselves alcohol consumers much more than for example people in regular employment. While over-consumption is still a male trait in this group, homeless women eschew the stigma of alcoholism.

2.4 Attitudes to drugs and drug-users

EROPP study. No new information.

⁷ 'Currently, do you ever drink wine, beer or alcohol?' 'often'; 'occasionally'; 'never';

'Over the last twelve months, have you ever felt that you need to reduce your alcohol consumption?'

'Over the last twelve months, have people around you ever commented on your alcohol consumption?'

Over the last twelve months, have you ever felt the need to drink in the morning to be at your best?'

⁸ '*Diminuer, Entourage, Trop, Alcool*'. A translation of the American test 'CAGE' (Cut down, Annoyed, Guilty, Eye-opener').

3. Prevention

Prevention: An Overview

(Cf. national report published in 2004 for further details)

Legislative framework:

The domain of drug prevention is not covered by French legislation. The founding law in the fight against drugs- law no. 70-1320 of December 31 1970- does not address it. The only exceptions in this area are the 'Évin' law of January 10 1991⁹ - regulating alcohol and tobacco use in public places and in advertising- and the Ministry of Education's national circulars, supporting the prevention of exposure to risk since 1990.

Today, two principal official texts shape current prevention policy in France and set the principal of harmonising and generalising prevention via a programme throughout the school curriculum, from primary school to middle school in particular:

- The 2004-2008 government plan to fight against illicit drugs, tobacco and alcohol, which emphasises prevention in terms of cannabis and tobacco at school, aiming to create the ideal conditions for adapted and effective prevention at all levels of education ;

-The 2003-2008 five-year prevention and education plan, drawn up by the national Ministry of Education¹⁰.

Also worth mentioning are the national initiative to fight cancer 2003-2008- which inspired real momentum and fund-raising for anti-tobacco activity- as well as the public health policy scheduling law of August 9 2004. This last set up a compulsory annual meeting in secondary educational establishments to discuss prevention, and fixed, among other things, objectives for reducing passive smoking in educational establishments, leisure areas and professional environments.

Policy Coordination, from national to local level:

Since 1999, the fight against drugs has been extended to legal psychoactive substances such as alcohol, tobacco and psychotropic drugs. It upholds two strong principles: early intervention with young people, to delay the age at which consumption begins, and intervention which not only aims to prevent use, but attempts also to limit abuse.

Driving and coordinating drugs prevention policy is the work of the MILDT. National guidelines are defined by the governmental plan, which is under the MILDT's care. In each ministry concerned, a service coordinates prevention goals between national and local levels, and addresses the subject with the MILDT.

Variations in national guidelines at a local level are based on decentralised State services, specifically on the drug policy plan coordinated by the MILDT. At the heart of the plan, each department nominates a 'drugs and dependency' project manager (CPDD) – taken from the prefecture- and a coordinator of decentralised services¹¹. The project manager defines and runs departmental prevention policy. To do this he has funds at his disposal, set aside for dependency prevention and to train professionals and consult local institutions (State services, judicial

⁹ Law no 91-32, January 10 1991 relative to the fight against smoking and alcoholism, JO January 12 1991, p4148 (NOR: SPSX9000097L)

¹⁰ Established by circular no. 2003-210 of December 11 2003; NOR: MENE0302706C.

¹¹ The partner function was instituted in 2004. Project managers posted in regional capitals ensure coordination at a regional level, especially regarding care.

authorities, territorial collectivities,¹² and main local firms if possible), in order to coordinate the goals of public figures and to determine financing.

At the same time, measures set up for territorial and trans-sectorial coordination, addressing health or social exclusion (PRSP), security or town policy (CLS, CEL)¹³ allow public funds to be distributed unambiguously.

In the educational environment, heads of establishments annually set preventative measures for pupils. Although they have some autonomy in the matter, they receive recommendations from their regional administration (rectorat) that come from ministerial guidelines. The majority of secondary schools have a Committee for health education and citizenship (CESC), involving the teaching community and external figures (companies, institutional figures, etc.) to coordinate prevention within their sphere.

Some benchmarks in the French prevention plan

Drug prevention has always been part of a philosophy of extending communal rights and services guaranteed by the State or delegated to the non-profit sector, depending on community resources (local decision-making and interventional levels). Thus the majority of actions for dependency prevention are based on universal prevention and unfold in the educational system, generally involving the educational community as much for coordination as for running the actions.

However, by identifying priority zones for intervention (ZUS or ZEP¹⁴), using socio-economic indicators, such as standards of accommodation or education (number of pupils behind in their schooling; number of subsidised pupils) supplementary funds can be directed towards underprivileged groups. 'Selective' or 'indicated' prevention is principally the act of specialised associative figures (note that the terms 'selective' or 'indicated' prevention are not common in France).

Drug prevention was characterised by little real State interventionism until the distribution of a guide to intervention in the school environment in 2006. However, thanks to various initiatives to make the domain more professional and harmonise the principles of action, certain approaches are being introduced: not just information on the risks, but interactiveness, development of psychosocial skills... However the modus operandi of psychosocial experts still seems hazy to many people.

Sustainable plans for prevention or for support from decision-makers and professionals:

There are several permanent structures or programmes for prevention:

- The national telephone helpline 'Drugs, alcohol, tobacco info service' (DATIS);
- The itinerant information and addiction prevention campaign organised by the anti-drug Mission (MILAD, Ministry of the Interior), which visits many schools and travels the French coast in the summer period.
- Listening Points: support, orientation and mediation structures for young people with problem drug use, and/or their parents ;

¹² Decentralised administrative bodies, either departmental or regional, that are autonomous and have their own jurisdictions, for example health, social work for children or protecting children.

¹³ PRSP: regional public health programmes that replaced the PRS (regional health programmes) and the Regional programmes for access to prevention and care for people in unstable situations (PRAPS); CLS: local security contracts; CEL: local educational contracts.

¹⁴ ZUS: sensitive urban zones; ZEP: educational priority zones

- Reception and counselling points for young people (PAEJ): more generalised, they are dedicated to young people at risk (unstable employment, homelessness) and their friends and family and aim to fight social exclusion.

Prompted by their sources of funding, there are many professional bodies involved in prevention. In the public sector, only the services charged with implementing the law train specialists who, at the request of schools or other establishments, are available to meet the public, young or adult. These are called FRAD, Educator Members of the State Police, and PFAD: Police anti-drug trainers.

Decision-making networks and professionals who use support structures

- The national Institute for prevention and health education (INPES) has a mission for expertise, development of prevention practices and implementation of national programmes (especially media campaigns).

- Regional centres for information on drugs and dependency (CIRDD) provide technical support for drug and dependency project managers and for administrative bodies, through their functions of documentation and methodological advice on developing projects and observation, particularly where prevention is concerned.

- 'Toxibase', a network for information on drug addiction, which also manages a directory of francophone resources relating to different areas of prevention.

- The Commission for validating preventative tools, coordinated by the MILDT, which provides an opinion on the quality of tools which are submitted to them, to encourage reliability and coherence of talks given.

In order to be represented in public debate and to promote professional communication, specialised associative figures are grouped into federative organisations –FNES, ANPAA, ANIT FFA, CRIPS¹⁵. All these associations organise training, conference cycles, discussion groups or networks of information linked to the prevention of psychoactive substance use.

Observation of prevention today:

France does not have an efficient system for observing prevention. Currently, this system is hindering any attempt to set up a rigorous national prevention plan in France, even with the explosion of information systems, operators and sources of funding. It explains the predominance of support groups and services within the description of national strategies in this report.

However, an observation plan based on the CIRDD network is being considered for 2006.

3.1 Universal prevention

In France in 2005, there was no monitoring system capable of giving exhaustive information on prevention activity. The existing tools for providing information had a primarily administrative purpose, in other words, they supported requests for subsidy or tracked financing.

¹⁵ FNES: National federation of health committees in education (www.fnes.info); ANPAA: National association for prevention in alcoholology and addictology (founded in 1872, www.anpaa.asso.fr); ANIT: National association of intervenants in drug addiction (www.anit.asso.fr); FFA : French federation of addictology (www.addictologie.org); CRIPS: Regional centres for information on and prevention of AIDS (www.lecrips.net/reseau.htm).

In order to make up for this deficiency, the OFDT has set up a centralised system to monitor drug prevention activity (ReLION), based on the network of Regional information centres on drugs and dependency (CIRDD). It aims to test a protocol for monitoring a little known element of the prevention process: activity which does not form part of the permanent activities of the long-term prevention structures. All the institutions where there is a demand for prevention are concerned: NGOs, primary schools, secondary and higher educational institutions, the Police and the Gendarmerie, Juvenile detention centres, prevention services provided by CLAMs and mutual insurances companies, all educational, social and health structures and firms situated in the region, among others.

A trial study was carried out from February 2005 to March 2006 by CIRDDs in Alsace, Burgundy and Brittany. Its conclusions were positive and prevention agency monitoring is due to be applied nationwide in 2007.

National policy on prevention in the educational environment

The governmental plan and the 2003-2008 prevention and education programme from the national Ministry of Education both allow for national prevention programming in the school environment. With this in mind, the MILDT and the national Ministry of Education, aided by several institutional partners, have developed a guide to intervention in school to prevent addictive behaviour. After being tested in 80 educational establishments the guide can now be accessed on the sites www.drogues.gouv.fr and www.eduscol.education.fr, and will be distributed in all the primary schools, middle schools and high schools in France.

After an introduction which details the guide's objectives and recalls the general context of its use- particularly the code of ethics of intervention in the school environment - two sections follow that mix theory with technical points.

The first section 'reference point for interveners' brings together facts to help with dialogue and choosing an approach. The components are chiefly factual- epidemiological data on use in France and the European Union; 'fact files' on each drug; ideas on the neurotoxicology of drugs; geopolitical data, a reminder of the law and available resources – all keys to addressing the subject in the light of adolescent psychoaffective development. A section on evaluation completes this first section of the guide.

The second part of the document addresses prevention 'sessions'. Aimed more at aspects of method and organisation, this part contains four intervention plans in 4 sessions, depending on the age of the pupils, each one proposing a division of actions into logical steps:

- An intervention plan in 4 sessions for pupils in CM2 and 6^{ème}¹⁶ (for pupils of 11-12 years old on average), tackling tobacco in particular;
- A second for pupils in 5^{ème} and 4^{ème}¹⁷, (for pupils aged 13-14 years on average), tackling alcohol in particular ;
- A third for pupils in 3^{ème} and 2^{nde} ¹⁸(for pupils of 15-16 years on average), aimed particularly at cannabis;
- The last for pupils in 1^{ière} and Terminale¹⁹ (for pupils aged 17-18 on average), tackling polydrug consumption in particular.

These are followed by appendices, notably a summarization by INPES on scientifically validated programmes and approaches.

¹⁶ The last year of primary school and the first year of middle school, corresponding to 4th and 5th grades.

¹⁷ The two intermediate years of middle school, corresponding to 6th and 7th grades)

¹⁸ The last year of middle school and the first year of high school (corresponding to 8th and 9th grades).

¹⁹ The last two years of high school (corresponding to 10th and 11th grades).

Universal prevention aimed at communities

The recreational environment:

The only new event on this subject since 2005 is the adoption of the decree of April 14²⁰, which introduced a national frame of reference for risk reduction linked to drug use. This decree prohibited testing practices which did not allow 'identification of the substances entering into the composition of tablets', in line with recommendations set out in the governmental plan to fight drugs. Preventative action on the party scene should conform to this frame of reference for intervention.

In practice, Marquis testing is prohibited. During the Teknival Bretagne (July 2005), the Médecins du Monde association ran a stand offering another kind of testing, by thin layer chromatography (TLC), against the will of the departmental authorities. While the Ministry of Health had ruled in favour of the organisation, the interpretation of test results is a laboratory practice and should be checked by a doctor, something which is still not routine today.

Telephone helpline:

DATIS' activity has fallen significantly since the telephone number was changed in 2004, a decrease in calls which continued in 2005.

From January 1 until 31 December 2005, DATIS received 377401 calls: 328521 for the Drugs Info Service ; 36945 for the Cannabis Listening line and 11835 for Alcohol Advice. Calls that were dealt with add up to a total of 190228, and are shared out as follows: 166627 calls for the Drug Info Service (DIS), 18582 for the Cannabis Listening Line (EC) and 5019 calls for Alcohol Advice (EA). More than 90% of the calls were considered 'live', (in that they were identified by the service as genuine). In the three cases users and their friends and family made up more than 90% of calls, and less than 5% were from professionals.

Table 5. Division of DATIS calls according to type of caller, 2005.

Category	Callers	%
User	28612	49%
Friends and family	24589	42%
Member of the public	3618	6%
Professional	2133	4%
Total	58 952	100%

Source: DATIS.

The 58952 calls in table 5 are all genuine. The majority were made by women (58.7% versus 41.0%, the rest being unknown). The data itself does not however does not show whether a call was the result of the acknowledgement of a drug problem, followed up by a consultation, or simply an enquiry from a friend or family member.

Cannabis, alcohol and tobacco are the products most often mentioned (42.6%, 35.3% and 14.4% respectively- allowing that several products could be mentioned per phone call). The proportion of prescription drugs is notable (10.1%). Heroin, cocaine and substitution drugs followed, but with a much lower representation.

²⁰ Decree n° 2005-347 of April 14 2005, approving the national frame of reference on risk reduction actions aimed at drug users and completing the public health code, NOR: SANP0521129D.

Budget

As detailed in part 1.3, the current structure of the MILDT budget, in use since 2005, does not allow for the itemisation of each budget area.

3.2 Selective Prevention

Cannabis is the most widely used psychoactive product in France, especially among young people. It has continued to rise in predominance since the 1990s: in 2003, 1 in 10 girls and 1 in 5 boys aged 17-18 used it regularly. Declared use of the drug has stabilised at a high level, as the latest studies of the general population show (see chapter 2). From February 2005, 250 cannabis consultation centres, announced in the governmental plan, opened throughout French territory. Aimed at young people and parents of young people with problems related to their consumption of cannabis or other drugs, these drop-in support centres are anonymous and free of charge.

Data from a study of these centres allows an overview of cannabis use habits to be built up (Obradovic 2006). From March 2005-February 2006, 15200 consumers and 1240 of their friends and family attended these centres. Their consumption was evaluated on a four point scale: occasional use, frequent use, harmful use, dependency. However, 13% of these consultation did not use any evaluation tools (58% used one; 20 used two; 12% used three or more).

In 80% of these cases, the consumers were boys, and 90% were aged between 14 and 25. In 38% of consultations, they had been sent by the Courts ; 31% went of their own accord, and 31% at the suggestion of a third person. Among the under 20s, 50% of consultations were prompted by a third person. In the 20-28 age group, 46% of consultations were the result of a court decision. At 29 or older, most attended of their own accord (in more than 60% of cases). Girls were more comfortable making their own approach, while boys were primarily directed by the Courts.

75% of those who made their own approach were dependent or consuming in a harmful way. Those sent by the courts were generally occasional consumers, or consumers at risk. Those who went at the suggestion of a third person were occasional or so-called 'problem' users. The frequency of use declared in the study is linked to how early they began experimenting, and, in general, those attending the centres began at an earlier age than that observed in the general population.

45% of consumers visiting the centres were daily cannabis users, 20% were regular users (10-29 times in the month preceding the study) and 35% occasional users. More than a third of consumers were considered dependent. 53% of daily users smoked 5 or more joints per day. Cannabis use correlates with tobacco consumption (90% of regular users and 93% of daily users smoked tobacco) and alcohol (20% of cannabis users drank regularly: 27% of daily users, 23% of frequent users and 8% of occasional users).

Consumers attended an average of two consultations. 23% were seen twice, 21% three or more times, 9% five times or more. The data reveals a high drop-off rate after the first and second consultations.

4. Problem Use

Problem use: an overview

Estimated prevalence: several methods were used in France to produce a national assessment of the prevalence of problem heroin and cocaine use in 1999 (Costes, 2003). Depending on the method, the number of problem users of opioids and cocaine is between 150 000 and 180 000, corresponding to prevalence rates of 3.9 per thousand to 4.8 per thousand among the population aged 15-54. In 1999, local assessments of opioid and cocaine use (heroin, Skenan®, Subutex®, methadone and cocaine) were carried out simultaneously in five French towns, using a capture-recapture study. Assessing the age group 15-59, the rate varied from 15.3 per thousand persons in Nice to 6.5 per thousand in Toulouse (Chevallier 2001) [epidemiological table no. 8].

In 2005 and 2006, the New Multicentric OFDT Study (NEMO) was carried out, to produce local assessments of the prevalence of problem use of opiates, cocaine and other stimulants, in six French cities (Lille, Lyon, Marseille, Metz, Rennes and Toulouse) and one overseas department (Martinique). These local assessments will be used to build up a national assessment of the prevalence of problem drug use. The results will be available in 2007. Currently, there are several validated tools in French that enable abuse or harmful use in adolescents and young adults to be evaluated. These comprise two tests translated from English and one test created by the OFDT, specifically on cannabis: the CAST (Cannabis Abuse Screening Test).

Until there is an official European definition, the French definition of problem cannabis use is as follows: 'use liable to damage the health and social welfare of the user and of other people significantly.'

In 2004, a system to record requests for treatment was set up in France, in line with European protocol [TDI; epidemiological table nos. 3 and 4]). The public Collection on addictions and people under care (RECAP) makes individual data available. This data is collected continuously from all patients under the care of Drug Addiction Treatment Centres (CSST), and is in theory exhaustive. There are three types of Treatment Centre: outpatients, hostels, and secure environments. The first RECAP results, which outpatient CSSTs were able to use, revealed the socio-economic traits and consumption habits of drug users who began treatment between January 1st and December 31 2005. Analysing the RECAP data also allows a more specific profile to be drawn of patients undergoing treatment for the first time (first time-patients).

A targeted study was carried out on users attending 'front line'²¹ structures (reception centres and needle exchange programmes), known as the 'front line' study, and carried out in the twelve sites covered by the French Observation of Recent Trends programme (TREND). It provided the means to build a profile of users attending front line structures.

In 2003, among users of 'front line' structures, the illicit substances consumed the most over the past month, apart from cannabis were, in descending order: cocaine hydrochloride, ecstasy, heroin and amphetamines. BHD and benzodiazepines were consumed by a significant proportion of people (Bello et al., 2003; Bello et al., 2004).

²¹ Professionals prefer this denomination to the more common one of 'floor level' structures (needle exchange programmes, reception centres...). The two terms are equivalent.

Based on observations of different social groups at risk of use, it was stated in 2003 that cocaine use was becoming more widespread and affecting more diversified social profiles. Equally, ecstasy use is observed more and more among street users in urban areas. Hallucinogens also seemed to be consumed more and more by the youngest user group (Bello et al., 2004).

Incidences of BHD misuse have been identified, apparently facilitated by the availability of the product on underground urban markets. Injecting and snorting of this product has emerged among users of 'front line' structures, as has non-substitutional use (primo-use and primo-dependency) (Cadet-Tairou et al., 2004a; Bello et al., 2004; Bello et al., 2003; Escots et Fahet, 2003).

Since 2001, recent injecting has decreased, while snorting has increased (Bello et al., 2003, Bello et al., 2004, Palle et al., 2003; Marseille CEIP, 2004). But information gathered in the field in 2003 tells a different story: some TREND network sites report a reduction in intravenous use, while others observe that injection has a certain appeal for younger groups (Bello et al., 2004).

Among those who had injected in the past month, almost 25% in 2003 had shared their equipment. Among snorters, three quarters had shared their drugs and 45% their straw (Bello et al., 2004).

New developments in the methods of consumption can be seen in the [epidemiological table no.17]

4.1 Prevalence and estimated incidence

No new information available

Problem cannabis use

See section 2 (overview of cannabis use).

4.2 Profile of people receiving treatment

In 2005, 94 Drug addiction treatment centres participated in RECAP, that is 44.8% of outpatient care centres. The data gathered concerned almost 21 000 patients who had begun a course of treatment during the past year. A third of them were first-time patients, or people who were seeking treatment for the first time. Others were seeking treatment again or recommencing treatment after an interruption in contact with the treatment centre of more than six months. The figure for first-time patients within the whole group of patients should be treated with caution, since information on the existence of previous care is not available in 40% of cases.

In the descriptions of consumption habits presented below, account must be taken of the fact, that, in responding to questions on the principal drug, around 7% responded 'no drug consumed'.

Patients in treatment (All treatments): Profile

80% of the patients are male, and aged 28 years on average, with three quarters aged between 15 and 35. The age range with the highest representation is the 20-24 group, and 41% of the patients were less than 25 years old. The over 40s make up around 11%. The distribution according to age is detailed in Table 6.

Table 6. Distribution of patients by age (in %) in 2005

Age	All treatments	First treatments
< 20 years	16.58	28.70
20-24 years	24.72	34.10
25-29 years	18.99	17.88
30-34 years	16.54	9.72
35-40 years	12.30	4.97
40 +	10.59	4.63
Total	100.00	100.00

Source: RECAP / OFDT - 2005

A third of patients seek treatment themselves, 26% of treatments are prompted by a court or police decision, and 11% are suggested by a family member or friend. Results on the reasons for care are presented in Table 7.

Table 7: Distribution of patients according to the reason for care (in %) in 2005

Reason for care	All treatments	First treatments
Patient's own initiative	33.10	24.79
Family or friend	11.24	11.48
Other specialised centres for drug users	10.47	5.77
GPs	5.64	6.08
Hospital or other medical establishment	5.80	4.48
Social services	4.89	3.88
Police, courts or sentencing	26.11	40.04
Other	2.74	3.49
Total	100.00	100.00

Source: RECAP / OFDT - 2005

The majority of patients lives with their parents or alone (42% and 2%) and most has a stable housing situation (75%). However, 23% stated that they lived in unstable housing conditions. Regarding socio-professional situations, 44% of patients were economically inactive or unemployed, on 23% had a regular job and 17% were still at school or students (Table 8). As far as educational levels are concerned, 63% of those in care at drug addiction treatment centres had reached secondary school level. Only 5% of users had not finished primary school and 31% stated that they were educated beyond the baccalaureat.

Table 8: Distribution of patients by professional situation (in %) in 2005

Professional situation	All treatments	First treatments
Regular job	23.09	25.32
Student or school pupil	17.23	26.77
Not economically active (e.g. housewife)	21.75	13.78
Unemployed	21.88	16.97
Other	16.05	17.18
Total	100.00	100.00

Source: RECAP / OFDT - 2005

Drug consumption

Almost half the patients (48%) turned to treatment centres in 2005 for problems linked to cannabis use. They were aged on average 23 and a half. Next came problems linked to use of opioids, mentioned as the principal drug for 40% of people, with an average age of just under 31. 78% were heroin addicts and 22% consumed methadone and other opioids (BHD)²². Cocaine is the third main drug : it was mentioned by 5.7% of patients, with an average age of almost 32. Table 9 shows in detail the distribution of patients and their average age according to the main drug of which they declared themselves consumers.

Out of all the patients who sought treatment in 2005, almost three in four people (73%) declared that they had never used injection as a means of consumption. For 14%, the intravenous duct had been used, but not recently, and 13% stated that they had injected a drug during the month before the interview.

Table 9: Distribution (in %) and average age of patients according to the principal drug

Principal drug	All Treatments		First Treatments	
	%	Age	%	Age
Opioids	39.79	30.77	24.14	27.68
Heroin	31.13	30.15	20.17	26.90
Methadone	1.21	31.54	0.39	27.33
Other opioids	7.45	33.24	3.59	32.17
Cocaine (total)	5.75	31.69	3.92	28.64
Cocaine	4.22	30.18	3.46	27.90
Crack	1.53	35.87	0.46	34.22
Stimulating agents	1.14	26.83	1.29	23.40
Amphetamines	0.25	28.57	0.21	23.13
MDMA and derivatives	0.88	26.34	1.08	23.45
Stimulating agents	0.01	41.00	0.00	0
Hypnotics and sedatives	2.63	34.39	0.93	35.50
Barbiturates	0.11	31.89	0.05	23.50
Benzodiazepines	1.90	33.95	0.57	34.86
Other opioids	0.62	36.20	0.31	38.67
Hallucinogens	1.23	26.54	1.34	25.35
LSD	0.21	26.60	0.21	26.25
Other	1.02	26.52	1.13	25.18
Glue and solvents	0.26	29.23	0.21	28.63
Cannabis	47.96	23.60	67.29	22.29
Other drugs	1.24	31.37	0.88	26.00
Total drugs	100.00	30.31	100.00	24.15

Source: RECAP / OFDT - 2005

57% of patients use cannabis daily as their main drug, 16% use it frequently (consumption two to six days per week), 10% infrequently (once a week or less) 16% occasionally. Almost nine in ten opioid users consume on a daily basis (77%) or several days a week (12%). Two

²² In the case of methadone and HDB, this means consumption not for therapeutic use.

thirds of cocaine use is daily (4%) or frequent (several days a week, 25%). The most frequent methods of consumption for opioid users were snorting (46%), then injection (31%). Cocaine is primarily snorted (47%) and smoked (37%), but a not insignificant proportion of patients inject it.

First treatments: Profile

The profile of patients undergoing treatment for the first time (first treatments) is slightly different from the group of patients as a whole. They are younger: 24 years old on average, with 63% under 25 (Table 6); the majority lives with their parents (54%) and has stable housing in 85% of cases. More than half of all in first time treatment have a regular job (25%) or are still at school or studying (27%) (see table 8). Their educational level appears to be slightly higher. The patients come for treatment after a court decision in 43% of cases, 24% come of their own accord, and 12% come at the suggestion of a friend or family member (see table 7).

Drug consumption

With the opening of 'young consumers' consultations, and given the profile of new patients, it is not surprising that in 2005 cannabis was the main drug for more than two in three new patients, aged around 22. Following were opioids (24%) and cocaine (4%). First treatment users of opioids were on average just over 28 years old, and those who came because of problems linked to cocaine use were just over 29 (see table 9).

In 2005, 90% of people in treatment for the first time in their life had never used injection as a method of consumption. The remaining 10% were divided equally between 'recent injectors' and those who had used this method in the past.

In terms of how frequently the main drug was consumed, the distribution among first time consultants was very similar to that of the patient group as a whole.

Users of opioids who sought treatment for the first time predominantly used snorting as a means of consumption (59%). Injection was the second favourite method for 18%. Snorting was also more common among first time patients who used cocaine (62%). In 27% of cases users smoked cocaine, and 8% injected.

Conclusion

The RECAP data seems to reflect the heterogeneity of the population attending outpatient drug addiction treatment centres, with a notable polarisation: on one hand, patients undergoing opioid substitution treatment, and on the other, young people attending because of problems linked to cannabis consumption. These last are strongly represented in the sub-group of first time patients, the vast majority of whom are young cannabis users.

Cannabis users in care are predominantly young daily or frequent consumers. Nonetheless, the proportion who consume infrequently or occasionally is significant (25%).

The preponderance of demands for care in drug addiction treatment centres for problem cannabis use can be explained, amongst other things, by:

- The creation, in numerous drug addiction treatment centres, of specialised counselling for young consumers of cannabis or other products²³;
- The importance of care following court decisions.

The number of demands for treatment of problem opioid use remained high, and came from older people. Recent injection (within the past month) was the principal means of consuming the drug for 13.5% of users. However, if users whose principal drug is cannabis are excluded, the proportion of patients who choose to inject reaches almost 25.4%.

Among first time patients, the proportion of injectors is low (4.6%). However, among users of drugs other than cannabis, 13% had recently injected.

²³ In the context of the *Government plan to fight illicit drugs, tobacco and alcohol 2004-2008*, 'young consumer consultations' were set up to respond to young people who were possibly struggling with their consumption of cannabis or other drugs. 75% of these consultations were begun in a drug addiction treatment centre.

5. Treatment

Treatment: an overview

Where treatment is concerned, the public authorities' strategy is to offer a diverse range of therapies and services, with the aim of enabling each person to receive the response best adapted to his or her needs, and thereby commit to improving the quality of care. Three systems contribute to the treatment of illicit drug consumers: a care system specialised in addictology (medico-social establishments), the general care system (hospitals and GPs) and the risk reduction system.

1. The specialised system

Treatment of illicit drug addictions has since the early 1970s been based on specialised structures. These structures were developed after the adoption of the 1970 French drugs law which included clauses to guarantee anonymous and free treatment to all illicit drug consumers who wished to be treated. Virtually all departments in France now have at least one specialised care centre for drug addicts (CSST).

Originally financed by the State, and since January 1 2003 by social insurance companies acting as medico-social establishments, the mission of these structures is to ensure joint medical, social and educational care which includes help with rehabilitation or reintegration.

There are three types of Drug Addiction Treatment Centres:

- Centres for outpatient care (numbering 204 in 2003)
- Care centres involving communal accommodation (numbering 48 in 2003);
- Secure care centres (numbering 16 in 2003).

The outpatient Drug Addiction Treatment Centres respond to the withdrawal demands of outpatients. They can also organise and accompany patients who wish to try detoxification themselves off the drug in a hospital environment. Where substitution is concerned, the Drug Addiction Treatment Centres were, from 1993/4 until fairly recently (2002) the only establishments where a patient could begin methadone treatment. Their prescription could subsequently be passed on to the town doctor. Patients could also be prescribed BHD by a Drug Addiction Treatment Centre. Moreover, within the system patients could seek support, psycho-therapeutic accompanying and help with social rehabilitation.

In France, the concept of 'Drug free treatment' is not really used, and it is difficult to make it correspond to a type of institution or treatment. However, the new five-year plan 2004-2008 recommends developing programmes without substitution, particularly therapeutic communities.

2. The general system

The development of a specialised care system does not necessarily meet all the care needs of illicit drug consumers. During the 1990s, emphasis was placed on improving reception of patients arriving in the general system (hospitals and GPs) with addiction problems.

2.1Hospitals

Treatment of addictions within hospitals (health establishments) is based on addictology care and liaison teams, town-hospital networks, and hospital beds

being made available for detoxification and for creating a medical-psychological-social balance.

Created by the circular of April 3 1996, addictology liaison and care teams are basically composed of three people, including a hospital doctor, and their mission is to train and to assist hospital care teams, to develop care protocols and to intervene with hospitalised patients and in emergencies. These teams must also develop links with the care system allowing the medical, psychological and social monitoring of the patients. They lead activities for prevention, information and raising awareness within the establishment. In 2003, around a hundred health establishments were equipped with active liaison teams. However, a large proportion of the activity of these teams is occupied by alcohol and tobacco addiction problems.

Hospital-town networks were also created by the circular of April 3 1996. In 1998, 67 networks were counted, spread throughout the country; in 2002, 114 addiction networks were listed, of which 107 were in cities. They were jointly financed by health-insurance funds and the State.

Lastly, and significantly, since 2002 every doctor practising in a health establishment is authorised to prescribe methadone.

2.2 General Practitioners

Today, GPs play a central role in prescribing opioid substitution therapy. Since 1996, they have been permitted to prescribe BHD to patients dependent on opioids. They can also prescribe methadone once treatment has been started in a Drug Addiction Treatment Centre.

GPs are moreover in a position to intervene first with patients who are just beginning to consume illicit drugs. Consequently, the public authorities plan to set up training programmes aimed at GPs, to encourage them to monitor this consumption and to use tailored methods of intervention.

On the basis of data from the Primary Medical Insurance Fund, (CPAM), taken in 13 different towns, it was established that 35% of GPs prescribed a course of substitution treatment during the second half of 2002. However, the act of prescribing, whether methadone or BHD, was often concentrated on a restricted number of doctors. The average 'standard dose' received by a patient on Subutex® substitution is from 9.6mg (maximum recommended amount 16mg/day), and 98.4mg for a patient on methadone (recommended maximum 100mg/day) (Cadet-Taïrou and Cholley, 2004).

3. Risk reduction system (see box 7 'response to health problems')

Epidemiological table no.21 shows the various treatments offered in France and their availability. Structured questionnaire no. 27 provides complementary information on available treatment programmes. Care based on opioid substitution treatment is relatively recent in France (1993) and was motivated by the need to combat the HIV epidemic. In 2003, the estimated number of people undergoing treatment was between 63 000 and 69 000 (Cadet-Taïrou et al., 2004b) : less than half the estimated number of opioid consumers in France.

Town doctors were authorised to prescribe methadone substitution treatments in 1995, after initial treatment in a specialised centre. The number of people receiving methadone substitution from their GPs was estimated at between 11 200 and 16 900 in 2003 based on sales figures (SIAMOIS/ OFDT).

On the grounds that access to substitution treatment via specialised centre is not sufficient to meet care needs, a concurrent BHD-based therapy was introduced in 1996. Procedures for initiating treatment and prescription are more flexible than

for methadone: any doctor is authorised to prescribe it with no particular conditions attached: the maximum prescription is for 28 days, divided into 7-day doses, unless expressly instructed otherwise. In 2002, between 71 800 and 84 500 people received Subutex®. 'Among them, a maximum of 52 000 had been undergoing treatment for at least 6 months; at least 22 000 were beginning treatment or were on 'intermittent substitution', and 6% (5000) people were selling on a significant amount' (Cadet-Tairou et al., 2004b)

Alongside the beneficial effects observed since substitution treatment was introduced (positive health and social impact), some undesirable consequences have been recorded, almost exclusively linked to BHD. These incidences of misuse are essentially linked to the flexibility of prescribing the product. They involve: injection of BHD, even in patients under medical supervision; use outside medical protocol (non-substitutional use) and use in conjunction with other drugs (benzodiazepines, alcohol...).

5.1 System

No new information available

5.2 "Drug free treatment"

No new information available.

5.3 Medical treatments (detoxification, substitution)

Detoxification carried out or accompanied by Drug Addiction Treatment Centre staff

In 2004, an average of nearly 17 patients per structure followed an outpatients detoxification programme at a Drug Addiction Treatment Centre (Table 10) and around 10 patients were weaned in a hospital environment, in partnership with a centre. The average number of patients who followed an outpatients programme seems to have increased significantly between 2003 and 2004. A new activity report was used in 2004 in which the question on detoxification by reducing the dose of prescription substitution drugs was removed. This may have caused changes to this figure. It is possible that a number of the positive responses to this question were transferred to the question on outpatient detoxification. There was no question on detoxification in hospital contained in reports preceding 2004.

Table 10. Average number of patients having undergone detoxification at a Drug Addiction Treatment Centre, 1998-2004

	1998	1999	2000	2001	2002	2003	2004
Average number per drug addiction treatment centre of patients who followed an outpatients detoxification programme in conjunction with the centre.	6.8	5.7	6.2	8.4	10.6	11.0	16.8
Average number of patients per drug addiction treatment centre who followed a detoxification programme in hospital, accompanied by the centre.	nd	nd	nd	nd	nd	nd	10.3

Source: Interpretation of typical activity reports of outpatient drug addiction treatment centres 1998 – 2003, DGS/OFDT.

Key: Per drug addiction treatment centre, an average of 6.8 patients underwent outpatient detoxification supervised by the centre in 1998. Note: Calculations exclude structures which had carried out more than 150 detoxification programmes or which did not respond to questions on their activity. The total number of patients who followed a detoxification programme is calculated by finding the average number of detoxifications throughout all the centres that have a file of under 150 patients currently undergoing treatment. To this figure is added the total for centres excluded from the first calculation because of the size of their active file of patients having undergone treatment.

According to data provided by the drug addiction treatment centres, the number of patients who underwent detoxification treatment in 2004 can be estimated at around 7500. A certain number of detoxification programmes are also carried out in hospitals without the aid of the centres, but current information systems do not allow this to be calculated satisfactorily.

Substitution

Patients supervised in Drug Addiction Treatment Centres

An average of 65 patients per structure have been prescribed methadone via a Drug Addiction Treatment Centre, a number barely lower than in 2003, even taking account of errors in calculation. For 2004 this is based on the responses of 154 Drug Addiction Treatment Centres. Almost 50 patients on average were prescribed BHD. The 2004 figures seem to confirm stabilisation of the number of patients who had been prescribed methadone by the Centres, and a downward trend in the number of patients who were prescribed high dosage buprenorphine. The total number of patients who received a substitution treatment prescription from a Drug Addiction Treatment Centre in 2004 can be estimated at around 26 000 (just under 15 000 for methadone and slightly over 11 000 for BHD).

Table 11. Average number of patients per structure who were prescribed a substitution treatment within the structure, 1998-2004.

	1998	1999	2000	2001	2002	2003	2004
Average number per structure of patients being treated with methadone	35.1	46.9	50.0	59.3	69.1	69.7	64.9
Average number per structure of patients being treating with BHD	41.4	48.5	50.4	51.9	57.2	54.7	45.9
Average number per structure of patients receiving other substitution treatments	2.9	2.5	3.4	1.9	1.7	3.9	0.9

Note: figures revised in relation to data 1998-2001.

(1) Structures that provided data on their activity. Moreover, data was not taken into account from the two Treatment Centres where the active files were larger than 1400 people and whose presence or absence in the database is likely to make the results vary significantly from year to year. Lastly, still with concern for consistency of data, figures from 2004 from the methadone bus.

Source: *Interpretation of typical activity reports of outpatient Drug Addiction Treatment Centres 1998 – 2003, DGS/OFDT.*

6. Health consequences

Health consequences: an overview

Mortality linked to drug use:

Information available in France comes from several systems that each covers some of the causes of drug-related death. These are deaths by :

- by overdose, when the death is the object of a judicial procedure (OCRTIS) [epidemiological tables no5 and no. 6]. This statistical source only covers deaths which are reported to the police service or the national Gendarmerie; it does not include deaths of French nationals by overdose recorded abroad and deaths in hospital.

Since 1995, the number of deaths by overdose recorded by the forces of order is in continuous decline (-80% from 1995-2003). This trend is apparently due to a combined effect of the introduction of new substitution treatments, the existence of structures and systems to reduce risk, and the modification of drugs and methods of consumption among users. The majority of deaths by overdose recorded by the forces of order are linked to heroin, but over the last two years, cocaine and prescription drugs (Subutex® and methadone) have become increasingly prominent;

- by drug-dependency (CepiDC-INSERM) [epidemiological table no. 5]. This category includes all deaths where the death certificate mentions drug-dependency. For reasons related to channels of information, it is not an effective means of counting overdoses, which are often added to the group 'death by cause unknown'. The number of drug-dependency deaths has continued to decrease from 1995-2003;

- with psychotropic substances present in the blood: The device DRAMES (Death related to drug and substance abuse- AFSSAPS) records cases of death which are the object of a judicial investigation, thus allowing undeclared deaths to be identified by INSERM or OCTRIS. Two retrospective studies were carried out for the years 1998 and 2002 as well as a prospective study in 2002 with 7 voluntary medico-legal toxicology laboratories. 16 laboratories were subsequently included in 2003 and 2004. A reduction was observed in deaths recorded in 2003 (64 versus 131 in 2002), followed by a slight increase in 2004 (91 cases). Concerning the substances involved, cocaine is very clearly on the increase and has caught up with heroin, which seems to be in retreat. Substitution treatments were involved in 2004, in 38% of deaths recorded, and, in particular, in over three quarters of cases, methadone was identified (Arditti et al., 2006);

- linked to AIDS in intravenous drug users (InVS). The number of AIDS-related deaths in intravenous drug users has been decreasing since 1994. Out of all AIDS-related deaths, those linked to drugs have stabilised since 1998 at between 22 and 27%.

In the absence of a cohort study responding to criteria fixed by the OEDT (recruitment of users in treatment centres), the OFDT carried out its own study on individuals arrested for use of narcotics. Standardised Mortality Ratios (SMR) values show that men arrested for heroin/cocaine/crack use have a higher overall risk of death than the whole French male population. This risk is 9.5 times higher for women. The study shows a significant reduction in mortality among people arrested for heroin/cocaine/crack use between the two inclusion periods (1992/93 and 1996/7); with death rates calculated for the four years following arrest passing from 10.3 to 6.2 per thousand people/years. This fall coincides with the

introduction of anti-retroviral drugs, the development of a policy of risk reduction in France and the spread of opioid substitution therapies (Lopez et al., 2004).

Diseases linked to drug use

1. Infectious diseases comprise the largest proportion of physical illness observed. Assessments of prevalence among drug users are based on:

- Declared prevalence of HIV, and Hepatitis B and C: in the 'November' study of patients attending Drug Addiction Treatment Centres (Tellier, 2001) and the study of users of 'front line' structures (Bello et al., 2003; Bello et al., 2004) [epidemiological table No. 9];

Declared prevalence of HIV and Hepatitis B and C varies according to the studies and the methods of consumption adopted by users (injection, snorting). The youngest individuals and those who do not inject create a flaw in the investigation. HIV-positive status declared by individuals attending 'front line' structures who have injected is around 14%, compared with around 4% among those who have never injected. Hepatitis C is prevalent in 55% of those who have injected, in the same group;

- Biological prevalence of HIV and Hepatitis C (from blood sample) in users in the Coquelicot study (Jauffret-Roustide et al., 2006). This study, aimed at evolving into a national information system, highlights the gulf between declared and measured prevalence of Hepatitis C, especially among the youngest individuals;

- Biological prevalence of HIV and Hepatitis C (from saliva sample) in users attending front line structures: the PRELUD study, which began in February 2006 in 9 French towns. The results of this study are still pending;

- Estimations of incidence of cases of AIDS and HIV infection. Notification of AIDS cases (InVS) has existed since the beginning of the 1980s, and has been compulsory since 1986. A new system for anonymous declaration was implemented in 2003 via a circular from the director-general of health- DGS- (No. 2003/60 of February 10 2003), making declaration of HIV infection also compulsory. This system is linked to a virological monitoring system of HIV.

The number of new AIDS cases linked to injectable drugs has been in continuous decline since 1994 (1377 in 1994, compared to 141 in 2004), as has the proportion of drugs-linked cases among total declared cases of AIDS (36% in 1991, 19% in 1997 and 11% in 2004). The number of cases of AIDS diagnosed in intravenous drug users shows similar evolution in both genders, with the number of male cases still higher than that of female cases (around 3 men per woman).

2. Psychiatric comorbidities: the few investigations in France do not allow consistent conclusions to be drawn on the prevalence of various psychiatric illnesses among drug users (Wieviorka 2033).

3. Other pathologies linked to drug use: there is no systematic compilation of information on the other pathologies that may accompany or be triggered by drug use (other infectious complication, cardiovascular complications, trauma...). The TREND study of users of front line structures provides indications of their perception and their state of health, as well as the appearance of certain pathologies (Bello et al., 2003; Bello et al., 2004). Pathological manifestations are most common in those in greater danger. A third of those studied declared that they had felt in bad or very bad physical health. Almost 70% declared having suffered fatigue in the past month; 44% a loss of weight; 4% an overdose ; 2%

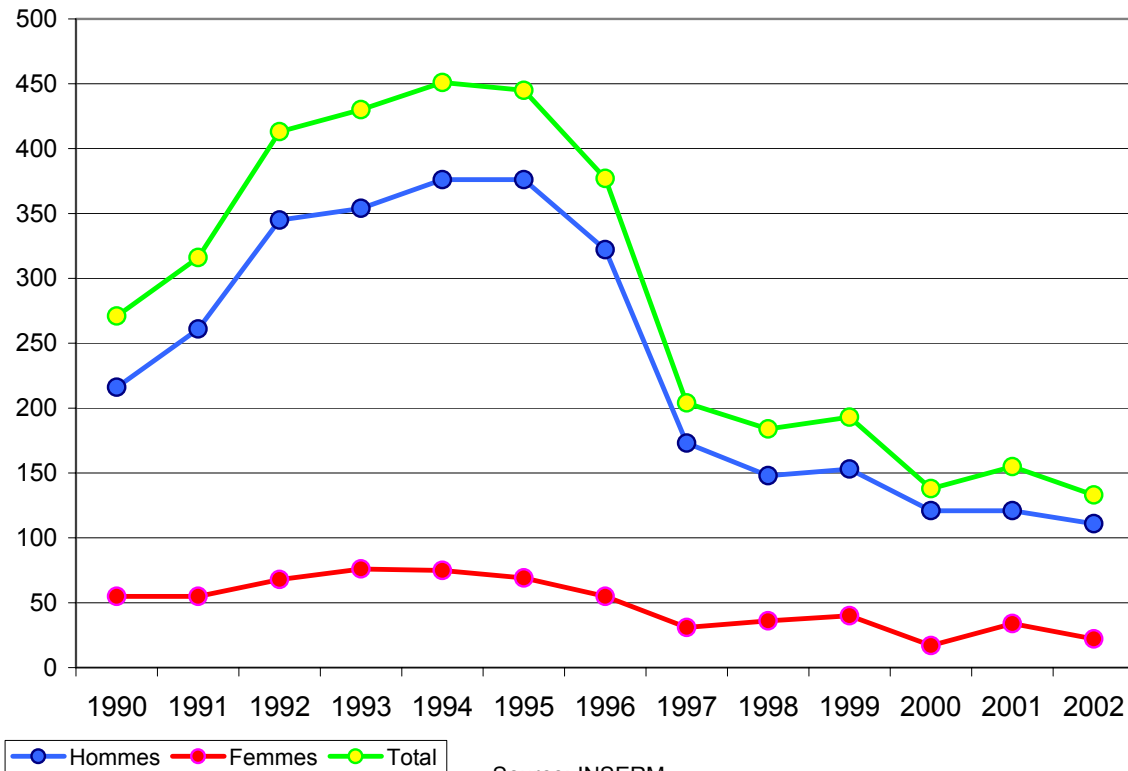
jaundice. The frequency of declared complications linked to injection was also assessed.

4. Driving: the law of February 3 2003 created a new offence whereby all drivers whose blood analysis reveals the presence of narcotics are liable to be penalised. They incur a penalty of two years of imprisonment and a fine of 4500€. The penalty may be increased to three years imprisonment and a 9000€ fine if alcohol has also been consumed. Driver screening is compulsory where there has been a fatal accident or one resulting in casualties, but it may also be used for any road accident, for highway code offences or when there is valid reason to suspect use of narcotics (OFDT, 2005a).

6.1 Drug-related mortality

Validated INSERM results are available for the year 2002.

Figure 4. Changes in the number of drug-related deaths according to the OEDT definition, 1990-2002, by gender.



[Men/ Women/ Total]

The general trend towards reduction that began in 1995 continued. Among the most frequent causes of death, the syndrome of dependency on other products or on multiple drugs is as common in men as in women (code F19.2 shows 86 of the 111 male deaths and 16 of the 22 female deaths), followed at a distance, as in 2002, by opioid dependency syndrome (code F11.02; 15 and 3 deaths respectively).

However, it must be borne in mind that this graph does not record all drug-related deaths: firstly, because drug addiction is not always mentioned on the death certificate. Secondly, because deaths by overdose may be considered suspicious and, therefore, classed as cause

unknown. It is necessary to use alternative sources: data from the Central Office for the Suppression of Narcotics Trafficking (OCRTIS) and DRAMES records.

Table 12. Deaths by overdose in France, according to OCRTIS data

	2004	2005
Total	69	57
Men	56	42
Women	13	15
Average age	30.1	31.3
Heroin	23	32
Cocaine	15	7
Designer drugs	5	5
Buprenorphine	4	2
Methadone	10	7
Other substitution drugs	7	1
No information	5	3

Source: OCRTIS 2006.

The number of deaths by overdose continues to fall- as a reminder, the latest peak recorded by OCRTIS was in 1994, with 564 recorded deaths by overdose. Deaths are principally linked to the use of opioids and prescription drugs. Overdoses of designer drugs remain stable. The majority of these deaths are concentrated in Ile-de-France (21 cases) and Alsace-Lorraine (16).

Another source of information are the DRAMES records (Death related to drug and substance abuse), a tool used by the Centres of Assessment and Information on Drug-Dependency (CEIP). It is a system for collecting information on cases of deaths linked to the abuse of psychoactive substances, carrying out toxicological analyses in different laboratories in a medico-legal setting. In November 2005, the results collected for the year 2004 were made public. Out of the 16 medico-legal laboratories that participated, 6 handed in results for the period concerned: the following information is therefore to be interpreted with caution, and offers more of a general indication than a precise description of mortality linked to drug use in France.²⁴

91 deaths linked to overdoses were recorded in France by DRAMES. 78% of the deceased were men (average age 33, median age 35), and 22% were women (average age 34, median age 37). In 61% of cases, overdose-related deaths took place at home or at the home of a third person. In 14% of cases, the bodies were found in the street/ by the police. 3% of deaths took place in a hospital, 2% in prison and 20% in other locations.

Psychoactive substances were directly involved in 86 deaths and indirectly in 5 deaths. The 86 directly drug-linked deaths involved illicit substances (44 cases), legal opioid prescription drugs (9 cases) or substitution treatment for opioid dependency (33 cases). The five indirectly drug-related deaths involved an accidental impalement linked to morphine, two drownings due to buprenorphine and cannabis and a fall from a cliff due to pholcodine (combined with a blood-alcohol level of 2.5g/L).

Mixing drugs: toxicological analyses report mixing with THC in 46% of cases, with alcohol in 47% of cases and with prescription drugs in 60% of cases. The most commonly mixed drugs

²⁴ Partial participation which heightens the imbalance of geographical coverage. Moreover, some deaths were not taken into account by DRAMES or not declared by the judicial authorities, or were declared but were not subject to toxicological analysis, or the analyses were carried out by laboratories which did not take part in the study. Lastly, some deaths which took place in a hospital were not declared to either the health authorities or the judicial authorities.

were benzodiazepines (91%) and drugs similar to benzodiazepines (88%), meprobamate (12%), neuroleptics (24%), antidepressants (13%) and analgesics (tramadol, dextropropoxyphene and paracetamol) (15%).

Illicit narcotics were implicated in 44 deaths (51.2%). In 30 cases, a single drug was found: heroin (18 cases) and cocaine (12 cases). In 14 cases, several drugs were combined: heroin-cocaine (2), heroin-methadone (1), heroin-cocaine-MDMA (1), cocaine-MDMA (1), cocaine-methadone (7), cocaine-morphine (1) and cocaine-buprenorphine (1). In 29 cases, there was an association with psychotropic drugs. Legal opioid drugs were involved in 9 deaths (10.4%): codeine (1), codeine-paracetamol (Efferalgan codeine®) (1), codethyline (1) and dihydro codeine (1). Five cases of morphine (including one of Skenan®) and a case of morphine-MDMA were also reported. 33 deaths involved substitution drugs for treating opioid dependency: 7 cases concerned buprenorphine, 25 cases methadone (including one association with codeine) and one case of a buprenorphine-methadone association. Psychotropic drugs were mixed in 15 cases.

6.2 Infectious diseases linked to drug use

Device for monitoring HIV infection and new cases of AIDS

Between January 2003 and June 30, 2005, notification was given of more than 9000 new HIV infections in France. According to the latest available report, (InVS 2006), 4033 declared cases corresponded to discovery of infection in 2004. 1194 cases of HIV infection were recorded during the first quarter of 2005. Only 3% of these new infections were the result of contamination by intravenous drug use (UDVI). The most common means of contamination in women is through heterosexual relations (80% of cases). Homosexual and heterosexual relations make up the same proportion in men (40% of cases respectively).

Table 13. Notification of new diagnoses of HIV infection, 2003-2005 (1st quarter 2005)

	2003			2004			2005 (1st quarter)			TOTAL		
	W	M	Total	W	M	Total	W	M	Total	W	M	Total
Intravenous drug user	20	71	91	22	68	90	5	22	27	47	161	208
Total new cases	1618	2213	3831	1643	2390	4033	459	735	1194	3720	5338	9058
Proportion of intravenous drug users (out of the known total)	1.2%	3.2%	2.3%	1.3%	2.8%	2.2%	1%	2.9%	2.2%	1.2%	3%	2.3%

Source: system of notification of HIV infection, InVS (data on 30/06/05)

The number of new AIDS cases amongst intravenous drug users has been in continuous decline since the middle of the 1990s. The proportion of new cases of AIDS amongst intravenous drug users out of the total cases recorded remained stable in 2004 compared to the two previous years.

Table 14. New AIDS cases amongst intravenous drug users, 1998-2005 (1st quarter 2005)

	1998	1999	2000	2001	2002	2003*	2004*	2005*
Intravenous drug users	357	308	246	256	203	166	141	29
Total new cases of AIDS	1 944	1 833	1 730	1 666	1 629	1438	1232	303
Proportion of intravenous drug users	18.3%	16.8%	14.2%	15.3%	12.4%	11.5%	11.4%	9.5%

* provisional data not rectified

Source: AIDS monitoring system (data on 30/06/05)

The results of the 2004 edition of the Coquelicot survey were made public. The data presented here is taken from Jauffret-Roustide et al. (2006).

Coquelicot is a transverse, multi-centric study covering five cities (Lille, Strasbourg, Paris, Bordeaux, Marseille), carried out on drug users (UD) who have snorted or injected at least once in their lifetime. Alongside a social-behavioural questionnaire led by an interviewer, the drug user gave a finger-prick blood sample onto a piece of blotting paper. This was then tested for HIV and Hepatitis C antibodies using Elisa tests. Ultimately, 1462 of the 2389 drug users who were approached with the questionnaire (61%) agreed to participate.

The overall prevalence of HIV was 10.8% [IC95%: 6.8-16.6]. It increases regularly with age: prevalence is virtually nil in those under 30 (0.3%) and reaches 17% in drug users aged 35-39, as well as those over 40. Analysis by year of birth reveals that the decrease in the prevalence of HIV in blood samples begins with the group born after 1970 (those under 30 today), while, for Hepatitis C, the decrease begins to be noticeable in the group ten years younger, born after 1980 (those under 24).

More than 95% of drug users declared that they had already been tested for HIV at least once, and the figure for Hepatitis C was 91%. Those under 30 had a lower level of HIV screening than older drug users (89% versus 97% $p < 0.001$), but the probability of being screened over the course of a lifetime naturally increases with age. The study shows that the drug users have a high level of awareness on the principal means of HIV and Hepatitis C transmission: the principal means of HIV contamination (sharing syringes, unprotected sexual relations) are known by 90% of drug users and those of Hepatitis C (sharing syringes) are known by 84% of drug users. On the other hand, where sharing equipment is concerned, the level of awareness falls to 71% for HIV risk and 65% for Hepatitis C risk. Moreover, those under 30 are less aware of the risks of HIV transmission linked to tattooing (3% versus 75%, $p = 0.02$) and piercing (63% versus 76% $p = 0.004$) than those over 30.

Prevalence of Hepatitis C in blood samples was 59.8% [IC95%: 50.7-68.3] and 28% in those under 30. In total, 27% of drug users mistakenly believed they were Hepatitis C negative. Prevalence of HIV in blood samples was 10.8% [IC95%: 6.8-16.6] and 0.3% in those under 30. Double infection with HIV and Hepatitis C was at 10.2% [IC95%: 6.3-15.9]. During the past month, 13% of drug users had shared their syringe, 38% their equipment, and 25% their straw for snorting. A high prevalence of Hepatitis C among young drug users implies that they had been contaminated from the beginning of their drug use. Risky practices persist, creating favourable conditions for tracking the transmission of Hepatitis C, as well as of HIV. Double infection with HIV and Hepatitis C is at 10.2% [IC95%: 6.3-15.9]. Almost all HIV-positive drug users were also contaminated with Hepatitis C.

These results will be completed by the study 'front line users', carried out by TREND/ OFDT in 2006, which aims to combine taking saliva samples with gathering declarative data to measure the prevalence of HIV and Hepatitis B and C infections in 4 towns not covered by the Coquelicot study.

6.3 Psychiatric comorbidities

No new information available

6.4 Other comorbidities linked to drug use

Atropine intoxication

The first wave of intoxication by a mixture of cocaine and atropine predicted in 2004 came to pass in 2005. Between December 2004 and April 2005, 26 cases were reported in France. In October and November 2005, five months later, several cases were noted in Europe, of which two were in the south of France. Descriptions of the actions taken in France and the symptoms presented in cases of atropine intoxication are detailed in the 2005 National Report.

Drugs at the wheel

Interpretation of the SAM study continues (see general presentation in the Selected Issue in the appendix; the 2005 National Report for the main results; Laumon et al. (2005) for the complete results). A complementary analysis of the results will be available at the end of 2007 (SAM 2). This time, only the use of alcohol at the wheel will be covered.

7. Responses to health problems

Response to health problems: an overview

Preventing mortality linked to drug use: in France there is no national policy or specific means of intervention to reduce overdoses. Access to substitution treatments and the risk reduction system act as indirect means of preventing deaths linked to opioid use. See [structured questionnaire no.29] for further details.

Prevention and treatment of infectious diseases linked to drug use:

Risk reduction policy is defined as all the measures set up to prevent not only contamination by the AIDS virus and Hepatitis, but also problems and complications stemming from using and seeking drugs. The principal concern is to prevent health complications linked to intravenous drug use and drug injections in unsanitary conditions (abscess, overdose, septicaemia).

In France, the focus of the system is preventative action, aiming to facilitate access to sterile injection materials and to spread the message of prevention, and increase access to screening among high risk groups.

Most of the activities are developed by a non-profit network outside the specialised system, which often benefits from support from the State or from local bodies.

The system is based on the following complementary actions:

- over-the-counter sale of syringes (sold without a prescription since 1987);
- automatons that distribute injection kits such as Steribox® (225 in total in 2002) or collect used syringes;
- associative needle exchange programmes (PES), numbering 118 in 2001;
- Reception centres or points of contact for drug users (40 in 2001);

On the whole, the risk reduction system covers most of French territory.

In theory, screening is facilitated by the existence of anonymous and free screening centres (CDAG), numbering 386 outside prisons, and 109 in prisons (in 2002). There is a programme to fight Hepatitis B and C (2002-2005), whose main objectives are: decreasing transmission, improving screening and the care system as well as access to treatment, increasing clinical research, monitoring and assessment. The prevention of contamination through snorting is disputed in France: certain organisations are involved, but it receives little State support.

Structured Questionnaire no.23 [risk reduction measures to prevent infectious diseases in drug users] provides a comprehensive view of chosen political stances and the resulting interventions that have been implemented in France.

Places where syringes are available, as well as an estimation of the quantity distributed are shown in epidemiological Table no.10.

Interventions linked to psychiatric comorbidities: there is no strictly specialised service to care for drug users presenting associated psychiatric pathologies. Some psychiatric hospitals have developed care for drug addicts over several years, but they remain rare. Since 1998, three different circulars from the Health Director-General (DGS) have been focused on improving care, recommending stepping up cooperation between the relevant services (CSST, hospital psychiatric service), but collaboration remains sporadic (Wieviorka, 2003).

7.1 Prevention of drug-related mortality

No new information available

7.2 Prevention and treatment of infectious diseases linked to drug use.

No new information available

7.3 Interventions linked to psychiatric comorbidities

No new information available

7.4 Other interventions targeting post-use sanitation

No new information available

8. Social Consequences

Social Consequences: an overview

Social Exclusion: the social and economic situation of drug users can be deduced from the socioeconomic characteristics observed when they attend a reception centre (Drug Addiction Treatment Centre or "front line" facility). Their level of risk varies according to the type of centre they attend. Users who attend "front line" facilities are characterised by greater social marginalisation than those who visit Drug Addiction Treatment Centres: more unemployment (50% of visitors to "front line" facilities live on benefits, compared to around 30% in Drug Addiction Treatment Centres), less stable housing (40% in "front line" versus 30% in Treatment Centres), more single people and fewer parents with dependents...

Reconstructing users' developments, lifestyles and exposure to risk (especially heroin users) provides an understanding of the situations and progressive instability (social and economic fragility, lack of education, weakening of support structures), that combine to favour a developing drug addiction problem in certain individuals. For Bouhnik and Touzé (1996), a combination of increasing instability in the living conditions of users and repression and repeated incarcerations, contributes to an increasing exposure to risk. According to Jamouille (Jamouille, 2001), users must experience several forms of instability: economic, social (as a citizen), health and psychological.

Among the homeless, drug addiction generally comes before an individual becomes socially marginalised (Dabit and Ducrot, 1999; Declerck and Henry, 1996; La Rosa, 1998). On the other hand, exclusion engenders a strong sentiment of relegation, which can drive an individual to drug addiction although he did not deliberately choose to be marginalised. But substances may also be a means of coping with the violence of life on the streets: "recourse to psychoactive drugs emerges as a means of coping with problems, and this recourse in itself brings further difficulties, precipitating instability sooner" (Joubert, 2003).

Crime and offences linked to drug use: according to the French laws relating to narcotics use, anyone who consumes and/or is in possession of and/ or is involved in drug trafficking is liable to a penalty up to imprisonment. The simple user may therefore be the object of arrest, followed or not by conviction and possible incarceration.

Penal data on Infringements of the Drug Law (ILS) has the advantage of being regulated and easy to access, as well as going back a long way. On the other hand, it does not provide a comprehensive view of how offences are treated, from arrest, to conviction, and implementation of a possible penalty.

Arrests for infringement of Drug Law are classed in two broad categories: simple use and trafficking (subdivided into dealing, local trafficking and international trafficking) [epidemiological table no. 11]

Convictions recorded by the National Criminal Records Bureau show sentencing of people taken to court for Infringements of the Drug Law. A conviction may include several offences, but, conventionally, the convictions are presented according to the principal offence. The statistical categories used are as follows: illicit drug use, being helped to use by others, possession/acquisition, manufacturing/work/transport, supply, possession and acquisition, importation/exportation, other infringements.

Since 2003, driving under the influence of substances or plants classified as narcotics has been an offence (law no. 2003-87 of February 3, 2003, NOR:

JUSX0205970L). The offence is subject to two years of imprisonment and a 4500€ fine simply for using narcotics. The penalty is more serious when it is combined with alcohol consumption. Screening is compulsory for all drivers involved in a fatal accident, and systematic if consumption is suspected, in all accidents where physical harm is done. Random testing may also be used.

Use in Jail: A study carried out in 2003 shows that 33% of people going into jail declare long-term, regular use of illicit drugs or misuse of detoxification drugs in the year preceding incarceration (Mouquet, 2005). In the general population, 6% of 18-25 year olds and 2% of 26-44 year olds consumed illicit drugs in 2002 (Beck et al., 2002). These figures show a clear over-representation of drug users in comparison with the general population.

Existing studies show that the all drugs smoked, snorted, injected or ingested before incarceration continue to be consumed, to a lesser extent, in prison (Rotily, 2000). Moreover, consumption habits, such as using prescription drugs, that are more easily accessible, develop in the prison environment. In general, consumption of illicit and rare drugs is replaced by prescription drug consumption (Stankoff and Dherot, 2000).

These incidences of narcotics consumption, whether they begin or are continued in prison, seriously affect the state of health of those concerned, leading to abscesses, risk of accident when drugs are combined, severe and more sustained cravings, emergence or exacerbation of psychological or psychiatric illness. Moreover, detainees are a group which accumulate risk factors where health and social consequences of drug use are concerned. The prevalence of risky consumption among those entering prison can be explained by lack of access to care for this group, and, more fundamentally, the situations of instability and exclusion which they were often faced with prior to imprisonment (lack of stable home or social security programme).

Injection is common within this risk group, although there is a downward trend in the number of intravenous users: 6.2% of new detainees declared having used drugs intravenously during the year preceding incarceration in 1997 (Mouquet et al., 1999), while in 2003, just 2.6% of new detainees said that they used injection (Mouquet, 2005). According to the studies, 60%-80% of detainees stop injecting in prison. However, those who continue, even if they inject less frequently, seem to inject more, and are more often infected with HIV and/or Hepatitis C, so that the risks of contamination from sharing equipment, from unprotected sexual relations or from tattooing are significant.

Lastly, detainees seem more affected by infectious diseases than the general population. The most recent figures indicate that the prevalence of HIV in the prison environment is 3 to 4 times higher than that outside prison, and that of Hepatitis C is 4 to 5 times higher. However, as outside, the prevalence of HIV in prison has decreased, while that of Hepatitis C has risen sharply.

Social cost of drugs: Public spending on all drugs has reached 115,912 million euros for the year 2003; most of this was on illicit drugs (80%), while the smallest portion was consigned to tobacco (5%). Ultimately, the proportion of spending attributable to the fight against licit and illicit drugs was 0.33% of total public spending in 2003. The social cost of alcohol, tobacco and illicit drugs was 2.37%, 3.05% and 0.18% of GDP respectively for the year 2000 (Kopp and Fenoglio 2006)

8.1 Social Exclusion

No new information available

8.2 Crime and drug-related offences

Information from the Ministry of Justice

Statistics pertaining to convictions, for Drug Law infringements as much as for alcohol-related offences, are published with a time lag of two years (Ministry of Justice 2006). The figures are presented in stock format (no information on offences that led to conviction when detainees were moved). Therefore, the following information refers to the year 2004, and it is not officially considered definitive.

31,497 convictions were pronounced in 2004 where an Infringement of the Drug Law was the principal offence²⁵: 11% more than in 2003, and over 50% more than in 2000-2002.

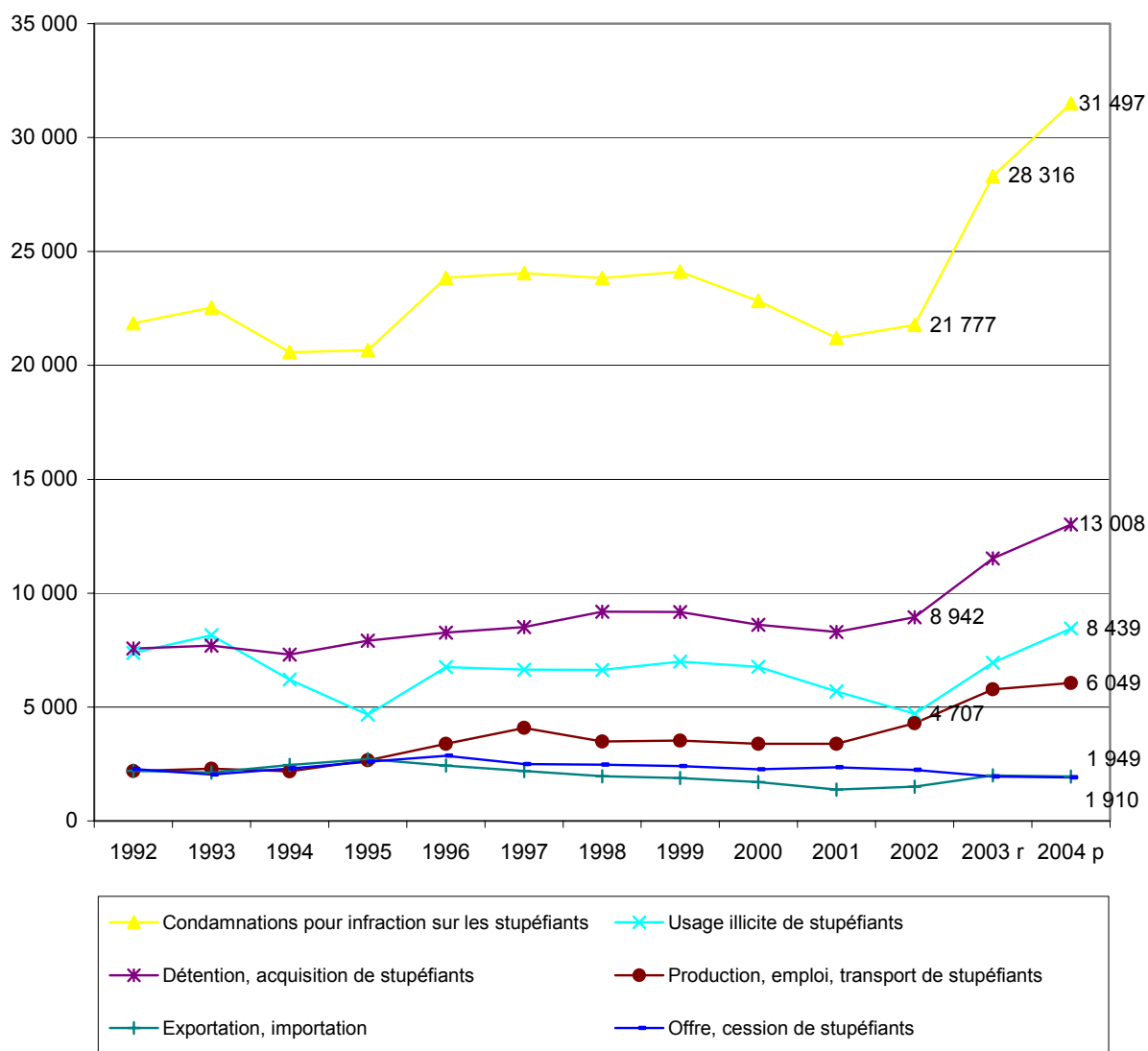
39,063 individuals had been convicted and imprisoned by 31/12/2004, of which 5937 were for Drug Law Infringement (15.2%).

By December 31, 2005, 5728 individuals had been imprisoned for Drug Law Infringements, out of a total 38,790 convicts (14.7%).

The following data concerns convictions:

²⁵ A conviction may cover several offences (common in Drug Law infringements). The principal offence is the first one written on the criminal record, but it is not always the most serious. The sum of offences of rank 2 and above show the number of Drug Law Infringements punished to be 101,000 for the year 2004.

Figure 5. Convictions for Infringement of the Drug Law pronounced in France



[Convictions for narcotics offences/ possession-acquisition of narcotics/ exportation, importation/ illicit narcotics use/ production, use, transport of drugs/ supply and dealing of narcotics]

This growth applies to virtually all Infringements of Drug Law, and especially the most frequently punished: 13,008 convictions for possession or acquisition in 2004 (13% more than in 2003), 8439 convictions for use (+22%) and 6049 convictions for production, use or transport (+5%). Where infringements of Drug Law are not the principal offence, conviction has been stable for several years. Trafficking (import-export) is penalised as the principal infraction in 1949 convictions, or 6-7% of Drug Law Infringements; 27% of convictions are for use and possession-acquisition still accounts for around 40% of them.

Overall, in 2004, an infringement of drug law as the main offence is penalised by imprisonment in 74% of cases (either a mandatory sentence or combined with partial deferment in half of all cases), by a fine in 16% of cases and by substitution in 7% of cases: a fine paid off by days in prison, or a community service order. Dispensations are rare. Educational measures, of which 1000 were pronounced in 2004, make up 44% of drug law infringement convictions concerning minors.

The profile of individuals convicted for an infringement of drug law is similar to that of all convicted people. The vast majority of those convicted for infringement of drug law are men

(94%). 7% are minors, with significant disparities between those convicted for dealing, (where only 1% are minors); and possession, use or supply (8%, 9% and 10% minors respectively). Overall, 13% of convicts for drug infringement are foreigners, but the disparities are even greater: 6% of those are convicted for use, 37% for trafficking (import-export), and between 12 and 20% for other offences.

Information from the Ministry of the Interior

Arrests for infringement of drug law. General data:

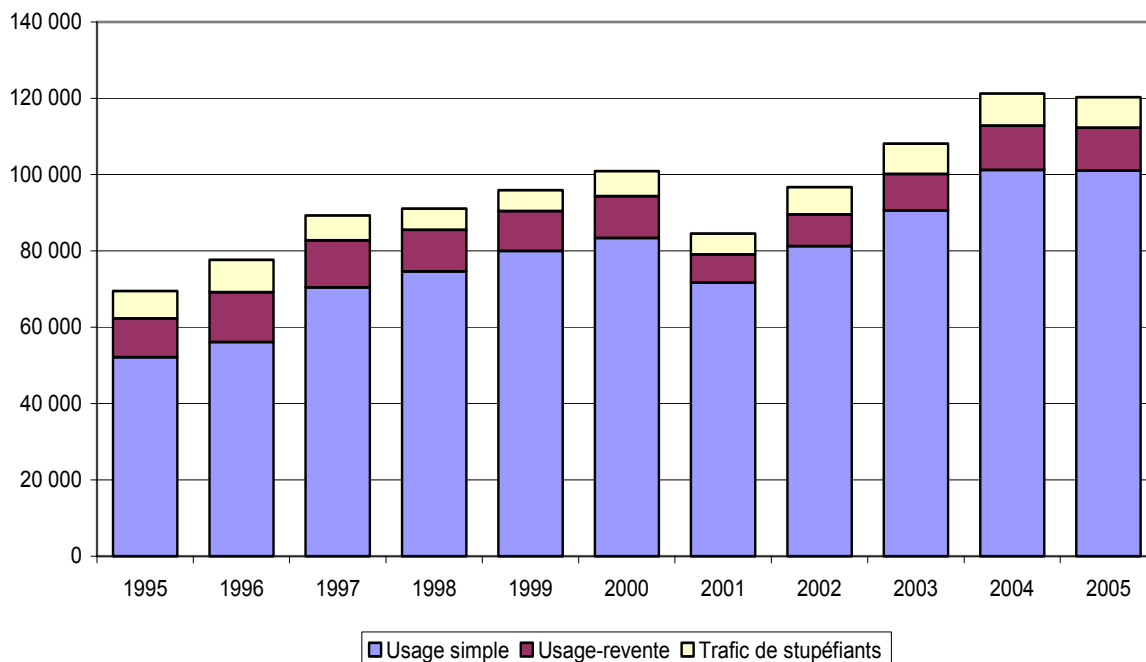
While trends showed an increase in arrests for Infringements of Drug Law by the police, the Gendarmerie and Customs, 2005 saw a slight reduction of 0.8% (figure 6 ; Central office for the prevention of illicit narcotics trafficking (OCRTIS), 2006). This decrease concerned all the categories of arrests, but is slightly more striking for cases of trafficking (-4.2%) and for dealing (-3.2%) than for simple use (-0.2%).

Reasons for arrest:

Simple narcotics use is the principal reason for arrest: out of 101,047 arrests, 84% were for Infringements of the Drug Law in 2005, a figure which has remained stable since 1998.

11,231 arrests were recorded for dealing, the second most common reason for arrest (9.3% of all arrests for Drug infringement). Arrests for trafficking are divided into: 1268 arrests for international trafficking and 8027 for local dealing (forming 6.7% of total arrests for Drug Law infringement).

Figure 6. Arrests for Drug Law Infringement since 1995.



Source: FNAILS OCRTIS. [simple use/ dealing/ narcotics trafficking]

The drug in question.

Cannabis is the main drug concerned in Drug Law Infringement arrests, whatever the reason for arrest: in 90% of arrests for use, in 77% for dealing and in 54% of cases for trafficking

(Table). Overall, heroin and cocaine are the next most common: the former is more common among arrested users and dealers, whilst the latter is more common in cases of trafficking. Classically, for France, there is a relatively high number of arrests for prescription drugs (especially Subutex®, but also undetermined drugs: these are users who have no medical prescription to justify their possession) and for magic mushrooms.

Table 15. Arrests for Drug Law Infringement per drug, 2005

	Use	% in column	Dealin g	% in column	Traffickin g	% in column	Total	% in column
Cannabis	90 905	90.0%	8 616	76.7%	4 313	53.7%	103 834	86.3%
Heroin	4 486	4.4%	1 027	9.1%	1 143	14.2%	6 656	5.5%
Cocaine	2 807	2.8%	756	6.7%	1 815	22.6%	5 378	4.5%
Crack	691	0.7%	172	1.5%	198	2.5%	1 061	0.9%
Ecstasy	1 272	1.3%	439	3.9%	373	4.6%	2 084	1.7%
Prescription Drugs (1)	313	0.3%	120	1.1%	80	1.0%	513	0.4%
Amphetamines	263	0.3%	59	0.5%	31	0.4%	353	0.3%
Mushrooms	175	0.2%	24	0.2%	15	0.2%	214	0.2%
Other (2)	135	0.1%	18	0.2%	59	0.7%	212	0.2%
Total	101 047	100%	11 231	100%	8 027	100%	120 305	100%

(1) Subutex®, methadone, Skenan®, Moscontin, fentanil, Rohypnol, valium....

(2) Khat , Methamphetamines, LSD , opium , morphine, solvents, other;

Source: FNAILS, OCRTIS.

Where drugs are concerned, the slight fall (or apparent stability) in the number of arrests masks considerable variation for the drug in question:

- The substantial increase in arrests for heroin use, dealing and trafficking: a growth perceived in 2004 and emphatically confirmed in 2005: +18% more arrests, +20% of users arrested. These figures seem to mark the end of the decline recorded throughout the 1990s. At the same time, the age of arrested heroin users has stopped rising.
- Cocaine is another drug that is seen more and more frequently in arrests: +14% among arrested users, +8% among dealers and +2% among traffickers (cocaine is the drug predominantly found among international traffickers, half of whom are arrested in Paris airports).
- The “upsizing” since 2003 of arrests for use and, to a lesser extent, dealing and trafficking of amphetamines.
- In a breach of the upward trend of the past few years, stability and a slight decrease has been observed in arrests for cannabis use (-1%) and a more striking reduction in arrests for dealing and especially for trafficking (-4% and -7% respectively).
- Ecstasy arrests, which rose sharply in 2004, are falling (-22%), and this decline continues across all categories of Drug Law Infringement.
- As in 2004, overall arrests for crack are falling (-12%); the decrease is clear in terms of use (-7%) and trafficking (-36%) but those for dealing increased by 14%. Consideration must be made of the fact that these figures are small compared to the drugs previously cited, and have fluctuated around 1000-1400 arrests since 1998, predominantly in the overseas departments and in the Paris region.

Some characteristics of individuals arrested for Drug Law Infringement in 2005:

- The average age of arrested users has increased slightly: 23.5 years in 2005 versus 23.1 in 2004
- Users of crack, heroin and prescription drugs (Subutex®) are the oldest: 33.4-29.2 and 32.8 years old respectively. Cannabis users are still the youngest (22.9), followed by magic mushrooms (23.1) and ecstasy (24.4 on average).
- Those arrested for Drug Law Infringement are predominantly men (no change).
- The majority of those arrested for Drug Infringement are French (9 in 10), except in the case of international trafficking, where only 28% were of French nationality in 2005 (23% in 2004).
- Where SPS is concerned, there is also a distinction between cannabis users on the one hand (35% without profession or of indeterminate professional status, 23% labourers and 24% students/school pupils) and heroin or cocaine users on the other (43-51% without profession or of indeterminate professional status, 12-26% labourers or employees, and 5% students or school pupils). Ecstasy users occupy a more or less intermediate position (no change).
- Lastly, around 90% of individuals arrested for an Infringement of Drug Law are only arrested once over the year. Multiple arrests are slightly more common in heroin users.

Driving after using narcotics: checks and penalties in 2004-2005²⁶.

Reminder of the current law.

The law of June 18, 1999, and the decree that implements it (27 August 2001) established systematic narcotics screening of drivers involved in a road accident with immediately fatal consequences. It also set up an epidemiological study (carried out between October 2001 and 2003) to precede a possible more general study (SAM). The law of February 3, 2003, created a new offence whereby any driver whose blood analysis reveals the presence of narcotics is liable to a penalty. They would incur a penalty of two years of imprisonment and a 4500€ fine. The penalty may be increased to three years imprisonment and a 9000€ fine in the cases where narcotics are combined with alcohol.

Screening (of blood, or in cases where blood screening is not possible, of urine by default) is compulsory in the case of immediately fatal accidents, or accidents involving casualties and where the driver is suspected of using narcotics. Screenings are also allowed of drivers who are: involved in any road accident, or who have committed an infringement of the highway code, or where there are several plausible reasons for suspecting that narcotics have been used. (art. L235-2 of the Highway Code).

Screening in 2004 and 2005.

Since 2004, the Ministry of the Interior has published statistics on all screenings and offences relating to drugs at the wheel²⁷ :

²⁶ Ministry of the Interior (...), *Evaluation of road user conduct, 2005*, 53 p. (http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere); special extract for the national criminal record by sub-directorate of statistics, studies and documentation.

²⁷ Figures published for 2003 were incomplete and only covered screenings carried out between July and December 2003 by the national police services (without the national Gendarmerie).

Table 16. Screening for narcotics at the wheel

	2004			2005		
	Number of screening	Number of positive results	% positive	Number of screenings	Number of positive results	% positive
Accidents :	9 563	1 052	11.0%	11 305	1 899	16.8%
fatal (immediately)	4 066	282	6.9%	5 248	629	12.0%
bodily harm (not fatal)	4 501	620	13.8%	5 547	1 041	18.8%
damage to property	996	150	15.1%	510	229	44.9%
Offences	1 198	548	45.7%	2 446	1 979	80.9%
Suspicion of use (with no accident or offence)	5 144	1 878	36.5%	7 284	4 095	56.2%
Total	15 905	3 478	21.9%	21 035	7 973	37.9%

Source: Ministry of the Interior, Evaluation of road user behaviour 2004 and 2005
http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere

In 2004, close to 16,000 narcotics screenings were carried out on the roads. The majority (60%) were carried out following an accident, especially if the accident had fatal consequences (compulsory screening) or had caused bodily harm (screening also compulsory in cases of suspicion).

The number of screenings increased sharply in 2005 (21,000, an increase of 38%). The increase was particularly marked for screenings carried out following a Highway Code offence (+104%).

Positivity rates are to be interpreted with caution because they reflect the way that groups are targeted for checking. Consequently, the highest positivity rates are for screenings carried out in cases of suspected use, with or without an offence (for 2005, the Ministry of the Interior indicated that these rates reflect the fact that, in the majority of cases, the forces of order have carried out screening "when the general state of the driver left little doubt that they were over the limit").

These figures cannot be taken as a measure of narcotics consumption by drivers, nor of driving under the influence of narcotics in the same drivers. (see the SAM results on this subject).

The only cases where screening is (usually) systematic are those involving a fatal accident. In these cases the positivity rate was 7% in 2004 and 12% in 2005.

Offences penalised in 2004 and 2005.

Table 17. Offences for driving after using narcotics

	2004	2005
Driving a vehicle after using narcotics	1 577	4 246
Driving a vehicle after using narcotics and under the influence of alcohol	528	922
Refusing to undergo screening for narcotics	112	435
Total	2 217	5 603

Source: Ministry of the Interior, Evaluation of behaviour of road users 2004 and 2005
(http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere)

During the first whole year the narcotics screening programme was in place, in 2004, more than 2000 charges were made of driving after having used narcotics, either alone (in 1577 cases) or mixed with alcohol (in 528 cases). The figures for 2005 are beyond comparison, since more than 4000 offences for driving after narcotics use were confirmed in this year, and almost 1000 for narcotics use combined with excessive alcohol consumption.

These rises reflect the progression of the programme as it is implemented, but the complexity of the narcotics screening programme is universally accepted, which discourages the forces of order from carrying out checks (by comparison, 11,387,829 alcohol tests were carried out in 2005, of which 9,017,161 were for preventative purposes- before any accident or offence occurred- and 140,000 offences of driving under the influence of alcohol were recorded).

Convictions in 2004.

In 2003, 37 convictions were pronounced for driving after narcotics use. In 2004, this went up to 601, to which were added 151 offences of driving under the influence of drugs and alcohol, and 85 cases of injury or manslaughter by drivers under the influence of narcotics (50 and 35 respectively). Finally, there were 10 convictions for refusing to undergo analysis or examinations as required by the law.

Table 18. Convictions of drivers under the influence of narcotics in 2004

	Total convictions	Sentences of imprisonment	Fines	Alternative sentenc	Educative measures	Dispensati ons
Total offences by drivers under the influence of narcotics	847	511	162	168	3	3
Driving after using narcotics	601	314	139	143	2	3
Driving after using narcotics and under the influence of alcohol	151	113	18	19	1	0
Injury or manslaughter by drivers under the influence of narcotics	85	80	2	3	0	0
Driver refusal to undergo analyses or examinations	10	4	3	3	0	1

Source: Ministry of Justice- sub-directorate of statistics, studies and documentation- special extract from the National Criminal Record Bureau

60% of all these convictions are punished by a sentence of imprisonment (only 13% with mandatory sentences, either partially or totally). Around 20% were sentenced to a fine and 20% to an alternative penalty (likely to be suspension of driving licence).

These penalties are similar to those for driving under the influence of alcohol (see summary on alcohol), although fines are proportionally less frequent, while alternative penalties are more common.

The penalties are less severe for driving after narcotics use only or for refusing examination. But they are more severe in cases of injury (9 in 10 convictions by imprisonment, 13% mandatory) and particularly in manslaughter cases, all punishable by imprisonment, 60% being mandatory and for an average period of around 14 months.

8.3 Use in Jail

No further information available.

8.4 Social cost

Kopp and Fénoglio (2006) are moving towards updating the 1998 assessment of the social cost of drugs, and they are proposing to include tobacco and alcohol in that assessment. In total, around 113,043 million euros were allocated by the public authorities in 2003 to fight drugs (not including MILDT funds). 80.24% is attributed to illicit drugs (907.03 million euros), 15.08% to alcohol (170.42 million euros) and only 4.69% to tobacco (52.98 million euros).

Table 19. Public spending attributable to drugs (in millions of euros).

	Illicit drugs		Alcohol		Tobacco	
	1995	2003	1995	2003	1995	2003
Ministry of Justice	228.13	196.93	122.28	14.03	--	--
Customs	81.12	58.30	NA	4.20	NA	14.12
National Gendarmerie	70.03	120.20	5.22	12.42	--	--
National Police	188.35	277.14	0.95	18.13	--	--
Ministry of Health	114.03	248.66	NA	52.39	NA	23.84
Ministry of Foreign Affairs and Cooperation	9.70	3.90	--	--	--	--
Ministry of National Education	6.66	0.40	NA	0.40	NA	0.40
Ministry of Youth and Sports	1.43	1.50	NA	va	NA	NA
Ministry of Agriculture	--	--	NA	68.85	NA	14.62
Total excluding MILDT	699.45	907.03	158.45	170.42	0.00	52.98
	Illicit drugs 1995		All drugs 2005			
MILDT	30.17		28.69			

Source: Table taken from Kopp and Fenoglio (2006).

By including the MILDT funds (28.69 million euros) public spending for all drugs reaches 1159.12 million euros in 2003 (table below). Considering that total public spending in 2003 reached 345.95 billion euros, the proportion of spending attributable to drugs (alcohol, tobacco and narcotics) was 33% of this whole.

9. Responding to social problems

Responding to social problems: an overview

Social integration: As well as addressing health problems, the risk reduction policy aims to reduce the social problems that typify the lifestyle of drug users: isolation; drifting; disruption to personal, professional and family life. Among the risk reduction facilities, “reception centres” are a point of contact for users, and hostels provide emergency overnight accommodation for drug users in high-risk situations (4 in 2002). The main goal of liaison teams is to improve care of drug users whilst acting as mediators in particular districts (4 in 2001). Drug users may also benefit from reception at one of the facilities set up to fight exclusion: emergency beds, Lodging and Social Readaptation Centres (CHRS), day reception centres, mobile aid teams.

Within the various facilities, social assistants and specialised educators work with users to facilitate the reintegration process.

See also Structured Questionnaire No. 28 [social integration].

One of the goals of substitution treatment, as well as bringing dependent users closer to the care system, is to contribute to their social integration. Several studies have shown the benefits to the user from 6 months to 2 years after beginning treatment: improved participation in the administrative system, better professional integration, and improvement in housing conditions (Bilal et al., 2003; Batel et al., 2001 ; Calderon et al., 2001; Duburcq et al., 2000; Reynaud et al., 1997; Fhima et al., 2001; Lavignasse et al., 2002).

Certain studies have also pointed out that treatment shifts the user away from crime and from committing offences, regardless of their socio-demographic and economic characteristics. (Facy, 1999; Calderon et al., 2001; Henrion, 1995).

Aid for users in jail:

-Prevention of infectious diseases: on their arrival in prison, all detainees are offered a medical consultation provided by a consultation and outpatient care unit (UCSA), with, in particular, tuberculosis screening, a voluntary and confidential HIV test and, more recently, screening for Hepatitis C alongside a Hepatitis B vaccination. Medico-psychological Prison Services are responsible for psychiatric care in 26 penitentiary institutions (larger prisons in general), while the UCSA take charge of physical care.

However, a Ministry of Justice report on reducing the risk of HIV and viral Hepatitis transmission in prisons points out that “measures to prevent HIV, AIDS and Hepatitis infection are not put into effect in every establishment” (Rotily, 2000). For the author, three aspects of the Risk Reduction Policy must be improved: informing and training detainees, offering screening (HIV, Hepatitis C) and vaccinations, and reducing overpopulation and promiscuity in the prison environment.

- Risk Reduction: there is no provision in French law for making materials available for injecting in prison: it is in contradiction with article D-273 of the code of criminal procedure, which states that detainees must not have at their disposal any object, medicine or substance that could be used for or to facilitate suicide, aggression or escape. A Penitentiary Administration circular has allowed free and systematic distribution of bleach to detainees since 1996.

No legal text explicitly prohibits tattooing. However, regulations state that condoms must be made available, especially in the establishment's UCSA.

- Care and treatment of addictions: of all 186 penitentiary institutions in France, few develop a specific care programme for drug addicts. Addiction centres exist in 16 large correctional institutions: Outgoing Preparation Units in Prison (UPS) were opened on a trial basis in 7 prisons in 1997 (2 closed in 2003); outpatient alcoholology treatment centres (CCAA) were opened in only 3 establishments. The 102 penitentiary services for reintegration and probation (SPIP) contribute to the objective of social monitoring of all detainees, and their reintegration on their release from prison; they ensure social reintegration for drug addicts (including those who began treatment in prison) by guiding them towards partner organisations in the form of government bodies or firms.

In theory, it is possible to prescribe substitution drugs in prison under the same conditions as on the outside, to start or continue substitution treatment with methadone or Subutex®. All penitentiary establishments have undertaken offering substitution or withdrawal treatment to new detainees requiring care (circular DGS/DH/DAP, December 5, 1996). The Ministry of Health subsequently carried out four annual studies on substitution treatment (March 1998, November 1999, December 2001, February 2004) which revealed that access to substitution treatments for heroin addicts in prison is, in spite of real progress, still more restricted than on the outside, even though the proportion of detainees on substitution treatment has increased: 2% in 1998, 3.3% in 1999, 5.4% in 2001 and 6.6% in 2004. The number of treatments that are interrupted on entering prison has fallen noticeably, passing from 19% in 1999 to 5.5% in 2001.

Evidence shows that the number of incarcerations (or reincarcerations) is lower amongst individuals who have benefited from substitution treatment before or during imprisonment (Totily et al., 2000; Levasseur et al., 2002).

Alternatives to legal proceedings and substitution sentences:

The priority given to the medico-social side of the fight against drugs in official texts (law of December 31, 1970), implies that alternative judiciary responses will be developed. In 1993, the plan for conventions on departmental objectives (CDO) was launched to improve communication between health and justice bodies so that health-based alternatives to court proceedings (court-ordered rehabilitation, orientation towards health and social structures) would be favoured.

The Ministry of Justice circular of June 17, 1999 (NOR: JUSA9900148C) called for Prosecutors of the Republic to favour fighting local trafficking over simple drug use when dealing with arrested users. These orientations were reaffirmed by the Ministry of Justice circular of April 8, 2005 (NOR: JUS D 05-300061 C). This recommends tailored and diversified penal responses in the fight against narcotics use, as well as a crackdown policy on addictions and on individuals who promote narcotics or alcohol consumption under the cover of licit activities.

Social studies and personality studies (on arrested individuals) should allow the sentence to be tailored to the individual, and the most appropriate measure chosen. The diversification of penal responses is highlighted: IT, those classified with orientation and those classified unsuitable for alternative measures; socio-educational court monitoring, with compulsory treatment, parole with surveillance, for pre-sentencing measures.

The pursuit of alternatives to imprisonment is the initiative of the Penitentiary Service for Reintegration and Probation (SPIP). At a local level, and under the

supervision of the sentencing judge, the SPIP identifies social structures, medical or otherwise, which would enable court-ordered rehabilitation to take place.

On the subject of court-ordered rehabilitation, which is an excellent and highly appropriate alternative measure for individuals under arrest who have an addiction problem, the national trend is towards stagnation, in spite of numerous circulars attempting to re-launch it.

Further along the criminal procedure, individuals who have infringed the 1970 Drug Law, may benefit from an alternative penalty rather than imprisonment or a fine: these alternative penalties may take the form of community service, days in prison paid off by fines, or other types of penalty. National data on this topic is fragmentary, in the sense that it does not, for example, reveal the proportion of these measures that were allotted to simple drug users. On the other hand, they show that community service orders are decreasing on a national level, in spite of reports containing expert recommendations (Warsmann, 2004).

9.1 Social Integration

No new information available

9.2 Prevention of drug-related crime

No new information available.

10. The market and supply

The market and supply: an overview

Three sources provide access to a continuous flow of information on the market and on supply of psychoactive substances.

- the TREND observatory, which gathers information, predominantly qualitative (accessibility, availability, average prices) from users and from people working in prevention, care or repression. It focuses on two areas of observation: urban space and parties. The first comprises areas in towns and cities where active drug users can be observed (squats, on the street); the second involves the party scene, particularly when related to techno culture : clubs, teknivals, open parties, private gatherings.

- The drugs observatory SINTES, which mainly gathers information on the composition of drugs, but also on prices.

- Data from repressive bodies (the police, customs, the gendarmerie) taken from the national file of infringements of narcotics legislation (FNAILS), managed by OCRTIS. This provides the number as well as the quantities seized on French territory. Seizures recorded by repressive bodies are only a partial indicator of the supply of illicit drugs, because they are directly linked to the activity of the services concerned, and because chance plays a not insignificant role in their annual variation. It is therefore indispensable for studying developments over long periods.

Availability and supply:

- Cannabis is the most available and easily accessible illicit drug in France. The two dominant forms, grass and resin, are both very easy to obtain. In French departments overseas (French Guiana, Martinique), grass is the prevalent form.

- Powder cocaine is a product which is becoming more and more widely available. In its 'base' form, cocaine is as widely available on the techno party scene as in urban areas, but it circulates under two different names: "freebase" on the party scene and "crack", predominantly available in French Guiana, in the Antilles and in central Paris among very marginalised groups of users.

- After cannabis, ecstasy is the most common illicit substance on the party scene, whether commercial or alternative.

- Heroin is a drug which is not widely available and not highly visible. This situation has been exacerbated by the disappearance of open scenes and by dealers turning to cocaine, which is more profitable. However, in 2005, an increase in the availability and visibility of heroin consumption was observed at rap and techno events.

- High dosage Buprenorphine (Subutex®) is still widely available and accessible on the black market in urban centres, in spite of stricter measures taken by the public authorities to control its prescription.

The consumption of natural hallucinogens, especially magic mushrooms, is developing, particularly in terms of increasing home cultivation and supply via the Internet.

In general, on the techno party scene, new regulations introduced in early 2002 governing event organisation contributed to unauthorised events of the "free party" type becoming rarer, to the benefit of commercial techno party organisers. This contributed to trafficking being displaced, to a certain extent, to urban areas;

clubs and discos, private property (house parties) and over the border (Spain, Belgium).

Seizure: France is a transit country for substances destined elsewhere, especially to the Netherlands, Belgium, the UK, Italy and beyond, and, therefore, it is difficult to separate the quantities of drugs destined for the domestic market from those that are only in transit. The subject of trafficking in France must therefore be addressed in terms of each particular drug, since the destination country and the country they came from vary according to the substance in question.

The following trends have been observed, per drug:

- The most numerous seizures involved cannabis, particularly the resin, of which the quantities seized have been on the increase since 2002.
- Since the end of the 1980s, a sharp growth in seizures of cocaine and crack, right up to the present day
- After an increase in the quantities of heroin seized in the 1980s which continued until 1994, the subsequent downward trend seemed to be reversed from 2002.
- since the early 1990s, the number of seizures of ecstasy and the quantities seized have grown sharply although the growth in seizures of amphetamines has been more moderate.
- the size and number of LSD seizures decreased for the period 1990-2002 after a peak in 1992 and 1993. The seizures carried out in 2003 and 2004 suggested a return to the levels reached from the end of 1990- the beginning of 2000.

For the quantities seized and the number of seizures carried out over the past four years, see epidemiological table no.13.

Price and purity: Information on the price and the purity of psychoactive drugs has been available in France since 2000.

In epidemiological table no. 14, the purity of drugs over the last three years is shown. The composition and prices of the main illicit drugs are in epidemiological tables nos. 15 and 16.

Cannabis

Since 2002, grass was sold for less than 5€ per gramme. In 2005, it increased slightly compared to previous years (6.4 euros), since users are tending to choose drugs of a better quality. More than 80% of the samples analysed in 2005 contained less than 15% tetrahydrocannabinol (THC). The level of THC is completely unpredictable. It is higher in samples thought to come from the Netherlands.

The price of resin is stable and has fluctuated around five euros per gramme for several years. Over 90% of samples contained less than 15% THC (2005).

Opioids

The average price of brown powder heroin in metropolitan France, which seemed to be falling from 2001, returned to 50 euros per gramme in 2005. This figure is still to be confirmed, and should be approached with caution, given the reduced number of sites taking part in the TREND studies. There are strong local disparities. Purity rates are predominantly between 0 and 20%.

The median price of an 8mg Subutex® (BHD) pill on the black market fell from 6€ to 3€ between 2000 and 2002, and returned to 5€ in 2005. The more restrictive conditions of prescription set up at the end of 2004 are the cause of this sharp increase.

Cocaine

The price of powder cocaine and base cocaine (crack) varies according to the site and the social areas under observation. In metropolitan France, the average price of a gramme of powder cocaine was 58.4 euros in 2005: the lowest recorded in six years. The purity rate of seized cocaine is usually between 60 and 100%. It is most commonly cut with lidocaine, phenacetine and procaine.

Ecstasy

The average price of an ecstasy pill has settled at around 7 euros per unit. However, it seems more and more common to buy them in lots. The price of the pill then easily falls below 5 or 3€. In 2003, among pills collected by SINTES, 89% contained MDMA and 90% at least an amphetaminic derivative. The average is 54 mg of MDMA per pill (versus 56mg in 2002, 63 mg in 2001 and 74mg in 200). Nearly 4% of pills contain strong doses (>100mg). The dose of powders and gel-caps containing MDMA is on average double that found in pills (51% MDMA in powders (33 doses); 53% in gels (34 doses) and 24% in pills).

10.1 Availability and supply

The information detailed below relates the principal trends observed by the TREND observatory throughout the year 2005.

Cannabis

Still just as accessible.

Heroin

Heroin remains a low-visibility drug, and still seems relatively unavailable for its "traditional" users. This situation, which has prevailed since the development of substitution treatments, is accentuated by conversion of small dealers to the sale of the more lucrative cocaine. Nonetheless, over the last few years, the availability of heroin has tended to increase slightly. On the other hand, there are still limits on its accessibility. It is only rarely directly available on the streets (almost disappeared from the open scene). To obtain it, it is most often necessary to turn to networks of dealers operating primarily on private property.

On the other hand, its accessibility and/or visibility seems to be growing on the techno scene, essentially in large underground events (free parties and teknivals). It would seem that this drug, which circulates under the name "rabla", is no longer associated with the degrading image of the drug addict injector. Because of this, heroin is becoming seen as more normal, which would make it a drug like any other, whose use will eventually become "accepted". This acceptance will facilitate the initiation of new consumers or make old consumers more visible, leaving them more likely to hide their consumption.

Cocaine

Cocaine, in powder form, is a highly available product, and it is consumed by very diverse social groups.

A study on micro-trafficking of cocaine was carried out in 2004 and 2005 by the OFDT, based on 150 statements taken at random from all police questionings concerning using and dealing cocaine. These statements contained relatively detailed descriptions of the contexts (urban, party scene) where the arrests took place, the profile of users, dealers and clients, the organisation of small dealing networks (means of procurement, buying price, resale price, means of selling, etc) (Gandillhon, forthcoming).

Expanding consumption of this drug, still expensive in spite of the price reductions recorded over the past few years, goes hand in hand with developing polymorphic micro-trafficking activity. Bulk buying or dealing are the most common means of obtaining it. Opportunistic dealing micro-networks, often of several different drugs, have also funded cocaine dealing, a more lucrative activity than cannabis or even heroin trafficking (see development in the *selected issue* "cocaine").

The base form is also present, but circulates under two different names: "free base" and "crack". "Free base" is consumed in different social circles to crack. While the latter is present in very marginalised user groups and limited to very specific geographic zones (Paris, French Guiana and Martinique), "free base" is essentially consumed by groups closely associated with the party scene (nomads, travellers). Moreover, in a further differentiation, there is hardly any dealing of "freebase", since this is manufactured by the users themselves, while crack is sold via very specific dealing networks, most often operating directly at street level.

Ecstasy, amphetamines and other designer drugs

Ecstasy, ever present on the commercial and alternative dance scene, is available in three principal forms: pills, gel-caps and powder. Depending on what form it takes, its availability according to the type of event varies. Consequently, pills and gel-caps are very common on the commercial dance scene, in clubs and discos, while the powder form circulates more easily in the so-called "alternative" or "underground" scenes.

In spite of articles published in the national press announcing the unstoppable arrival of methamphetamine on the illicit drugs market, no TREND site has indicated the presence of Yaa Baa or Ice in either scene of investigation.

This year, the emergence of mCPP has been noted: in December 2004, m-chlorophenylpiperazine (mCPP) was identified for the first time in France in pills sold as Ecstasy. Indications via the National System for identifying toxic products and substances (SINTES) multiplied over the course of the year 2005 in different parts of the country, and several seizures took place, of which one involved over 5000 pills.

The first pills containing the substance were easily identifiable: they had a homemade appearance, were colourful and bore the name "Harlequin". New versions appeared subsequently, which were closer in appearance to normal Ecstasy pills.

Contrary to other European countries, mCPP was most often the only psychoactive substance found. A single type of heart-shaped pill contained both mCPP and MDMA.

To our knowledge this substance has never been sought out or identified by users who thought they were consuming MDMA. Unpleasant side effects were reported after consumption via the oral duct: nausea and vomiting, headaches, feelings of oppression and hot flushes. Two statements following use via the intravenous duct report facial swelling with violent hot flushes and respiratory blockage.

Hallucinogens

The availability of Magic Mushrooms is difficult to gauge due to four principal factors:

- the means of supply are difficult to observe (picking, home production, Internet);
- the importance of exchange and gifts in the circulation of this type of drug, resulting in a lack of structured dealing sphere.
- use mainly in contexts relative to the private sphere;

- the erratic nature of part of the total consumption, due to seasonal and climactic factors.

Although these reservations exist, it still seems doubtful that the demand for magic mushrooms has been on the increase over the past few years. Consumption is a phenomenon particular to the party scene, and especially private gatherings or the alternative techno scene. The groups concerned are predominantly young and frequently come from areas claiming to be marginal in terms of the dominant system of values.

10.2 Seizures

As for arrests for Infringements of the Drug Law, in 2005 a slight fall was recorded in seizures carried out by the police, gendarmerie and customs services: 83,932 seizures, compared with 85,810 in 2004 (-2.2%) and the quantities are reduced for many products (see below) (Central Office for the repression of illicit narcotics trafficking (OCRTIS, 2006). This fall goes against the growth trend of the past few years.

Analysis per drug for 2005 shows the following developments:

- slight fall in the number of cannabis seizures (-2.4%), much more clearly defined in the quantities (-20% compared to 2004); this decrease can be interpreted in the light of exceptional results for 2004, since, compared to 2003, seizures in 2005 are predominantly on the increase; no long term trend can be identified yet. All cannabis products (grass, resin, oil, feet and seeds) are on a downward trend.
- A greater fall in seizures of crack (-11% of seizures carried out compared to 2004 and -40% in terms of quantity seized.)
- And above all, an exceptional fall in seizures of ecstasy, which had seen strong growth since the 1990s: -24% fewer seizures and -56% fewer pills seized. The sharp decline in ecstasy seizures can be explained by the low number of large seizures, contrary to previous years.
- There were marked rises for cocaine (+3% of seizures and 16% more kg), with a sharp rise in very large seizures (>5kg) which, as in 2004, make up more than 60% of the total number of cocaine seizures ;
- But even more so, and for the second consecutive year, for heroin: 15% more seizures of 34% more heroin; quantities already rose in 2002, but, as for all products, the growth in quantity is less striking because it is depends on exceptional seizures.
- The rise in amphetamine seizures is in line with growth across Europe (+20% in Germany).

Table 10. Number and quantities of the main illicit drugs seized in France, 2004-2005

	2004		2005		Evolution (en %)		
	No	Qty	No	Qty	No	Qty	
Cannabis (kg)	75 800	107 748	73	986	86 603	-2%	-20%
resin	63 728	103 705	62396	83 471		-2%	-20%
grass	10 208	3 932	10202	3 062		0%	-22%
feet	1 492	81	1141	54		-24%	-33%
Heroin (kg)	2 828	558	3 242	749		15%	34%
Cocaine (kg)	3 175	4 484	3 278	5 186		3%	16%
Crack (kg)	769	18	687	11		-11%	-40%
Amphetamines (kg)	252	76	317	111		26%	47%
Ecstasy (doses)	2 135	1 893	226	1 620	833 648	-24%	-56%
Magic Mushrooms	287	24	195	26		-32%	9%
Total	85810	--	83932	--	--	-2%	--

Source: FNAILS, OCRTIS.

Origin and destination of the main drugs seized in France:

No major changes...

The ORCTIS summarization points out that:

- Cocaine supply from South America has increased on European markets and France is still a transit country (17% of cocaine seized is destined for the French market). This justifies the rise in cocaine seizures
- That the increase in heroine seizures can be explained by the sharp rise in seizures of heroin in transit, primarily to the UK and Spain; “activism in trafficking networks (Turkish, Albanian, Chinese) and the return to production on a grand scale in Afghanistan threaten to renew and exacerbate supply” . Seized heroin still comes predominantly from the Netherlands (47% of heroin seizures), but Pakistan emerged as the second biggest source country in 2005, accounting for 6% of heroin seizures
- The sharp fall in ecstasy seizures can be explained by the virtual absence of large seizures, contrary to previous years. Also new is the sharp decline in seizures during transit from France to the UK in 2005.

Table 21. Number of seizures and quantity seized of the main drugs in France

	2001		2002		2003		2004		
	No ⁽¹⁾	Qty ⁽²⁾	No ⁽¹⁾	Qty ⁽²⁾	No ⁽¹⁾	Qty ⁽²⁾	No ⁽¹⁾	Qty ⁽²⁾	
Cannabis (kg) ⁽³⁾		62 172		57 113		82 512		75 770	107 748
resin		58 195		50 836		78 347		63 701	103 705
grass		3 922		6 146		3 994		10 205	3 932
feet		41		96		84		1 492	81
oil		3		5		49		26	3
seeds		11		30		38		346	26
Heroin (kg)	2 650	351	2 633	476	2 560	545	2 828	558	
Cocaine (kg)	1 650	2 096	2 048	3 651	2 636	4 172	3 175	4 484	
Crack (kg)		6		7		12		761	18
Amphetamines (kg)	111	57	149	151	181	274	252	76	
Methamphetamines (kg)		0		16		4		0	0
Ecstasy (doses)	1 589	1 503 773	1 782	2 156 937	1 864	2 211 727	2 135	1 893 226	
LSD (doses)		6718		4262		10 383		101	19 374
		No(1)		No(1)		No(1)		No(1)	
All drugs		53 534		65 907		76 124		85 810	
Development, based on 100 in 1998		112,4		138,3		159,8		180,1	

(1)number of seizures during the year (2) quantities seized during the year. (3) Between 2001 and 2003, the total of quantities seized only includes cannabis resin and grass.

Source: FNAILS, OCRTIS.

10.3 Price and purity

The following data relates to the year 2005.

Cannabis

Price

In 2005, the average price for grass stabilised at 6.4 euros per gramme, a slight increase on previous years. It seems that users are favouring quality of the drug to a greater extent, and it is this demand which has contributed to the slight rise in price.

The average price of a gramme of resin is around five euros, in line with the previous five years, and may fall to four or even three euros when bought in bulk. The average price of a gramme of grass is slightly higher than in previous years (6.4 euros), since users are increasingly tending to favour a quality drug.

Purity

From May to August 2005, cannabis samples were gathered from users, to assess the THC content of the resin and grass consumed in France. This study follows on from a similar one carried out in different sites in 2004. The samples were collected in six towns and cities: Lyon, Marseille, Metz, Paris, Rennes and Toulouse. There were 391 samples in total, divided into 60% resin and 40% grass. The majority of users (95%) who submitted a sample consumed cannabis at least once a week.

Half of the THC doses were between 6 and 14% in grass and between 7 and 12% for resin. Around 5% of the samples in both forms reached levels higher than 20%.

A North-South divide was apparent for THC levels, which was more striking for grass than for resin. Consequently, in the southern cities (Toulouse, Lyon and Marseille) the median THC levels were 6% in grass and 7% in resin, while in the northern group (Paris, Rennes and Metz) they reached 12% in grass and 11% in resin.

No other psychoactive substance was found in any of the samples analysed.

Heroin

See frame.

Cocaine

In 2005, the median price of a gramme of cocaine was 60€, showing little change from 2004. The average price, at just under the 60 euro mark, is the lowest recorded over the last six years.

Ecstasy

According to SINTES, the price of Ecstasy (in euros) in 2005 is as follows, according to its different forms (pill, gel-cap, powder):

Table 22. Price in euros of Ecstasy in 2005, according to TREND

	Minimum	Maximum	Average price	Median price
Pill	2	15	6.7	6
Gel-cap	4	15	9.8	10
Powder	10	80	50.6	60

Source: Data and interpretation TREND/SINTES/ OFDT

SECTION B: SELECTED ISSUES.

11. Drug use among young adolescents

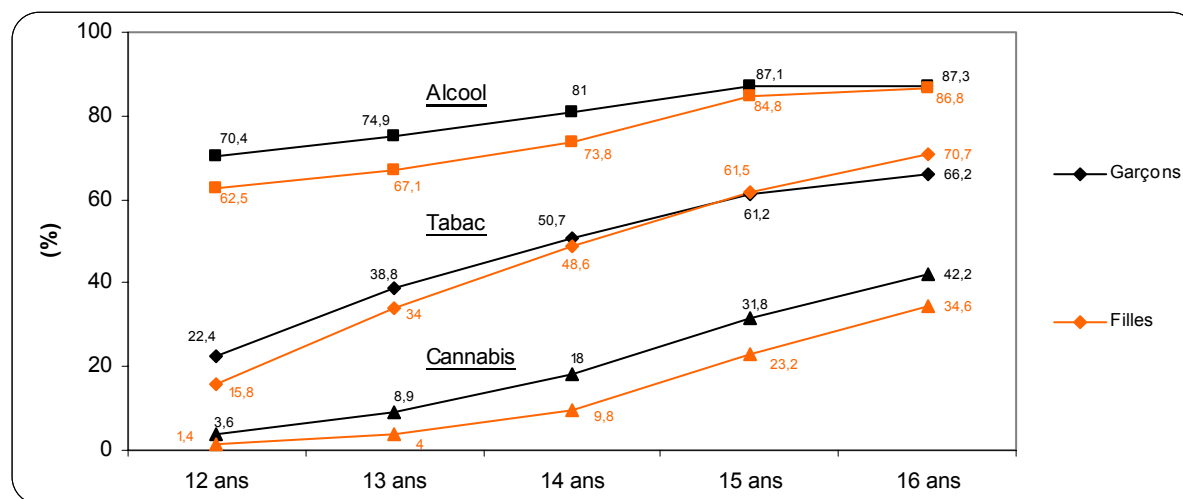
Beck François, Godeau Emmanuelle, Karila Laurent, Legleye Stéphane, Mutatayi Carine, Obradovic Ivana, Spilka Stanislas

Adolescence is the age at which experimentation with psychoactive substances takes place and, in some circumstances, can be the age at which more regular use begins. This article aims to evaluate the situation surrounding the consumption of illicit drugs among very young people (adolescents under the age of 15) and the consequences of entering into drug use at such a young age. Legal products such as alcohol and tobacco will be mentioned comparatively. Surveys of the general population provide an opportunity for the exploration of these questions and the observation of the distinctive features of very young people in comparison with behaviours observed at the end of adolescence. They have certain limitations, which should be mentioned here. In addition, they may equally effectively be carried out by other sources, illustrating the manners of usage and the discussions, preventative measures and suggested treatments offered to very young adolescents in France, and especially those facing drug use problems.

1. Use among very young people

In terms of general population outline data, three surveys dealing with adolescents can be called upon. All three are carried out via an automatically administered questionnaire and are strictly anonymous. The *European School Survey Project on Alcohol and Other Drugs* (ESPAD), carried out in 2003, offers the opportunity to observe use among young people in school (Choquet *et al.*, 2004), particularly those aged between 12 and 16 who are obliged to attend school. The Survey on Health and Drug uses During Call-up and Preparation for Defence Day (ESCAPAD) allows for the annual evaluation of the levels of psychoactive substance consumption of young people aged 17-18 and demonstrates recent trends in these practices at the end of adolescence (Beck *et al.*, 2004). These two surveys therefore allow the distribution of drug uses throughout adolescence – between 12 and 18 years old – to be observed, particularly the regular use of tobacco, alcohol and cannabis. In the *Health Behaviour in School-aged Children* (HBSC) survey carried out in 2002, pupils aged 11, 13 and 15 were questioned (Godeau *et al.*, 2005). Adolescents aged 11 and 13 were not asked questions relating to the consumption of illicit drugs, the questionnaire dealing only with the use of alcohol and tobacco for these age groups.

Figure 7. Experimentations with tobacco, cannabis and alcohol: prevalence over the course of a lifetime, according to age and gender



Source: ESPAD 03 – INSERM – OFDT – MENRT

Whilst experimentation increases with age for the three products, the progression appears rather different when they are compared to each other. For cannabis, whilst prevalence remains low at ages 12 and 13, especially among girls, it increases significantly from the age of 14. For tobacco, the proportion of people experimenting increases rapidly from 12 to 13 years old, after which the rate of increase becomes less and less marked, whilst the gap between the genders decreases. The increase in experimentation is nevertheless more significant among girls than among boys. Finally, in contrast with the other products, experimentation with alcohol is already widespread at 12 years old: the rate of increase is therefore slower, particularly after the age of 14, with girls catching up with boys.

For the other psychoactive products dealt with in the ESPAD survey, experimentation levels turn out to be low. Indeed, they are all below 5%, except for inhalants (glues, solvents) and hallucinogenic mushrooms. Whatever the age or the product, experimentation appears more frequent among boys than among girls. Whilst this experimentation increases with age for hallucinogenic mushrooms, it remains stable among boys, and even falls slightly among girls, for inhalants. Inhalants appear to be a one-off case, with experimentation beginning at a very young age (three quarters of those experimenting with inhalants did so for the first time before the age of 15), but their use is almost never continued into adulthood. In the following table, too much importance should not be accorded to the precise values and to the gaps between the different ages, since the majority of these figures are not significant (and are often small in size, especially among very young people) and because the validity of the declaratory survey for very young people, and for these substances, is questionable. It is possible to conclude that, from the age of 14, 2% of adolescents have experimented with most illicit drugs other than cannabis. Nevertheless, the majority of those who have tried one of these products do not repeat the experience. The percentage of amphetamine experimenters among young people is clearly linked to medical treatments for hyperactivity.

Table 23. Experimentation with other psychoactive products: prevalence over the course of a lifetime, according to gender and age (in %)

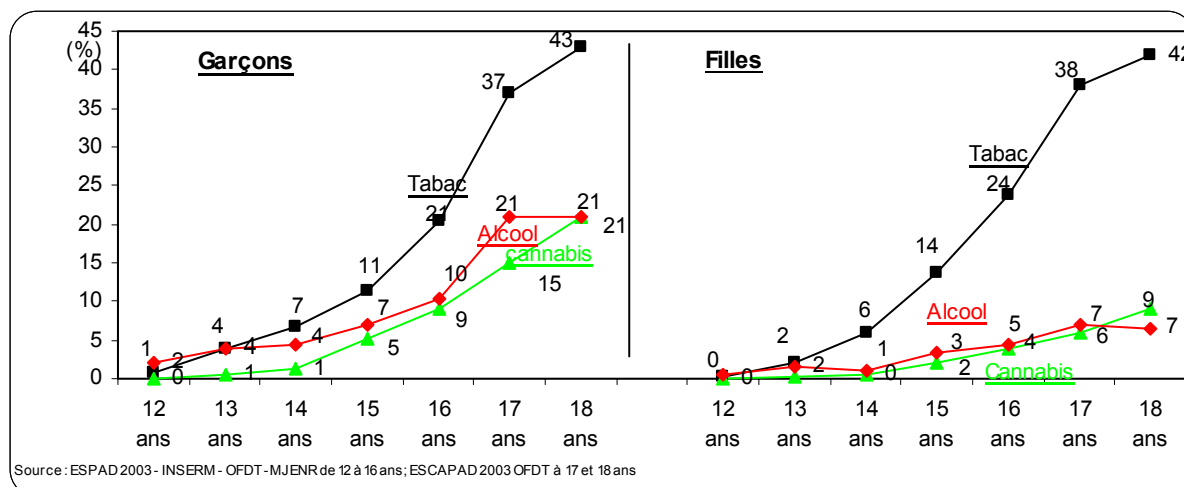
boys	12 yrs*	13 yrs *	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs
inhalants	7.5	9.7	11.3	11.6	11.6	12.4	17.3
amphetamines	0.9	2.1	2	3.4	2.8	3	3.2
ecstasy	0.5	2	1.7	3.9	3.5	5.2	7.2
hallucinogenic mushrooms	-	-	2.1	5.2	6.9	6.7	11.3
LSD	-	-	0.3	1.4	1.3	1.8	2.3
heroin	-	-	1.3	2.7	2.3	2.1	1.8
cocaine	-	-	2.5	4	2.7	2.6	3.1
girls	12 yrs*	13 yrs*	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs
inhalants	6.5	6.8	8.4	12,0	9.7	9.6	9.8
amphetamines	0.1	0.9	1.4	1.9	2	1.8	1.5
ecstasy	0.4	0.8	1.4	2.9	3	2.6	3.1
hallucinogenic mushrooms	-	-	0.4	1.8	2.8	2.8	2.6
LSD	-	-	0.1	0.8	0.8	0.5	0.9
cocaine	-	-	2.2	2.6	2.5	1.6	1.9
heroin	-	-	0.5	1,0	1.4	1.5	0.8

Source: ESPAD 03 – INSERM – OFDT – MENRT

(*) For pupils aged 12 and 13, the questionnaire was simplified and some products removed.

Regular tobacco or alcohol use appears relatively infrequent under the age of 14 and cannabis use is very rare under the age of 15. Regular use of these products then increases with age, with daily tobacco use taking a clear lead over the regular consumption of alcohol and cannabis. Between the ages of 12 and 15, the proportion of daily tobacco smokers increases from 1% to 11% of boys and 0% to 14% of girls. There is also an upward trend with age for alcohol and cannabis, especially among boys, and to a lesser extent among young girls.

Figure 8. Regular* tobacco, alcohol and cannabis use, according to age and gender among 12-18 year-olds in 2003



* at least ten uses during the last 30 days for alcohol and cannabis; daily use for tobacco

According to the answers given in the HBSC survey of 2002, at the age of 11, 14.4% of boys and 9.7% of girls ($p < 0.0001$) stated that they had already tried smoking tobacco. The levels of current smokers appear vastly inferior: whilst 1.6% of 11-year-old pupils stated that they smoke once per month, only 0.6% said they do so daily. No gender difference was observed in current tobacco use among 11-year-old pupils.

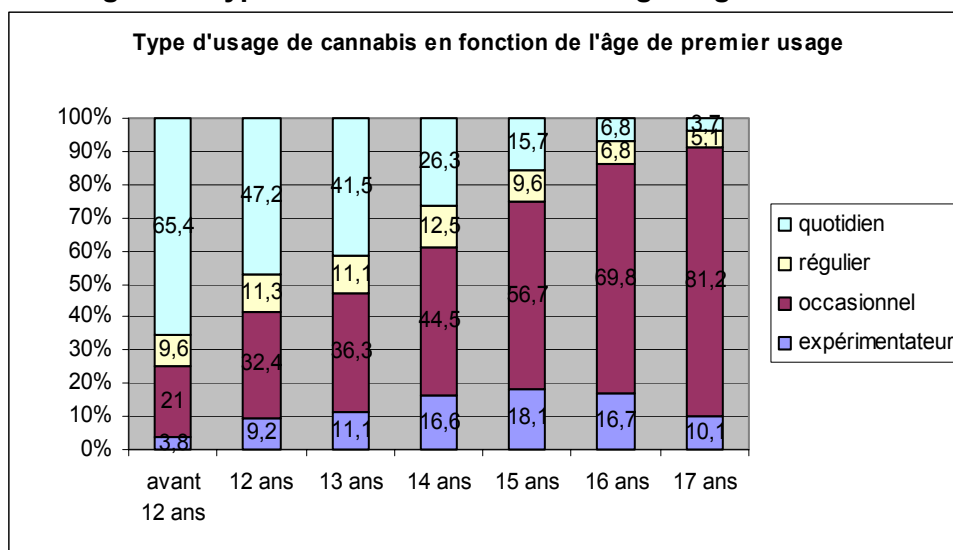
In terms of alcohol use among 11-year-olds, 81.6% of boys and 92.2% of girls stated that they did not drink at the time of the survey. If we now look at consumption, occasional use is the most frequent type of use at this age, with daily consumption remaining quite rare (2.5% of boys and 0.8% of girls), and at this age should be interpreted with a note of caution. As with older individuals, this type of alcohol consumption is more frequent among boys than among girls (Godeau *et al.*, 2005).

2. Use at a young age: a retrospective approach

From the answers to the question about the age of first use of the different products, the timeline of consumption appears relatively weak compared with the most recent North American studies (Johnson and Mott, 2001). The effect of the first drug use being at a very young age on the probability of persistent use (Robins, 1984, Windle, 1996), even problematic consumption or the movement to other products such as cocaine or heroin in adulthood (Yamaguchi and Kandel, 1984), has been widely dealt with by epidemiologists, across all psychoactive substances (Kraus, 2003) and alcohol in particular (Hawkins *et al.*, 1999; Kraus *et al.*, 2000; DeWilt *et al.*, 2003; Hingson *et al.*, 2003). In terms of cannabis, this influence has been judged fundamental and can compromise cognitive development (Pope *et al.*, 2003), as well as being linked to psychiatric comorbidity (Armstrong and Costello, 2002) or to social problems such as unemployment, academic failure or delinquency (Fergusson and Horwood, 1997). As a result of the American SAMSHA study, Gfroerer *et al.* (2002) demonstrated that 62% of adults over the age of 25, who had been introduced to cannabis before the age of 15, declared having consumed cocaine at some point in their lifetime, as well as 9% for heroin and 54% using psychotropic medicines regularly. These figures are significantly higher than those observed across the general population, which were 0.6%, 0.1% and 5.1% respectively.

Several recent studies temper these claims, however, citing possible biases in the measurement of cannabis dependency (Chen and Anthony, 2003). According to the Roques report (1998) on the level of danger posed by different drugs, whilst a childhood family and socio-cultural environment characterised by conflict is a particularly high risk factor for dependency on a psychoactive substance, it seems aggravated when the first experiment is at a very young age. It is possible to explore this question through the data of the 2003 Escapad survey (Beck *et al.*, 2004). This data also tends to point towards the primacy of the first use being at a very young age over other possible variables (school situation, proportion of consumers among friends and family, signs of anxiety and depression, consumption of medicines and professional status of parents).

Figure 9. Type of cannabis use according to age at first use



Source: ESCAPAD 2003, OFDT

Across all the adolescents questioned in the 2003 Escapad survey, we can observe a marked trend in the distribution of types of cannabis use as the age of the first use increases: a very young age is linked to future heavy consumption of cannabis. Two-thirds of 17-19 year-old adolescents who smoked their first joint before the age of 12 became daily cannabis smokers, and only 3.8% of them stopped consuming it altogether. In contrast, those who did not start smoking it until the age of 16 or 17 are almost always occasional smokers.

It is not possible here to give an outline of any reflections on the strength of the link between very young experimentation and regular use. Grass-roots drug addiction activists, particularly social workers, agree that very young engagement in consumption is one of the signs to be monitored carefully. Should the fact that young adolescents find themselves trapped by the addictive potency of the product not be considered? It would seem that very young people are often psychosocially vulnerable, which can lead to situations throughout adolescence where use becomes problematic. In addition, the question of age at first use of these products was only asked for the first time in France in 1999 in the ESPAD survey, a fact which does not allow for the high levels of dissemination of cannabis and any change in the age at which it is first consumed to be put into perspective. The trend observed between 1999 and 2003 is therefore not particularly informative, with the average age of introduction falling slightly among 17-year-olds (from 15.3 to 15.2 years old), although this fall is not significant. It must nevertheless be noted that the widespread dissemination of the product coincides with relatively disinterested individuals beginning to consume the drug and experimenting recreationally as and when the product is available.

3. The questioning of very young people through general population surveys: a question of methodology?

The questioning of very young people through general population surveys poses several limitations. In 1997, in the Health Barometer of Young People (Baudier *et al.*, 1998), adolescents aged from 12 to 14 years old were not asked the questions relating to the consumption of illicit drugs. This precautionary measure was taken following the pilot survey, carried out in October 1997, during which the researchers had noted that very young people were frequently uncomfortable with this theme, creating a high level of non-response. The

research team also decided that such questioning, taken out of the context of preventative action and without any possibility for in-depth discussion on the subject, was likely to worry the least informed respondents to the survey, often including very young people. It should be noted that this same concern in the HBSC survey meant that questions on illicit substances were only asked to 15-year-old pupils. What is more, with this survey having been carried in the classroom with the prior agreement of the educational establishment and parents, the posing of questions on these products to very young people would have risked the acceptability of the entire survey, given that this is a general survey normally acceptable even to very young people. This sensitivity is more marked in some countries than in others but, for the sake of standardisation, it was preferred across the board to remove these questions for the versions of the questionnaire intended for 11 and 13 year-olds, as well as questions dealing with sexual activity.

In the 2000 Health Barometer, however, this question was posed to very young people (12-14 year-olds), but only for cannabis. It was noted that, over the telephone, they declared very low usage levels (3.6% of boys and 3.7% of girls aged 12-14 years old stated that they had experimented with the drug), whilst the number who had been offered it was already quite significant: at this age, 9.9% of boys and 13.6% of girls said they had been offered cannabis (Beck, 2000). These usage levels can be compared retrospectively (by looking at the question of the age of first use) with the answers given by the 18 year-olds questioned in the 2001 Escapad survey:

Table 24. Use of cannabis over the course of a lifetime among 12-14 year-olds, according to the declarations of age of first use given in 2001

	Boys	Girls
12 yrs	1.7 %	0.6 %
13 yrs	5.0 %	2.3 %
14 yrs	13.8 %	7.3 %
12-14 yrs	6.8 %	3.4 %

Note: 13.8% of boys stated they had already smoked before the age of 15
Source: ESCAPAD 2001, OFDT

Whilst the levels among girls appear very similar in the two surveys, twice as many boys stated they had smoked cannabis when the question was asked retrospectively, despite a negative generational effect (those aged 18 in the 2001 Escapad survey were 12 years old in 1995, at a time when the levels of cannabis use were lower than in 2000).

4. The legal framework

In France, the protection of minors under the age of 16 against tobacco smoking is based on two recent legal acts (the law of July 31st 2003, which aims to restrict the consumption of tobacco among young people and, more significantly, decree no. 949 of September 6th 2004, which sets the courses of action for preventing the sale of tobacco to minors under the age of 16, under which the vendor has the right to demand a form of identity). In general, tobacconists follow these two laws strictly for very young people (under the age of 12) but this obedience tends to weaken from aged 15 and beyond. The law of 2003 also forbids the sale of cigarettes in packs of less than 20, as smaller sizes were mainly aimed at young children.

In terms of alcoholic beverages, the legislation relating to minors under the age of 16 is much older: it is based on the order of January 7th 1959 and the law of July 5th 1974, which forbid their sale to minors under 16 years of age. More recent legislation has been brought in to protect very young people from products specifically designed for them: premixed alcoholic

beverages. Heavy tax penalties were levied against these products when they appeared on the market in 1996, causing the originally high sales figures to collapse in 1997. These products reappeared in 2002 due to alcohol producers bypassing the legislation. The law also prohibits the presence of a quantity of beverages in a “protected zone” (including the area around stadiums, educational establishments, swimming pools...) in order to protect very young people.

5. Very young people subjected to questioning

Using data from the *Office Central de Répression du Trafic Illicite de Stupéfiants* (OCRTIS), which records infringements of drug laws dealt with by the police, the proportion of individuals aged 15 and under subjected questioned by police about drug use can be observed. This has varied from 1.6% in 1996, to 3.3% in 1999 (OCRTIS, 2005). In 2004, the figure was 2.4% of the total number of people questioned, equating to 2,415 individuals nationally. More than 99% of them were for cannabis use, with the number of individuals questioned about other products never climbing above ten (8 for ecstasy, 6 for heroin).

The proportion of individuals aged 15 and under questioned about cannabis use represents 2.6% of the total number of people questioned about this drug, whilst the number questioned about selling or trafficking cannabis represents 1.9%. In 2004, the youngest person questioned was 7 years old (one case), but observations show that the number of individuals questioned for cannabis use becomes significant from the age of 13 (185 cases in 2004), and is rises at 14 (596 cases) and 15 (1567 cases). This figure mainly concerns boys (85.3% of these cases), but young girls are becoming more and more involved. The sex ratio is 97% for 16-20 year-olds and 92% for 21-25 year-olds, subsequently diminishing with age.

This trend among the population of 10-15 year-olds is dealt with by the law via cannabis clinics (see *infra*): out of 160 consumers in this age group admitted in one particular month, 36 had been ordered to go there by the courts, and 94% of them were boys.

6. Requests for help, consultation, offers of treatment and prevention

The survey of people attending cannabis clinics was introduced in 2005, and offers a complementary view of very young people. This survey was carried out by means of a questionnaire aimed at the professionals who dealt with patients (and/or their family and friends) between March 15th and April 15th 2005, and followed them until June 30th 2005. It deals with a sample of 229 cannabis treatment clinics, which received 4202 people in the course of one particular month, 72% of whom were consumers and 28% being the consumer’s family or friends. Young people aged between 10 and 15 account for 6% of the total number of people attending cannabis clinics (which numbers 3000 consumers in an average month). Two thirds of these 160 young people are aged 15, 21% are aged 14 (33 individuals) and 10% are aged 13 or under (17 individuals). For comparison, the number of active consumers attending these specialist clinics comprises 41% adolescents aged 16-19, 40% young people aged 20-25 and 13% older consumers (26 or over).

The sex ratio is weighted towards boys at all ages, although less so among 10-15 year olds: girls represent 30% of this age group; this falls to 21% of 16-19 year olds, 18% of 2-25 year olds and only 17% of those over 25.

Requests made by a third party (from a family or school environment) are the main reason for attendance among 10-15 year olds: 61% of those attending do so on the advice of their family or friends – often accompanied, usually by one or more parent(s) – whilst 23% are required to attend by court, and 16% attend of their own free will. The proportion of court referrals is significantly smaller at this age than among older age groups (33% of 16-19 year olds, 48% of 20-25 year olds): at all ages, it is mainly boys who attend for this reason.

The reasons for attending cannabis clinics do in fact show significant differences according to gender: whilst the main reason for attendance is the advice of a third party for both sexes (71% of girls and 57% of boys), girls are much more likely to attend of their own free will and boys are more often referred by court.

In the 10-15 age range, approximately half of all those attending (46%) state that they are an occasional cannabis user (consumption on less than 10 occasions in a month), 22% are regular users (between 10 and 29 times per month) and 32% are daily users. In comparison with other ages, the proportion of occasional users is particularly high in this age group.

Those aged between 10 and 15 attending cannabis clinics began to smoke at an average age of 13, for both boys and girls. One quarter experimented with cannabis before this average age. Around 60% of those attending aged between 10 and 15 are one-off or “at risk” users, and almost 40% are judged to be harmful users of, or dependent on cannabis²⁸. Compared to use among adults, it is at this age that the proportion of those falling into the dependency category is the lowest, and the “at risk” category is the highest.

Table 25. Diagnostic of use among those attending aged between 10 and 15

	Use	“At risk” use	Harmful use/abuse	Dependency	
Boys	27%	37%	22%	13%	100%
Girls	20%	33%	23%	25%	100%
Total	25%	36%	22%	17%	100%

Source: Survey on those attending cannabis clinics, OFDT, 2006.

In a context where drug prevention is characterised by low-profile concrete interventionism by the State, there is so far no standard model of action for networks of professionals or institutions. Such a model may develop in the near future. In fact, the *Plan gouvernemental 2004-2008 de lutte contre les drogues illicites, le tabac et l’alcool* (2004-2008 government plan for the fight against illicit drugs, tobacco and alcohol) outlines the creation of effective prevention conditions which are adapted for all levels of education, echoing the principles set out in the *programme quinquennal 2003-2008 de prévention et d’éducation élaboré par le ministère de l’Éducation nationale*²⁹ (2003-2008 five-year plan for prevention and education developed by the Ministry for National Education). This political will from those in power was cemented in autumn 2005, with the finalisation of the “*Guide d’intervention en milieu scolaire pour la prévention des conduites addictives*” (“Guide for school-based intervention for the prevention of addictive behaviour”). The distribution of the recommendations made in this guide is aimed at standardising the preventative measures offered to young pupils, insofar as the majority of counter-dependency actions take place in an educational setting and involve the wider educational community in both the coordination and implementation of these actions.

²⁸ Classification under these categories was carried out by the person in charge of the adolescent. This could be a doctor, social worker... The person was able to utilise a grid to help them (CAST, DEP-ADO, CRAFFT, CAGE-cannabis, ALAC, or internal evaluation grid) but without using a reference threshold.

²⁹ Established by circular no. 2003-210- of December 11th 2003; NOR: MENE0302706C.

Since 1990, the Ministry of National Education has encouraged an approach to at risk behaviour which requires primary and secondary education establishments to deal with the question of drugs from a behavioural perspective rather than from one of the products themselves. The guide reaffirms this principle. It provides the key information needed to deal with all drug-related issues with pupils from *CM2* to *Terminale* (4th to 11th grades), deepening the principles of the legal and illegal psychoactive products consumed by these generations. The guide includes successive intervention plans, which deal with the following subjects:

- tobacco for pupils in *CM2* and 6^{ème} ³⁰ (11 to 12 years old on average) ;
- alcohol for pupils in 5^{ème} et 4^{ème} ³¹ (13 to 14 years old on average) ;
- cannabis for pupils in 3^{ème} et de 2^{nde} ³² (15 to 16 years old on average)
- and finally, polydrug use in 1^{ère} -*Terminale*³³ (17 to 18 years old on average).

From the point of view of reference strategies for problematic use, as a general rule, the clinician takes the at risk consumption methods and the seriousness of the individual and environmental factors into account, looks for clinical signs and/or complications linked to the consumption of the product, refers to approved questionnaires and evaluates the patient's motivation to change. This evaluation strategy for the risks linked to the use of psychoactive substances is exactly the same for young adolescents. Several questionnaires permit the assessment and evaluation of the harmful consumption of psychoactive substances among adolescents, especially those which are illicit. The CRAFFT questionnaire, a 6-question tool which assesses harmful use of psychoactive products, has been subjected to a validity study across the general population of France (Karila *et al.*, 2006). Similarly, the CAST (Cannabis Abuse Screening Test) questionnaire, also containing 6 questions which are specific to cannabis consumption, has been subjected to a validity study across the general population, and is currently undergoing clinical tests. Standardised tools such as these are used more and more regularly, whatever the age of the respondent. They demonstrate that dependency is rare but abuse is relatively frequent in the under-16 age group (Reynaud, 2002). In any clinical approach, it is important to evaluate the patient's motivation. Motivational support is a therapeutic technique whose effectiveness has been proven to help addictive behaviour. It consists of a patient-centred approach, which aims to bring about a change in behaviour by helping the patient to explore and resolve his/her possible ambivalence. The therapist must force the patient to accept his/her problems, and to think of possibilities and ways of going about introducing change. This therapeutic technique is based on the principles of empathy, the exploration of ambivalence, the fight against resistance, the reinforcement of the feeling of self-empowerment, freedom of choice and the removal of obstacles. This approach can serve as a platform for pharmacotherapy (Miller and Rollnick, 2002; Miller, 1996). It is well suited to young users who are already in problematic situations linked to their drug use.

³⁰ The final year of primary school and the first year of secondary school (corresponding to 4th and 5th grades).

³¹ The middle two years of secondary school (corresponding to 6th and 7th grades).

³² The last two years of secondary school (corresponding to 8th and 9th grades).

³³ The two years of sixth form college (corresponding to 10th and 11th grades).

12. Cocaine and Crack Use: prevalence, risks and responses

Cadet-Taïrou Agnès, Touffik Abadalla, Gandilhon Michel, Bello Pierre-Yves and the TREND network

Apart from a short period of time around the First World War, the consumption of cocaine in France has remained moderate and has never been considered as a major public health issue. Its use has always been insignificant compared to opiates. The increase in the use of cocaine since 1995 has represented a break in the history of this product. The 1990s saw not only an increase in the dissemination of the chlorhydrate form of cocaine (powder), but also the emergence and relative increase of the base form (free base or crack) (see Bello and Toufik 2004, Bello and Toufik 2005).

Looking more specifically at the dissemination of the base form of cocaine, its use was introduced almost simultaneously by two distinct groups, aiming at two distinct types of user:

- People who travelled to or stayed in the United States during the 1980s introduced it to cocaine powder sniffers in relatively affluent city environments of under the name *free-base*, usually making the base form of cocaine themselves³⁴;
- People of West Indian origin preferred distributing it on the streets of Paris, exclusively under the name crack, which they acquired already in base form in rocks.

This double origin has probably contributed to the confusion surrounding the name of the base form, which some people call *crack* and others *free-base*, believing they are talking about two different products.

The market for crack thus first appeared in the three French overseas territories (Guyana, Guadeloupe, Martinique) in the middle of the 1980s. Their proximity to cocaine-producing regions (South America) and to Spanish- and English-speaking islands, which became one of the main transit zones for cocaine and crack destined for Europe and the United States, contributed to the development of the local crack market in these territories, to the point where it became the second most widespread illegal local product after cannabis.

Of all French cities, it was Paris where crack first appeared. The existence of an open scene in the north of the capital acted as a platform for its dissemination. When crack first appeared in Paris around 1990, the consumers, like the petty traffickers, were of Caribbean origin. The spread of consumption to other French and North African ethnic groups, and of trafficking to Africans, as well as the spread of the drug to other French cities, only came about several years later (Bello and Toufik 2005). In comparison with fears of an epidemic in the French Antilles and Guyana, where crack users can be found in affluent circles, use of the drug under this name seems numerically and geographically limited to cities. Use of the free-base form, however, has spread to new groups of consumers: young people involved in the dance scene or from the inner city.

1. Observation of cocaine and crack use. Consumption: a strong increase but still a moderate level

The extension of consumption across the general population

In 2005, 2.6% of 15-65 year-olds in France had experimented with cocaine. Although this prevalence remains low in comparison with the consumption of other psychotropic drugs

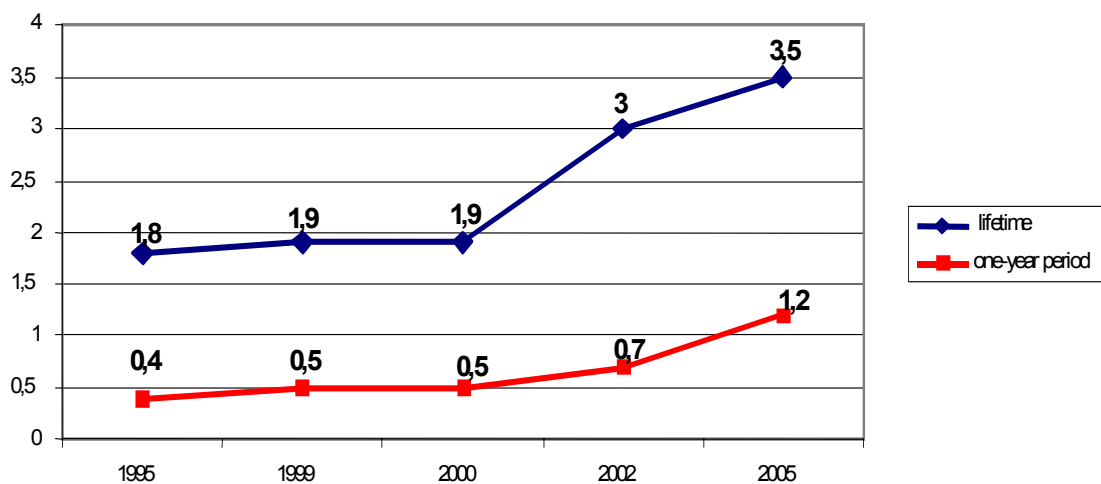
³⁴ Etienne Matter (A.S.U.D). *Rapport national sur le 'Freebase' et le 'Crack'*, January 2003 (unpublished report carried out within the framework of the TREND system)

such as cannabis, the product nevertheless seems easily accessible, as 8% of 15-65 year-olds had been offered it (Beck and Cytrynowicz 2006). The most significant proportion of people who had tried cocaine was in the 25-34 year-old category, with a figure of 4%, compared with 3.4% of 18-25 year-olds and 1.3% of 45-64 year-olds (Beck, Legleye et al. 2006). The average age at which cocaine was first taken among 15-65 year-olds is 22.6 years (Beck, Legleye et al. 2006).

It is estimated that 200,000 people consumed it in the year 2005, accounting for 0.6% of 15-65 year-olds. This rate rises to 1.5% among 18-25 year-olds. Men consume cocaine three times as often as women (0.9% vs. 0.3%).

Cocaine use is most often found among young adults and children. In 2005, among young people aged 17, it was estimated that 2.0% of girls and 3.0% of boys had already experimented with cocaine (Beck, Legleye and Spilka 2006). This data, collected during the compulsory citizenship day for all young French people aged 17-18, is in line with data from the ESPAD survey, which shows that 2.6% of boys and 2.0% of girls aged 16-17 had experimented with cocaine by 2003 (Coquet, Beck et al. 2004).

Figure 10. Trends in the frequency of cocaine consumption among French people aged 15-34 (1995-2005)



Source: Health Barometer, OFDT/INPES

All available indicators show a spread in cocaine consumption. In fact experimentation across the general population (15-65 year-olds) as more than doubled in 10 years (1.1% in 1995, 1.6% in 2000 and 2.6% in 2005). Use in a one-year period among 15-64 year-olds has tripled between 2000 and 2005 (0.2% in 2000, 0.6% in 2005) (Beck, Legleye et al. 2006).

Among very young people, the acceleration is even more marked. In 2000, 0.6% of girls had experimented with cocaine by the age of 17. In 2003, this figure was 1.1%, and 2.0% in 2005. Among boys, experimentation by the age of 17 rose from 1.3% in 2000 at 2.0% in 2003, finally reaching 3.0% in 2005 (Beck, Legleye and Spilka 2006).

The social environments affected by cocaine have become rather heterogeneous, and it is therefore difficult to draw up of profile of types of user. Cocaine is no longer used only in upper social classes or by marginalised drug users, but also affects the economic middle classes and users found in the dance scene (Bello and Toufik 2005). However, it is possible to identify a core group of users, comprising mainly people who frequent night clubs and parties, former drug abusers who have moved onto methadone and Subutex®, and finally more or less marginalised drug users who are able to frequent so Low Threshold” structures.

A substance which is firmly embedded in the dance scene

In the “electronic music” dance scene of the five towns which participated in a study in 2004-2005 (Nice, Toulouse, Rennes, Bordeaux, Metz), 34.6% (n=1,496) of people surveyed said they had consumed cocaine during the previous month and more than two thirds had taken it at least once in their life. Of those questioned, 6.1% said they had consumed crack/free-base in the previous month. It should be noted that there is a low prevalence of daily consumption of cocaine and crack within this mainly festive population, with figures of 2.7% (14/518) and 3.2% (3/91) respectively (Reynaud-Maurupt 2006).

The frequency of cocaine consumption varies according the different “scene groups” identified within this dance scene population. These “scene groups” correspond to a typology of populations frequenting the recreational dance music scene. Based on an ethnographic study, these groups are formed according to the style of music and type of establishment visited.

Table 26. Prevalence of cocaine consumption in the population frequenting the “electronic music” dance scene, 2004-2005

Scene groups	Consumption	Monthly		More than once per week
		Non-base form	Base form	
“Alternative”	(free party, rave), n=276	50.0 %	13.4 %	16.0 %
“Urban”	Pubs, n=398	27.1 %	4.5 %	8.0 %
“Clubbing”	Night clubs, electronic clubs n=430	27.9 %	1.4 %	11.2 %
“Select ”	privileged admission clubs, "selective" pubs n=192	27.1 %	1.6 %	10.4 %

Source: Reynaud-Maurupt [8]

The Alternative scene group comprises the population frequenting *rave parties* and *free parties*.

The Urban scene group comprises people who visit pubs or occasional parties in specially hired premises with a capacity of less than 1,000 people, and very occasionally “Electronic” festivals.

The Clubbing scene group comprises those who attend night clubs specifically dedicated to electronic music, called “Electronic clubs”.

The Select scene group comprises people who visit clubs where entry is by invitation only or pubs with free access, but where a specific dress code is in force (Reynaud-Maurupt 2006).

Frequent consumption among drug users who are in contact with risk reduction and socio-sanitary structures

The most recent data available (2003) shows that 35% of drug users encountered in low threshold structures³⁵ who responded to the survey carried out in these structures had consumed cocaine in the course of the previous month (Bello and Toufik 2004).

For the powder form of cocaine, the proportion of daily consumers varies from 25% in 2001 to 8% in 2003. It remains at around 40-50% for the base form of cocaine and, according to

³⁵ Corresponds to the urban space as defined in the OFDT’s TREND information system: all areas of a town/city where active drug users can be observed. It essentially comprises people who may be encountered in low threshold structures (reception centres and syringe exchange programmes), in certain specialised care centres and in “open” locations such as streets and squats.

the year observed, represents two to four times more than the proportion of daily cocaine consumers. This difference can be explained, at least partly, by the socio-demographic characteristics of the users: cocaine users are more socially integrated and consume occasionally and “recreationally”, whereas crack users are rather marginalised and consume more compulsively (Bello and Toufik 2005).

Table 27. Proportion of cocaine and crack/free-base consumers in the previous 30 days among low threshold structure users

	Cocaine		Crack/free base	
	In last 30 days	of whom daily	In last 30 days	of whom daily
2001* (n=799)	39 %	25 %***	20 %***	50 %***
2002* (n=964)	42 %	19 %	26 %	39 %
2003* (n=1082)	35 %	8 %	18 %	40 %

*** The question asked did not mention free base

Sources: Data and interpretation: * TREND/OFDI; [1-3];

The average age of recent cocaine chlorhydrate consumers among users of low threshold structures is 28.4 years, compared with 31.7 years for those not using these structures. Three quarters of users are less than 32 years old, and 4 out of every 5 users are male. Almost 60% of consumers experimented with cocaine for the first time between the ages of 17 and 22 (Bello and Toufik 2005). Users of the base form of cocaine within this framework are older. The average age is 32.5 years and 41% of them are aged 35 or over. Men outnumber women by four to one (Bello and Toufik 2005).

While the proportion of drug users in risk reduction structures consuming cocaine remains stable, it has seen a steady increase in socio-sanitary centres specialising in drug use since 2001: 8% in 2001, 9% in 2002, 10% in 2003 and 11% in 2004 [9]. Amongst these users, 20% consume it daily.

In French cities, the consumption of the base form of cocaine known as crack remains relatively concentrated in the north-east of Paris (18th *arrondissement* and the neighbouring *arrondissements*), tending to extend into the Seine Saint Denis region. These areas contain a population of between 2,000 and 3,000 drug addicts (Lebeau 2006).

This particular group of crack users in the north-east of Paris has formed the focus of a specific study, not yet published, demonstrating the extreme social difficulties of this population (absence of stable housing, lack of access to rights and due to a lack of identity papers, absence of social security and work) and cites the poor access to healthcare. These users take many more risks and may undergo extended periods of consumption (3 consecutive days for example) without eating or sleeping. The lack of housing removes access to any basic hygiene facilities (EGO 2004). This population is 80% male, with ages ranging from 18 to 57, and an average age of 36 (EGO 2004).

Crack, the most frequently-consumed drug in the Caribbean

In the three French overseas territories, Martinique, Guadeloupe and Guyana, the situation differs significantly, in that crack is the most widespread illicit product among drug users. In Martinique, 66% of people attending low threshold structures had consumed crack and cocaine chlorhydrate within the previous month. In Guyana, 58% had consumed crack, but only 2% had taken cocaine chlorhydrate recently. There is a marked difference between the daily life of a cocaine consumer and a crack consumer. Given the differences in price and supply methods, the two products do not concern the same audience, with cocaine use remaining the privilege of relatively affluent communities (who do not attend low threshold

structures). In contrast, crack affects a much more socially marginalised population. In Guyana in particular, the homeless and/or marginalised population comprises most crack users. They are becoming more and more visible and numerous. The “recruitment” of these individuals is carried out by dealers among the most fragile population groups: the mentally ill, unemployed, those on welfare benefits and illegal immigrants. Nevertheless, crack consumers are not all social outcasts from disadvantaged social environments. In Martinique, it has been noted that many people manage to consume crack, usually occasionally (in the form of black joints), whilst maintaining a job and a family. Among these users are several former heroin addicts or polydrug consumers returning to the country to discover a drug to which they had not formerly had access. Moreover, it is among these users that unusual usage methods can sometimes be found, such as injection after acidification. In Guyana, it is becoming more and more common to find crack consumption in affluent environments (Bello and Toufik, 2005).

A contrasting situation in prostitution environments

The situation regarding cocaine seems significantly different in male and female prostitution environments.

Whilst the proportion of male prostitutes who had experimented with cocaine at least once in their life appeared quite high in 2002 (50%, n=258) (42% of “boys”³⁶ and 58% of “transgender individuals”³⁷), consumption in the previous month appeared rather low (13%; 4% of boys and 12% of transgender individuals). Among boys, cocaine was seen as a drug of “high-class” customers, which was consumed occasionally when offered by the client. Among transgender individuals the use of cocaine seems more widespread and more frequent, especially recreationally. Although such use turned out to be controlled, the testimonies of some transgender individuals pointed to periods of dependency [12]. Six percent of boys and ten percent of transgender individuals (eight percent in total) had consumed crack at some point in their lifetime. Of these, 0.8% had consumed it in the month preceding the survey. In this population, cocaine is most often taken by sniffing, rarely smoked, but never injected.

A study carried out in female prostitution environments in 2002 found a lower level of experimentation with cocaine or crack among prostitutes (30 out of 165, or 20%). In contrast, all current consumers of cocaine or crack were dependent on opiates (13 out of 165). Whether or not prostitution had preceded drug addiction, dependence on opiates had always preceded crack or cocaine use, having been used to “replace” the pleasure lost through the dependence on opiates (Cagliero and Lagrange 2004). All those who had consumed within the previous month had either smoked or injected the base form of cocaine.

2. Consumption methods: the sniffing majority

Different methods according to user groups...

Among those frequenting the “electronic music” dance scene, cocaine is mainly taken by sniffing (98%) and smoking “base” (19%), but very rarely injected (0.6%). In comparison, among users attending low threshold structures³⁸, who are usually active users, sniffing is the majority method (62%), but injection is widespread, concerning more than four users out of ten (43%) (Bello and Toufik 2005, Reynaud-Maurupt 2006). In specialised centres for drug

³⁶ Boys practising prostitution regularly or occasionally display their masculinity. In this case, they practice prostitution only with men.

³⁷ The term transgender refers to a person whose gender identity does not correspond to his/her sex at birth. Here, the term refers to people of male sex who dress as women to practise prostitution, whether or not they have undergone an operation or hormonal treatment, to fulfil the sexual desires of the market or for their personal pleasure.

³⁸ Risk reduction and drug addict support structures

addicts, the proportion of users who smoke cocaine is around one third of all consumers (CEIP Marseille 2005).

Table 28. Cocaine chlorhydrate administration methods* in the previous month among the 2003 “low threshold” survey and in the electronic dance music scene 2004/5

Method of use*	Low threshold** (n = 303)	Music scene*** (n = 506)	Socio-sanitary structures**** (n=374)
Injection	43%	0.6%	29 %
Sniffing	62%	98%	55 %
Inhaling, smoking	15%	19%	28 %

* one person may employ several administration methods

Data and interpretation: **TREND/OFDT; *** GRVS/TREND/OFDT **; * OPPIDUM/CEIP/AFFSAPS

Most users employ only one administration method: just under half (46%) of users attending low threshold structures stated that they do not use sniffing, a third (33%) only inject, 9% smoke and sniff, and 5% sniff and inject (Bello and Toufik 2005).

The administration methods varied dramatically according to age: for low threshold structures, injection is more common among older users (69% of those aged 39 or over), whereas sniffing and smoking are more frequent among younger users (80% of 15-24 year-olds) (Bello and Toufik 2005).

In the three overseas territories of the Antilles and Guyana, crack is almost exclusively inhaled, whereas in Paris it may also be injected. The practice of injecting³⁹ crack remains limited almost exclusively to the Paris region and particularly inner city Paris. Elsewhere, this practice is rare.

To control and manage the anxiety associated with taking cocaine chlorhydrate or its base form, users turn to four families of psychoactive substances, according to their location: alcohol (rum) and cannabis in the Antilles and Guyana; opiates (heroin, Subutex® ; morphine sulphate), benzodiazepines and alcohol in cities (Bello and Toufik 2005).

... which correspond to distinctive motivations

Often unaware of the fact that crack and base cocaine are identical, users differentiate between homemade base cocaine and crack. Since the two names are considered to be different products, the motivations behind the choice of usage method are different. When consumed nasally (sniffed), it is the image of “control” over consumption which attracts many users to this method of administration. Cocaine, in comparison with crack, seems like a less risky alternative in terms of the personal health and social image of the user (Bello and Toufik 2005).

Several main motivations can be identified for consuming the drug in its smokable form (Bello and Toufik 2005):

- Inhalation allows the effects of the cocaine to be felt more quickly and intensely (flash effect) than sniffing, and less intensely than injecting.
- In addition, “basing” cocaine is seen as a purification process by those who consume free base, allowing the removal of any products with which the cocaine may have been cut, rather like a chemical process which is necessary for transforming cocaine into its smokable form.

³⁹ To turn crack into an injectable form, users employ the same chemical agent as for the base form of heroin – lemon juice.

- The base form of cocaine may also be smoked in a joint, mixed with cannabis, or in a cigarette joint with tobacco, and passed inconspicuously, unlike sniffing or injection, in locations such as nightclubs. Perceived as “normal”, the act of smoking provokes little or no social disapproval.
- Finally, smoking is seen as a less risky practice than injection in terms of HIV and hepatitis contamination, and is also much less stigmatised.
- In Martinique and Guadeloupe, a small minority of cocaine users, for price or availability reasons, may resort to taking crack.

Users employ the following methods for smoking crack:

- By heating it directly with a lighter and inhaling it through a glass or home-made pipe (a plumbing pipe, covered with a layer of pierced aluminium foil). This equipment allows the “oil” to be collected, namely the residue at the bottom of the pipe once several rocks of crack have been smoked. Some people believe that this “oil” is much stronger than the rock itself;
- A beer or Coca-Cola can, with several holes pierced in it. The crack is placed on top, heated with a flame, then inhaled via the orifice used for absorbing the liquid;
- The method inspired by the “hookah” principle: a glass, partially filled with water, covered with aluminium foil, with several holes and pierced with a straw. Cigarette ash is placed on the foil, along with a lump of crack, which is heated directly and then inhaled. In Martinique, the water is sometimes replaced with alcohol, which is then consumed after the crack.
- By “*chasing the dragon*”, which involves placing a small amount of cocaine chlorhydrate mixed with bicarbonate on a piece of aluminium foil, then heating it until the chemical reaction takes place and then drying off the water and smoking the resulting substance.
- In a “*bong*” (a type of water pipe for inhaling the product without air, resulting in more rapid effects)
- And finally via the black joint or “*blaka jango*” method, used in the Antilles and Guyana, which involves smoking a cigarette containing crack mixed either with tobacco or cannabis.

3. Representations: the three images of cocaine

Cocaine is subject to radically different opinions and images according to the name and form in which it appears. Cocaine in its chlorhydrate form is seen as a luxury product, the privilege of “trendy” environments. This is one of the reasons why this substance enjoys a “positive” image, associated with social success and the belief that it is relatively easy to manage in terms of moderate consumption. The fact that the principal method of administration is sniffing reinforces this perception. In the dance scene, group-consuming cocaine and the ritual of sharing the product are often associated with “conviviality”, similar in some ways to that associated with cannabis. Cocaine is also seen in a positive light by young, occasional consumers, who either sniff or smoke the drug, and who are socially well integrated.

This positive image is tempered, however, especially among regular and chronic users. These individuals are in fact aware of the problems linked to its use, such as psychological dependence and the cost of the product. Regular use is seen as synonymous with the loss of control. Injectors of this substance also suffer from the repercussions of an administration method which is seen as degrading (Bello and Toufik 2005).

The representation of crack is quite the opposite to the prevailing image of cocaine “chlorhydrate”. Its image is, without exception, negative, no matter what the location, context or length of time. From its first appearance on the French scene, crack has been labelled as a devastating, violent, criminal substance by the American media, and one which “hooks” an individual from the very first time it is taken. In the overseas territories, the stigmatisation of crack has reached its peak. The product is seen as the “rock of the devil”; the “product of the darkness” and dealers are presented as “devil’s disciples”, whilst consumers are considered to be “possessed”.

Apart from Paris and the overseas territories, where the smokable form of cocaine is known as crack, other locations call the same form free base. Although they are chemically identical, “crack” and “free base” are not synonymous. The two nomenclatures denote different senses and meanings, with diametrically opposed representations. While crack is seen as a substance consumed by socially marginalised users, “base” appears more frequently in the dance scene and is consumed by users who are more socially integrated, many of whom believe that basing the cocaine is a form of purification (Bello and Toufik 2005).

4. Poorly-assessed health consequences

Cocaine and crack consumption are only rarely the cause of admittance to specialised centres for drug addicts (CSSTs). The proportion of patients admitted mainly due to cocaine use has remained stable for several years (6.1% in 2004, including crack⁴⁰). The proportion of treatment requests for crack use varies from a quarter to a third of this total, depending on the year [14, 15]. One theory is that requests for care from non-excluded populations are not well expressed in this framework.

In contrast with opiates and benzodiazepines, cocaine does not cause physical dependence, but a strong psychological dependence. Therefore, among individuals who attended socio-sanitary structures in 2004, 4% said that cocaine was the product to which they were most addicted (CEIP Marseille 2005).

Cocaine consumption is one possible cause for death by overdose. The number of deaths recorded by the police is showing a progressively increasing trend. In 2004, 10 recorded deaths were uniquely attributable to taking cocaine, and 5 deaths to a mixture of cocaine and another product (OCRTIS 2005).

Table 29. Trends in overdoses linked to cocaine recorded by the police services, and percentage in relation to all overdoses

	1999	2000	2001	2002	2003	2004
Number	7	11	10	12	10	15
Percentage	5.9 %	9.2%	9.3 %	12.4 %	11.2 %	21.7 %

Source: OCRTIS 2005.

According to reports from health care activists in the TREND network, there are numerous health problems linked with regular consumption, consistent with data from literature on this subject. Quantified data is not available at this time. In terms of crack users, it can be said that such individuals are in extremely poor states of health, suffering both from pathologies linked with crack use and health problems associated with violence and difficult living conditions.

⁴⁰ Alcohol is included in the total. If alcohol-related treatment requests are removed, the percentage of requests mainly for cocaine use rises to 6.9%.

5. The marketing and trafficking of cocaine and crack

An increasing number of individuals questioned by the police – evidence of an expanding market

Police questioning for cocaine use has been on the increase since 2001 (+65%), reaching 2458 cases for trafficking in 2004, and 2484 cases for users dealing in the product in 2004, according to the police system. Police questioning for those simply using the product, however, represents only 2.4% of the total for illicit drugs, with questioning for dealing and trafficking occupying 12% of the total.

The average age of cocaine users questioned has been falling steadily for several years, reflecting the extension of questioning to younger age groups. The average age was 28.4 years in 2004, compared with 29.4 years in 1999. The number of minors questioned in 2004 (30 minors) represented a rise of 17% against the 2003 figure.

The volume of cocaine seized in 2004 was 4,484 kg. This represents an increase of 7.5% compared with 2003, which itself was a record year for the forces of prevention. This data shows that trafficking involves increasingly larger amounts of cocaine, imported directly by air from Latin America, or indirectly via Spain and the Netherlands. France remains a transit country: the proportion of cocaine destined for the French market was no more than 24% in 2004. Large quantities seized were destined for Italy and the Netherlands. Finally, the French Antilles are still used as transit or storage locations for products destined for the North American and European drug markets (OCRTIS 2005).

In terms of crack, the Interior Ministry statistics demonstrate a double dissemination phenomenon, both social and geographical: 22 individuals questioned in 1990 in five counties for the use or re-sale of crack and 16 for trafficking, compared with 744 for use and 462 for trafficking and re-sale in 40 counties in 2004 (OCRTIS 2004, OCRTIS 2005). Trafficking activity, however, remains marginal. Seizure amounts were around 18 kg in 2004, and almost 70% of the total related to trafficking in the three French Caribbean territories (OCRTIS 2005).

The organisation of cocaine chlorhydrate trafficking

Three main types of cocaine chlorhydrate trafficking networks can be identified in France (Gandilhon 2006).

- Networks linked to organised crime, found in the major cities (Paris, Marseille). This type of network imports huge quantities of cocaine into France via wholesale dealers, generally located in Spain, Holland and Belgium. These networks normally buy the product uncut and sell it on after it has been cut by smaller wholesale organisations, which provide the link to the networks of small dealers.
- Networks of smaller wholesalers and/or professional dealers. These networks obtain their supplies either from wholesale dealers in France linked to organised crime, or from abroad: Spain, Holland or even the French Antilles. These networks retail the product via a relatively structured organisation (touts, sellers), who normally operate in the highly-populated suburbs of large cities or at large dance scene gatherings such as electronic music festivals. Most of these networks formerly specialise in the sale of cannabis.
- Micro-trafficking networks. This is probably the most common type of network in France. They are generally loosely structured, managed by one, two or sometimes three people, and only serve about a dozen clients. These micro-networks can be sub-divided into three main categories:

- “Start-up” networks: Networks managed by people who are not drug consumers and who enter into cocaine trafficking for purely financial reasons. Their nature is similar to networks found in suburbs.
- User-dealer networks: These are the most common networks according to studies. These micro-networks are managed by individuals who enter trafficking to finance their consumption and to make a small amount of money. They may or may not be highly dependent on the drug. In general, the network is small, with no more than about ten clients, recruited from family and friends and by word of mouth.
- Non-profit networks. These networks comprise people who wish to finance their consumption directly and as cheaply as possible, as well as providing for groups of friends. Financial considerations do not figure in these networks, nor does the wish to make profit. Cocaine is sold on at cost price (Gandilhon).

Table 30. Price of a gram of cocaine and heroin from medium-sized wholesale dealers in Belgium and Holland in 2004/2005

Country and city	Number of transactions	Cocaine	Heroin
Belgium	28		
Anvers	15	35	10
Gand	10	30	10
Mons	2	40	07
Bruges	1	25	15
Netherlands	30		
Amsterdam	15	30	15
Rotterdam	14	35	10
Maastricht	01	40	15

Sources: OCRTIS data, interpretation by OFDT [18]

The supply methods of cocaine trafficking networks are mainly via medium-sized wholesalers in France or via such wholesalers in the countries neighbouring France. The advantage of cross-border purchasing lies in the low price of cocaine from these wholesalers. A study of 150 transactions via police questioning for cocaine use and dealing shows that the price of cocaine from medium-sized wholesalers in Belgium and Holland is an average of 30 euros. This is then sold on in France for around 60 euros, resulting in a net profit of 30 euros per gram of cocaine sold. This data is consistent with the figures collected within the TRENDnetwork, which confirmed the average price of a gram of cocaine at around 60 euros in 2004. It is interesting to note that almost all the small cocaine dealership networks studied through the OCTRIS process sell multiple products, especially those such as heroin (Gandilhon 2006).

Whilst the average price of a gram of cocaine has fluctuated in recent years at user level, the average price in cities in 2004 was the lowest recorded in the last four years.

Table 31. Estimated average price of cocaine chlorhydrate in the locations observed by the TREND system

Location	2001	2002	2003	2004
Bordeaux	53	80	65	45
Dijon	72	55	55	60
Lille	62	52	55	50
Lyon	61	65	65	60
Marseille	61	73	50	65
Metz	65	75	70	60
Paris	76	60	77	55
Rennes	83	56	60	67.5
Toulouse	53	67	60	65
<i>All cities (average)</i>	<i>62</i>	<i>65</i>	<i>63</i>	<i>60</i>
Guyana	24	25	30	17.5
Martinique	122	60	55	52.5

Data and interpretation: TREND/OFD (Bello and Toufik 2005).

6. Risk and care reduction – few specific answers

Harm-reduction in France: crack is the main focus

The spread of cocaine consumption observed among young people and/or the middle classes has led to the belief, among decision-makers in the field, that its use is becoming trivialised. Action on the question of cocaine (in its chlorhydrate form) is a recent phenomenon and has not yet produced a risk reduction strategy for cocaine on a national level.

In contrast, the concentration of open dealing and consumption in the north east of Paris since the 1990s, and the failure of the traditional care structures to adapt, have led harm-reduction structures to develop specific approaches for crack users. The EGO association, which has a drop-in centre and syringe exchange programme in the affected area, has taken measures such as the distribution of a risk reduction tool called “Kit base”, introduced at the end of 2003. This tool allowed the association to initiate contact with 2,000 crack users during 2004, with an active membership of 2,500 users in 2006. In addition, the concentrated presence of crack users in the area has caused numerous problems with residents. An association called “*Coordination Toxicomanie*” (CT-18), which brings together harm-reduction structures and residents’ associations in the 18th *arrondissement*, was created to implement social mediation and action in the field of drugs, with the aim of maintaining the approach of risk reduction, whilst relying on a minimum level of consensus, involving all interested parties in the area (Lebeau 2006). The 2004-2008 five-year Inter-ministerial Mission for the Fight Against Drugs and Drug Addiction (MILDT) plan incorporates and formalises this activity in a crack programme which will also be carried out in the Antilles and in Guyana (MILDT 2004).

The care of cocaine consumers: no consensus

The methods of care for cocaine users in France have not yet been studied, and no consensus or developed guideline exists. A conference organised by the MILDT in April 2006 on this subject demonstrated the disparity of practices in specialised centres, both in terms of the organisation of courses of treatment as well as the medical treatments chosen and the psycho-therapeutic methods offered. Although not formally documented, the fact remains that unprepared or untrained physicians feel inadequate in dealing with problematic

cocaine use, partly caused by the range of care methods resulting from the dissemination of opiate substitutes, with a therapeutic substitute available for each product consumed.

The therapeutic options discussed in French literature or among French practitioners are the same as those contained in international literature (Véléa and Caro 2006). Despite this, no data relating to successful therapeutic treatments carried out by professionals on cocaine and crack users in France is available.

In addition, one major question surrounding cocaine is that of access to healthcare or the adequacy of the care offered. It seems that the care system offered to drug users is still adapted to the “junkie” model of opiate dependency which was fashionable in the 1980s, and has not been adapted to cocaine users who do not consider themselves to be “drug addicts”.

In terms of crack users, there are reports of continuing difficulties with health and social care, associated in particular with the extreme marginalisation of these populations, and with the fact that medical teams are not always sufficiently sensitive to the specific pathologies caused by crack. In addition, many non-injecting crack users do not perceive themselves as drug addicts and, as such, attend CSSTs rarely or not at all. The lack of substitutive treatment for cocaine and/or crack hinders patient retention, as well as their willingness to follow the associated pathological treatments. In Paris in particular, there have been reports of difficulties in caring for users of West Indian origin, especially those who use rum to manage their “come downs”. The care of these particular patients requires cultural factors to be taken into account (Bello and Toufik 2005, EGO 2005).

To address the significant healthcare needs of this population, which are difficult to integrate into traditional, and even specialised care methods, a risk reduction association, *Espoir Goutte d’Or* (EGO), is attempting to look again at the risk reduction care offered from a geographical and temporal perspective. It is doing so through proposals for a specialised healthcare centre project, aimed specifically at users of the base form of cocaine. The project looks specifically at the need to combine healthcare with social insertion strategies (EGO 2005).

7. Conclusion

The increasing use of cocaine in France, both problematic and non-problematic, has provoked wide questioning of the public powers in France, underlying which is the fear that its use is becoming trivialised among young people. The increase in the base form of cocaine, outside of populations of crack users, constitutes another point of concern about the current trends. For a clearer view of the situation in France, the French Focal Point has decided to undertake a series of studies in 2006 and 2007, to improve understanding of both use and users.

- The first, as part of the SINTES system, will provide an opportunity to analyse the composition of 519 samples of cocaine in its chlorhydrate form, taken directly from users (results mid-2007)
- The second aims to improve understanding of the hidden population of cocaine users not detected by healthcare, risk reduction or preventative service systems (results at the end of 2007).

As a prelude to a quantitative survey, a qualitative publication will have the following objectives:

- Update qualitative, descriptive knowledge relating to cocaine use in France and its consequences on the daily life of individuals who are unknown to the health and social care system;
- Produce a typological classification of different social profiles and consumption methods;
- Offer a user experience analysis;
- Produce the necessary elements for a questionnaire which will lead to the creation of a quantitative publication.

Another publication of observations relates to therapeutic treatments carried out by healthcare professionals in contact with cocaine and crack users. Two studies are under development to document this information. The first will look at professionals who provide treatment in specialist care centres (CSSTs). These centres are seeing a rise in the number of requests for treatment for cocaine use, as well as in cases of problematic cocaine or crack use among patients on methadone or buprenorphine substitution programmes. It will attempt to construct a typology of the treatment requests or needs of these patients, as well as of the treatment and monitoring programmes carried out by the professionals. A second study with the same objectives will be carried out in ER and cardiology services, which form another point of entry into the healthcare system for cocaine-related problems. After all the research is finished, these two studies will provide an opportunity to assess the correlation between the needs of a varied public and the intervention of the relevant professionals. They will constitute the first step towards the establishment of a more comprehensive set of practices for all professionals who encounter or are contacted by cocaine and crack users.

13. Drugs and driving

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1. Policy. Cannabis: a new legal device

The policy against drug driving in France has been characterised by two major changes in recent years. In August 1999, the first law (and its decree of applicability in 2001) introduced compulsory drug testing (cannabis) in fatal accident cases for a period of two years (from September 2001 to October 2003), with the aim of carrying out an epidemiological study. After more than a year of debate, the legislating body finally decided on the creation of a specific offence of driving under the influence of drugs, and decided to link its eventual introduction to the conclusions of a vast preliminary epidemiological study. This would lead to a legal framework which would authorise the carrying out of screening tests on drivers (see the results of this study in section 2).

Finally, before the conclusions of this study were made public at the end of 2005, the debate was re-launched by one MP, via the proposal of a new law “relating to driving a vehicle under the influence of illegal and psychotropic drugs”, submitted to the National Assembly in September 2002. On February 3rd 2003, law no. 2003-87 relating to driving under the influence of substances or plants classed as drugs was adopted and published in the Official Journal on February 4th 2003.

This law ratifies the decision for compulsory drug screening for drivers involved in a fatal accident, but also contains major changes to the system. Firstly, it creates an offence of “driving after using plants classed as drugs” (whereas the previous system had made it compulsory only after an epidemiological study), punishable by two years in prison and a supplementary fine of €4,500 or above in the case of associated alcohol consumption. It also extends the compulsory drug screening to accidents causing physical harm, when there are reasonable grounds to suspect that the driver has used drugs⁴¹. Furthermore, it authorises the screening of drivers involved in any type of traffic accident, of those accused of certain road traffic offences (those which are punishable by suspension of the driving licence, those relating to speed limits, seat belts or safety helmets), for whom there are again reasonable grounds to suspect drug use. The screening and drug consumption confirmation system will be detailed later (section 3).

2. Benzodiazepines: essentially preventative measures

In terms of benzodiazepines (BZDs), the system set out in the law of June 18th 1999 states that, for fatal road accidents only, drivers may be searched for psychoactive medicines, but only if they have tested positive for drugs. Searching for medicines here serves only as a confusing factor when calculating the risk of being involved in an accident after consuming drugs. For cost reasons, searching for medicines was not extended to all drivers involved in a fatal accident. A specific study on the risk linked to the consumption of psychotropic medicines will have to be carried out in addition.

More generally, the consumption of BZDs by drivers is legal in France. The ban on an individual “driving a vehicle whilst under the influence of a substance or pathology which may hinder his/her performance and constitute a danger to others” is deemed to limit such driving,

⁴¹ An article of the law of November 15th 2001, entitled “daily safety”, had previously extended the scope for searching for drugs after an injury-causing accident, therefore not exclusively a fatal accident, without requiring the authority of the Court.

but its weakness when applied to medicines renders it relatively theoretical in nature (Cadet-Taïrou, 2006).

Finally, only preventative measures can limit this type of individual behaviour, but the implementation of such measures carries obligations for certain professionals (prescribers and manufacturers of psychotropic medicines):

- compulsory advertisements in the usage instructions of the medicines or the addition of a pictogram on the packaging itself for certain products (decree no. 99-338 dated May 3rd 1999). It is however impossible to know what the effects of such descriptions are on the practices of users. Some professionals called for a revision of this system of written notices or pictograms and proposed a new classification of psychotropic medicines according to their effect on driving, which would allow the information given to patients to be graded according to known risks. This classification would have no legal status in terms of the ability to drive, but would aim to help practitioners better to evaluate the risks of medical prescriptions to drivers (see the work of Charles Mercier-Guyon, especially Mercier-Guyon, 2001). The decree of July 18th 2005 (Official Journal of August 2nd) introduces new pictograms and a three-tier risk classification system (de la Sablière, 2005).
- The obligation for the doctor to prove that he has provided full and appropriate information to his patient about the risks (even highly unlikely risks) of the secondary effects linked to the medical treatments he has given or prescribed. The doctor's obligation for patient information was imposed by several decrees of the State Council.
- The medical aptitude criteria for the provision or renewal of driving licences, defined by decrees, and falls under the jurisdiction of the Primary Medical Commissions for driving licences of the Prefectures responsible for the application of this system. It applies to all drivers of lorries, public transport, taxis and ambulances and to drivers of motorbikes, cars and light trailers who are known to have an at risk pathology.

These three disposals are not specific to BZDs.

Prevalence and epidemiological methodology

The following information about cannabis is taken from: Biecheler M.-B., *Cannabis, conduite et sécurité routière : une analyse de la littérature scientifique*, Observatoire national interministériel de sécurité routière, February 2006, 23 p.

[\[http://www.securiteroutiere.equipement.gouv.fr/IMG/pdf/Cannabis.pdf\]](http://www.securiteroutiere.equipement.gouv.fr/IMG/pdf/Cannabis.pdf)

At the end of 2005, the results of the SAM (acronym standing for *drugs and fatal road accidents*) study were published in France. Due to its size, this study revolutionises French research in this field, both in terms of results and methodology. Previous French studies will be mentioned comparatively.

The reference study for cannabis: The SAM study (drugs and fatal accidents)

Published at the end of 2005 (SAM group, 2005; Laumon, 2005), the SAM study deals with more than 17,000 accidents and 11,000 drivers involved in fatal accidents between September 2001 and 2003. It is by far the largest study in France. It also represents another first in that it is based on a quasi-exhaustive sample of road accidents (all the instantly fatal accidents which took place during the two years studied) and concerns drivers who were killed, injured or unhurt, whereas previous studies only looked at injured and hospitalised drivers.

How many drivers test positive for cannabis?

It was found that 7% of drivers were positive for cannabis (blood THC level of more than 1ng/ml), 2.8% of whom had also consumed alcohol. The prevalence of cannabis rises to 17% among the under-25s. Although not its main objective, the study also suggests that the prevalence of cannabis among all “currently active” drivers is 2.8%. The SAM study, however, goes much further than the calculation of prevalence levels due to the presence of a control group...

Are drivers who test positive for cannabis more likely to be responsible for a fatal accident?

To answer this line of questioning, the analysis compares those drivers who are responsible for such accidents and those who are not responsible⁴². Drivers under the influence of cannabis (blood THC level > 1ng/ml) are 1.8 times⁴³ more at risk of being responsible for a fatal accident than those testing negative, with the odds ratio rising to 14 [8.0 – 24.7] if they have consumed alcohol as well. In addition the study is the first to demonstrate that the risk of being responsible for this type of accident increases slightly with higher blood THC levels, with the odds ratio rising from 1.6 [0.8 – 3.0] for a level of under 1ng/ml, to 2.1 [1.3 – 3.2] for a level above 5ng/ml. This dosage effect strengthens the case for the existence of a causal link.

Final question: How many road accident deaths can be attributed to cannabis?

Taking all concentrations together, the proportion of fatal accidents which can be attributed to a positive cannabis test is in the region of 2.4% [1.5 – 3.4]. The annual number of victims directly attributable to the risks attached to driving under the influence of cannabis is in the region of 170 deaths, based on 6,000 fatal accidents per year. In terms of proportions, young men (18-24 years old) are more likely to be the victims of such accidents than those killed in accidents where the driver has not consumed cannabis. In addition, the study shows that the risk of death for a driver is increased by a positive cannabis test, even if he is not responsible for the accident. The annual number of victims attributable to this specific vulnerability of drivers under the influence of cannabis is in the region of 50 deaths. The annual number of victims attributable to cannabis, either through their direct responsibility for the accident, or through their increased vulnerability, is in the region of 230 deaths.

3. Other epidemiological studies on cannabis

The majority of French epidemiological studies on driving whilst under the influence of cannabis have been carried out on injured, hospitalised drivers. They show that cannabis is present in approximately 1 in 10 of these drivers (variable results of between 6% and 14%; see Biecheler, 2006):

- The oldest study (Schermann, 1992) was carried out on a large sample (2,471 drivers involved in accidents and hospitalised in 1989-1990). Its conclusions were that there was a cannabis prevalence of 6.3%, with an insignificant relative risk (responsible/not responsible) of 1.1 for cannabis alone, and 6.9 for cannabis and alcohol together. The technique employed at that time for analysing blood samples has today been

⁴² The risk of death for the driver being significantly heightened by a positive cannabis test, drivers not responsible for the accident, but who died in it, are not included.

⁴³ Odds ratio of between 1.4 and 2.2, with a confidence interval of 95%

called into question, although this study was based on a sample which was not balanced out over several years.

- Two further studies (Pélissier, 1996; Marquet, 1998) were carried out on smaller samples (60 and 296 injured and hospitalised drivers). The cannabis prevalence levels (THC and its derivatives) were higher (10% and 14%) because cannabis testing was only carried out on urine (more/less sensitive) and on young adults (18 – 35 years old). The presence of a control group in the two studies (recruited from patients who had been hospitalised for other reasons than a traffic accident) meant that it was not possible to conclude that cannabis consumption was higher among those involved in traffic accidents (higher prevalence in one study, and lower prevalence in the other).
- The next survey (Mura, 1999) should not be taken into account because the samples were taken at the request of the judiciary authorities, and therefore from those who were under suspicion of having consumed psychoactive substances. As a result, the prevalence is much higher (26%). The Kintz study (2000) is interesting in its comparison of detection methods (it is part of the European Rosita project). Of 198 drivers involved in injury-causing accidents, 9.6% had THC in their blood, demonstrating driving under the influence, while 13.6% had metabolites on their urine, which can sometimes demonstrate past consumption.
- Several publications (Mura, 2001 and 2003) have mentioned a large, multi-centric study on the blood samples of 900 drivers involved in an injury-causing accident and subsequently hospitalised, in which these samples were compared to those of 900 patients who had been hospitalised for other reasons. At the intermediary stage (analysis of 420 drivers and 381 control samples) the prevalence levels were 11.2% among the drivers and 10.8% among the control samples, with the only differences appearing among younger drivers (18.6% of 18-20 year-old drivers were positive for cannabis in the blood, compared with only 8% among the control samples). The final analysis revealed prevalence levels of 10% among drivers and 5% among the control samples, with the gap appearing even larger among the under-27s (24.8% of drivers were positive for THC against 8% of the control samples). The limitation of these studies rests on the lack of information available about the representativeness of the drivers' and control patients' samples.

Finally, the samples carried out on drivers involved in a fatal accident, within the framework of the law of June 18th 1999, have also been analysed by certain laboratories which are responsible for providing blood analysis (outside of screening results). Given that system for detecting cannabis in drivers was compulsory for the first time in France, the samples analysed are even more important. The results of 3,751 blood samples were brought together in October 2001 and October 2002 (Pépin, 2003). They appear to show the presence of cannabis (THC and/or THC-COOH) in 13.8% of drivers who underwent an immediate blood test, with this prevalence rising to 27.2% among the under-27s.

The most recent survey was also carried out by toxicologists, on a wide sample of 2,003 blood tests from drivers killed in road accidents between January 2003 and December 2004 (Mura, 2005). All samples were from drivers under the age of 30. The prevalence of cannabis was found to be 28.9% for THC in the blood. By comparing these results to those of the previous study (Pépin, 2003), the authors concluded that there was an increase in the prevalence of cannabis among French drivers, although the sample was not identical (drivers killed as apposed to those involved in a fatal accident who were killed, injured or unhurt) and the THC detection threshold was higher in the 2nd study (0.2ng/ml instead of the 0.1ng/ml set out in the legal system).

4. Comparison with the SAM results relating to cannabis

As with international studies, the comparison between the French studies is limited due to differences of scale: populations studied (drivers involved in an accident, killed, hospitalised, etc.), screening methods employed (urine and/or blood, testing for THC and/or THC-COOH) and the size of the samples.

Overall, across comparable studies, the prevalence levels given by the SAM study are slightly below those normally found in French studies, because the research deals with blood THC, and excludes THC-COOH on its own (a narrower search).

The main difference, however, lies in the size of the population studied and this explains the lower prevalence levels. The SAM study is the only one to use an exhaustive driver base (those involved in an instantly fatal accident), which acts as a denominator for calculating prevalence levels.

The recent toxicology studies use only results from blood tests (with or without a preliminary positive urine screening). They therefore have a vastly reduced population sample to use as a denominator than the SAM study (which automatically increases prevalence levels). They also deal with a specific population sample, mainly comprising drivers who were unable to undergo preliminary urine screening due to their condition (killed or seriously injured). The SAM study showed that a driver under the influence of cannabis, even if not responsible for the accident, is more likely to die as a result of the accident than another driver (increased vulnerability). These drivers will be more highly represented in the population sample of toxicology studies, which also increases the prevalence of cannabis.

In addition, the other studies which adopt an approach based on the risk attributable to cannabis use a control group comprising patients hospitalised for a reason other than accidents on public highways. According to the Mura et al. (2003) study, which looks at under-27s, the accidents would be 2.5 times more frequent with cannabis alone and 4.8 times more frequent with cannabis and alcohol. There remain reservations about the choice of control group: can it really be said to be free from cannabis consumption?

5. The results of declaratory surveys

The data produced by epidemiological surveys can be complemented by certain declaratory surveys which look at the general population or cannabis users:

The 2005 OFDT ESCAPAD survey, looking at the health and behaviour of young people aged 17-18 during call-up and preparation for defence day⁴⁴, shows that 4.3% of these young people said they had driven a vehicle (mainly two-wheeled vehicles) after smoking cannabis (5.8% having also drunk alcohol), but less than 1% said they did so often. Finally, 0.4% said they had had a road accident after smoking cannabis and 0.2% after smoking and drinking alcohol (although it is not possible to confirm whether or not these events were separate) (Beck, 2006).

Another survey carried out in 2004 by OFDT, this time on regular cannabis users⁴⁵, shows that 71% of these users said they had driven a vehicle (car, two-wheeled vehicle) whilst or

⁴⁴ A day introduced in France as a replacement for national military service. In 2005, this survey questioned 37,512 young people aged 17-18 in mainland France.

⁴⁵ 1,633 people aged between 15 and 29 years old who had consumed at least 20 joints in the previous 30 days, questioned in 2004 in 11 French towns or cities, recruited in specialised centres for drug addicts, in the street, from within the dance music scene or privately.

after (within 4 hours) consuming cannabis, at least once in the last 12 months: 35% did so often, 23% from time to time and 13% had done so once or twice (Bello, 2005).

6. Epidemiological studies relating to benzodiazepines

Several studies have measured the consumption prevalence levels of benzodiazepines among drivers involved in accidents in France (information from: Assailly, 2001; Mura, 1999; Cadet-Tairou, 2006):

- A survey carried out in 1987 on 341 subjects involved in accidents (half of whom were victims of road traffic accidents) via a questionnaire about the consumption of medications and samples of blood and urine, showed that psychotropic drugs were present in 14.5% of those involved in road traffic accidents, with BZDs the most common of all (Larcen, 1987).
- A study carried out on blood samples from 363 road accidents (including pedestrians), between June and September 1998 in a general hospital (the Angers CHU) demonstrated a prevalence of BZDs of 7.7% (Merlin, 1991). The role of the BZDs in causing the accident, as well as the absence of alcohol consumption, could not be confirmed (insignificant result).
- The same year, a study carried out in the Toulouse region on 570 drivers who had been the victim of a road traffic accident and hospitalised showed a prevalence of declared consumption of medications (via a questionnaire) of 7.7%, which was confirmed by blood analyses (Monstatruc, 1988).
- Two prevalence studies were carried out by the same team, one published in 1989 (Deveaux, 1989), which looked at 501 injured subjects (drivers or pedestrians) via BZD blood and urine screening. This study found that 15.3% were under the influence of psychotropic medicines, especially BZDs (no precise detail given). The other study was published in 1991, following the analysis of the results of the blood samples of 132 people who had been killed in traffic accidents. This showed the presence of psychotropic drugs in 10.6% of drivers, with BZDs the most common (Deveaux, 1991).
- A study focusing on BZDs (and alcohol), carried out on 2,010 subjects injured in all types of accidents (41% of which were road traffic accidents), showed the prevalence of BZDs among 9.6% of victims of road accidents (Girre, 1988). This figure was similar to that observed across the general population.
- A wider, multi-centric study carried out on 3,147 drivers involved in accidents, both responsible and not responsible for the accident, shows that BZDs were found in 7.9% of those involved in accidents, and does not show any significant difference based on responsibility for the accident (8.1% for those responsible, and 7.1% for those not responsible) ('Benzodiazepine/Driving' Collaborative Group, 1993).

Together, these rather old studies demonstrate a use level of approximately 10% of drivers involved in accidents. Few studies give clear proof of a correlation between BZD consumption and the likelihood of an accident or the driver's responsibility for such an accident, due to problems with the control group or significant differences between the groups of those involved in/responsible for the accident and the control groups.

Another difficulty in establishing the causality link between the consumption of medications and the likelihood of an accident is that the role of the pathology which causes the taking of

the medication remains unknown, as does the user's ability to drive in the absence of this treatment.

7. Detection, measurement and law enforcement.

Testing conditions

In France, the current legal framework allows for the drug screening of drivers (and not passengers or pedestrians) involved in a road accident⁴⁶. In order that new testing methods may be carried out in the future, the law of 2003 does not specify which screening method should be applied, although only urine tests are currently valid in France. There is wide debate on the effectiveness of saliva tests for drug consumption screening but, in the absence of any consensus, such tests have not yet been adopted by law enforcement authorities.

The current system therefore allows for urinary screening for drugs (cannabis, amphetamines, cocaine, opiates), to be carried out as follows: the law enforcement authorities must take the driver, if his conditions permits, to a medical premises (hospital, doctor's surgery, clinic) to urinate; the equipment required for this screening (sterile beaker, test) is provided by the hospital or by the law enforcement authorities if the screening is not carried out in a hospital.

If the screening is positive (immediate result), if the driver refuses to be subjected to this test (rare), or if (more frequently) he is unable to urinate (killed or seriously injured driver), a blood test is carried out (also at the medical premises) and the quantity of blood taken is divided into two samples, one of which is preserved should there be a need for a second opinion. The blood sample is sent to a laboratory which is designated as an expert by the public prosecutor (since this process takes place within a legal framework). The laboratory is responsible for determining the dosage level of any drug products found in the driver's blood, as well as the nature and quantity of any psychotropic medications. The screening and blood test results must be stored in files provided for this purpose, attached to the police road traffic accident files. These measurements are in addition to the compulsory alcohol test, which has been standard in France since 1978; the legal limit has been set at 0.5g/l of blood since 1995.

Within the framework of this system, testing for possible consumption of benzodiazepines is only carried out in the event of a positive drugs test, via the examination of the blood sample taken; the information provided in this case is: a positive or negative medication test and the nature of the medication and/or metabolites found.

Search methods used

The search for and dosage of drug products in the blood are carried out via the technique known as "gas chromatography coupled with mass spectrometry". A minimum detection threshold is set by decree (1 ng/ml of blood for $\Delta 9$ tetrahydrocannabinol), below which the presence of drugs is judged as insignificant (uncertainty in measurement). Above this threshold, whatever the level found in the blood, the presence of $\Delta 9$ tetrahydrocannabinol is considered an offence (see section 1.). A simple positive urine tests is however insufficient, it must be confirmed by a blood test.

⁴⁶ For a description of the situations in which these tests may take place, see the legislative context in section 1.

The complementary search for psychoactive medications (including benzodiazepines) is carried out by techniques known as “high-performance liquid chromatography coupled with a diode array” and “gas chromatography coupled with mass spectrometry”.

Behavioural examination?

In the system set out by the law of 1999, a clinical and medical examination was introduced should the drug screening be positive and when the condition of the driver allows it. This examination, formalised by a document which must be completed by the doctor and added to the police file, looks at: medical history (including the medical prescription of drugs, anaesthetics, withdrawals), alcohol or drug consumption, and a psychomotor test (breath, general behaviour, physical condition, speech, chrono-spacial orientation, balance, pupil dilation...).

This document is also interesting in that it creates a point of reference in terms of possible medical prescriptions. The behavioural test has no legal status (neither for verifying drug use, nor even for detecting it) and was introduced more as experimental measure. It is currently undergoing evaluation within the framework of the SAM study. The corresponding document was completed for the file of one in three positive drivers.

In the case of this system, therefore, no individual judgement is taken into consideration when determining that a person is driving after consuming cannabis; only the result of the blood analysis is taken as evidence. Since 2003, however, the judgement of the law enforcement authorities has been taken into account, in certain circumstances, when referring a candidate for screening (if they are suspected of driving under the influence of drugs). The criteria are not clearly defined (see section 1).

8. Police statistics: screening and offences

Since 2004, the Interior Ministry has published overall statistics on drug driving screening and offences, although it does not specify the product screened or the origin of the offence:

Table 32. Screening for drug driving.

	2004			2005		
	Number of screenings	No. positive	% positive	Number of screenings	No. positive	% positive
Accidents	9 563	1 052	11.0%	11 305	1 899	16.8%
fatal (immediate)	4 066	282	6.9%	5 248	629	12.0%
injuries (not fatal)	4 501	620	13.8%	5 547	1 041	18.8%
structural damage	996	150	15.1%	510	229	44.9%
Offences	1 198	548	45.7%	2 446	1 979	80.9%
Suspected use (no accident or offence)	5 144	1 878	36.5%	7 284	4 095	56.2%
Total	15 905	3 478	21.9%	21 035	7 973	37.9%

Source: Interior Ministry, "Bilan du comportement des usagers de la route, années 2004 et 2005" (http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere)

In 2004, almost 16,000 drug screenings were carried out on the roads, the majority (60%) having been carried out following an accident, particularly for fatal accidents (compulsory screening) or injuries causing physical injuries (screening also compulsory if drug use is suspected). The number of screenings increased significantly in 2005 (21,000 – a rise of 38%). The increase was particularly marked for screening following a road traffic offence (+104%).

The rates of positive screenings should be interpreted carefully because they are affected by the way in which the population tested is targeted. The rates of positive screening are therefore highest among screenings carried out following suspected use, whether or not associated with an offence (for 2005, the Interior Ministry suggests the levels of positive screening recorded, which are particularly high in the case of an offence or suspicion, are effected by the fact that the law enforcement authorities only carried out screenings “when the general condition of the driver gave the undeniable impression that the level of probability was high”). These figures, and those relating to rates of positive screening in particular, may be taken neither as an indication of the level of drug consumption by drivers on French roads, nor of their driving under the influence of drugs on these same roads.

The only case where screening is (normally) automatic is following a fatal accident; the levels of positive screening here are 7% in 2004 and 12% in 2005. This trend, however, is probably not indicative of the behaviour observed across the entire population of drivers.

Table 33. Recorded offences for driving after using drugs

	2004	2005
Driving a vehicle after using drugs	1 577	4 246
Driving a vehicle after using drugs and under the influence of alcohol	528	922
Refusal to be subjected to drug product screening	112	435
Total	2 217	5 603

Source: Interior Ministry, "Bilan du comportement des usagers de la route, années 2004 et 2005" (http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere)

In 2004, the first full year in which the drug screening system was in force, more than 2,000 statements were drawn up in relation to driving after using drugs, be they for drugs alone (1,577 cases) or associated with alcohol (528 cases). The figures for 2005 are incomparable, since more than 4,000 offences of driving after using drugs were recorded in that year, and almost 1,000 for using drugs and excessive alcohol.

These increases are a result of the implementation of the system, but the complexity of the screening process has been widely highlighted, and it does not encourage the law enforcement authorities to carry out these tests (in comparison, 11,387,829 alcohol tests were carried out in 2005, of which 9,017,161 were pre-emptive – i.e. not related to an accident or offence – and 140,000 offences of driving under the influence of alcohol were recorded).

9. Prevention

For cannabis...

Whilst drink driving has long been the object of preventative campaigns in France, the problem of drug driving has only recently been a topic of discussion, both in political/power circles (see section 1), and among road user victim support groups. This second category of individuals is particularly active in France, alerting public opinion to the problem of drug driving.

The first national prevention campaign against driving under the influence of cannabis was launched in 2006 (May 24th 2006 – June 10th 2006). It was organised jointly by the Inter-ministerial Mission for the Fight Against Drug Abuse (MILDT) and the Inter-Ministerial Delegation for Road Safety (DISR). It comprised an Internet site (www.cannabisetconduite.fr), a discussion forum (active throughout the period of the campaign), two radio slots, and posters and leaflets. Aimed mainly at young people, it

pointed to the main consequences of cannabis consumption when driving a car or two-wheel vehicle (loss of control, suppression of reflexes, lowering of vigilance) and gave warnings about the risk taken – both for oneself and others – when driving after consuming cannabis. The main statistical results of the SAM study were used as an epigraph: 230 cannabis-related deaths per year, the increased risk of being responsible for an accident, increased by a factor of 2 for cannabis and 15 for cannabis and alcohol together. The Internet site also reproduced recent legislation. The idea behind this campaign, according to the government, “was not to demonise cannabis but, in line with the government campaign launched in 2005, to highlight the fact that cannabis consumption is not harmless and to remind people of the problems and risks associated with driving a vehicle whilst under the influence of cannabis”. Its budget is rather small for a road safety campaign: €800,000 in total.

The prevention of cannabis use in France is generally the responsibility of several agencies, particularly the National Education departments or the Interior Ministry departments (police force). Little is known about the size and content of preventative measures. The information available to the OFDT suggests that the question of the ban on driving under the influence of cannabis is used to complement more traditional arguments in alerting young people to the dangers of this product. The police force suggests that the threat of driving licence withdrawal for driving under the influence of cannabis carries weight among young people (who may also feel they can consume it freely, despite the blanket ban) and that it is used in this way in certain prevention programs.

For benzodiazepines...

The problem relating to driving under the influence of medications is a much older one and, although it has not been widely communicated to the general public, information has been put in place for consumers of these medications, via a pictogram, which indicates the dangers of driving after consuming each particular medication (see section 1).

SECTION C: BIBLIOGRAPHY AND ANNEXES.

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15. Annexes.

15.1. ST and SQ completing the report's sections.

Section	ST	SQ
Section 1: National policy and context		
Section 2: Drug use	#1: Use in adult population #2: Use in schools (blank) #30: Methods dans surveys' results among young people	
Section 3: Prevention		#32: Policy and institutionnal framework
Section 4: Problematic use	#7: Universal prevalence #8: Selected prevalence #17: New trends	
Section 5: Treatments	#3: Treatment demand #4: Evolution of treatment demand #34: TDI #21: Treatment availability	
Section 6: Health consequences	#5: DRD #6: Evolution of DRD #18: DRD in cohorts #9: Prevalence of infectious diseases (VIH, VHC, VHB)	
Section 7: Responding to health problems	#10: Seringe availability	
Section 8: Social consequences	#11: Drug law offences (blank) #12: Drug use in jail	#31: Treatment as alternative to imprisonment.
Section 9: Responding to social problems		
Section 10: Market and supply	#13: saisies de drogues (blank) #14: Purity #15: Synthetic drugs composition #16: Products' prices	

15.2. Table index.

Table 1. Specific allocations to inter-ministerial action in the fight against drug addiction voted in the Finance Laws and executed 2002-2004.	10
Table 2. Assessment of consumers aged 15-64 per type of drug considered, in France in 2005 (%).	14
Tableau 3. Cannabis users, aged 15-64 (%), France 2005.	15
Table 4. Use of psychoactive drugs, at 17 years old, over the course of a month.	19
Table 5. Division of DATIS calls according to type of caller, 2005.	26
Table 6. Distribution of patients by age (in %) in 2005.	30
Table 7: Distribution of patients according to the reason for care (in %) in 2005.	30
Table 8: Distribution of patients by professional situation (in %) in 2005.	30
Table 9: Distribution (in %) and average age of patients according to the principal drug.	31
Table 10. Average number of patients having undergone detoxification at a Drug Addiction Treatment Centre, 1998-2004.	36
Table 11. Average number of patients per structure who were prescribed a substitution treatment within the structure, 1998-2004.	37
Table 12. Deaths by overdose in France, according to OCRTIS data.	41
Table 13. Notification of new diagnoses of HIV infection, 2003-2005 (1st quarter 2005).	42
Table 14. New AIDS cases amongst intravenous drug users, 1998-2005 (1st quarter 2005).	43
Table 15. Arrests for Drug Law Infringement per drug, 2005.	52
Table 16. Screening for narcotics at the wheel.	54
Table 17. Offences for driving after using narcotics.	55
Table 18. Convictions of drivers under the influence of narcotics in 2004.	55
Table 19. Public spending attributable to drugs (in millions of euros).	56
Table 10. Number and quantities of the main illicit drugs seized in France, 2004-2005.	65
Table 21. Number of seizures and quantity seized of the main drugs in France.	66
Table 22. Price in euros of Ecstasy in 2005, according to TREND.	67
Table 23. Experimentation with other psychoactive products: prevalence over the course of a lifetime, according to gender and age (in %).	70
Table 24. Use of cannabis over the course of a lifetime among 12-14 year-olds, according to the declarations of age of first use given in 2001.	73
Table 25. Diagnostic of use among those attending aged between 10 and 15.	75
Table 26. Prevalence of cocaine consumption in the population frequenting the "electronic music" dance scene, 2004-2005.	79
Table 27. Proportion of cocaine and crack/free-base consumers in the previous 30 days among low threshold structure users.	80
Table 28. Cocaine chlorhydrate administration methods* in the previous month among the 2003 "low threshold" survey and in the electronic dance music scene 2004/5.	82
Table 29. Trends in overdoses linked to cocaine recorded by the police services, and percentage in relation to all overdoses.	84
Table 30. Price of a gram of cocaine and heroin from medium-sized wholesale dealers in Belgium and Holland in 2004/2005.	86
Table 31. Estimated average price of cocaine chlorhydrate in the locations observed by the TREND system.	87
Table 32. Screening for drug driving.	97
Table 33. Recorded offences for driving after using drugs.	98

15.3. Figures index.

Figure 1. Patterns of use and associated problems among those who consumed cannabis over the past year (15-64 years old)	17
Figure 2. Population distribution according to CAST (drug addiction centre) score among 15-64 year olds, following the frequency of cannabis use (%)	17
Figure 3. Context of the most recent alcohol and cannabis consumption (1)	20
Figure 4. Changes in the number of drug-related deaths according to the OEDT definition, 1990-2002, by gender.	40
Figure 5. Convictions for Infringement of the Drug Law pronounced in France	50
Figure 6. Arrests for Drug Law Infringement since 1995.	51
Figure 7. Experimentations with tobacco, cannabis and alcohol: prevalence over the course of a lifetime, according to age and gender	69
Figure 8. Regular* tobacco, alcohol and cannabis use, according to age and gender among 12-18 year-olds in 2003	70
Figure 9. Type of cannabis use according to age at first use.....	72
Figure 10. Trends in the frequency of cocaine consumption among French people aged 15-34 (1995-2005).....	78

15.4. Abbreviations.

AAH	Allocation adulte handicapé
AFSSAPS	Agence française de sécurité sanitaire des produits de santé
AMM	Autorisation de mise sur le marché
ANAES	Agence nationale d'accréditation et d'évaluation en santé
ANIT	Association nationale des intervenants en toxicomanie
ANPAA	Association nationale de prévention en alcoologie et addictologie
ANRS	Agence nationale de recherche en santé
ASSEDIC	Associations pour l'Emploi dans l'Industrie et le Commerce
ASUD	Association d'auto-support des usagers de drogues
BEP	Brevet d'étude professionnelle
BHD	Buprénorphine haut dosage
CAARUD	Centre d'accueil et d'accompagnement à la réduction des risques des usagers de drogues
CAMPS	Centre d'actions médico-sociales précoces
CAP	Certificat d'aptitude professionnelle
CAST	Cannabis abuse screening test
CCAA	Centres de cure ambulatoire en alcoologie
CDAG	Centre de dépistage anonyme et gratuit
CDO	Convention départementale d'objectifs justice-santé
CEIP	Centres d'évaluation et d'information sur la pharmacodépendance
CEL	Contrats éducatifs locaux
CépiDC	Centre d'épidémiologie sur les causes médicales de décès
CESC	Comités d'éducation à la santé et la citoyenneté
CFES	Comité français d'éducation à la santé (maintenant INPES)
CHRS	Centre d'hébergement et de réinsertion sociale
CIFAD	Centre interministériel de formation à la lutte anti-drogues
CIM	Classification internationale des maladies
CIRDD	Centres d'information et de ressources sur la drogue et les dépendances
CJN	Casier judiciaire national
CLS	Contrats locaux de sécurité
CNAMTS	Caisse nationale d'assurance maladie des travailleurs salariés
CNRS	Centre national de la recherche scientifique
COM	Collectivités d'outre mer (Polynésie française et Nouvelle Calédonie)
CPAM	Caisse primaire d'assurance maladie
CPDD	Chefs de projets drogues et dépendances
CRIPS	Centre régionaux d'information et de prévention du Sida
CSAPA	Centres de soins, d'accompagnement et de prévention en addictologie
CSST	Centres spécialisés de soins pour toxicomanes
DAP	Direction de l'administration pénitentiaire (ministère de la Justice)
DAPSA	Dispositif d'appui à la parentalité et aux soins des addictions
DATIS	Drogues, alcool, tabac, info service (téléphonie sociale)
DDASS	Direction Départementale des affaires sanitaires et sociales
DESCO	Direction de l'enseignement scolaire (ministère de la Jeunesse, de l'Education nationale et de la Recherche)
DGS	Direction générale de la santé (ministère de la Santé et de la protection sociale)
DH	Direction hospitalière (ministère de la Santé et de la protection sociale)
DLPAJ/CSR	Direction des libertés publiques et des affaires juridiques, sous direction de la circulation et de la sécurité routière (Ministère de l'Intérieur et de l'Aménagement du Territoire)
DOM	Départements d'outre mer
DRAMES	Décès en relation avec l'abus de médicaments et de substances (AFSSAPS)
DRD	Mortalité liée à l'usage de drogues (définition de l'OEDT) [Drug related deaths]

DRESS	Direction de la recherche, des études, de l'évaluation et des statistiques (ministère de la Santé et de la protection sociale)
DSM	Manuel de diagnostic et statistique des troubles mentaux [Diagnostic and statistical manual of mental disorders]
ENVEFF	Enquête nationale sur les violences envers les femmes
EROPP	Enquête sur les représentations, opinions et perceptions sur les psychotropes (OFDT)
ESCAPAD	Enquête sur la santé et les consommations lors de l'appel de préparation à la défense (OFDT)
ESPAD	European School survey Project on Alcohol and other Drugs (INSERM- OFDT- MJENR)
ESSAD	Equipe de soins spécialisés à domicile
FFA	Fédération française d'addictologie
FNAIS	Fichier national des infractions à la législation sur les stupéfiants (OCRTIS)
FNES	Fédération nationale des comités d'éducation pour la santé
FRAD	Formateurs relais antidrogues (Gradés de la gendarmerie nationale)
GECA	Groupe d'étude grossesse et addiction
GIP	Groupement d'intérêt public
IC	Intervalle de confiance
ILS	Infraction à la législation sur les stupéfiants
INPES	Institut national de prévention et d'éducation pour la santé (ancien CFES)
INRETS	Institut national de recherche sur les transports et leur sécurité
INSERM	Institut national de la santé et de la recherche médicale
INVS	Institut national de veille sanitaire
IST	Infections sexuellement transmissibles
IT	Injonction thérapeutique
IVG	Interruption volontaire de grossesse
JAP	Juge d'application des peines
JAPD	Journée d'appel de préparation à la défense
JO	Journal officiel
LOLF	Loi organique relative aux lois de finances
M€	Million(s) d'euros
MILAD	Mission interministérielle de lutte antidrogue (ministère de l'Intérieur)
MILC	Mission interministérielle de lutte contre le cancer
MILDT	Mission interministérielle de lutte contre la drogue et la toxicomanie
MST	Maladies sexuellement transmissibles
OCRTIS	Office central pour la répression du trafic de stupéfiants
OEDT	Observatoire européen des drogues et des toxicomanies
OFDT	Observatoire français des drogues et des toxicomanies
OMS	Organisation mondiale de la santé
OPPIDUM	Observation des produits détournés de leur utilisation médicamenteuse (CEIP)
OR	Odd ratio (risque relatif ; rapport de cote)
PA	personne année
PAEJ	Points d'accueil et d'écoute jeunes
PES	Programme d'échange de seringues
PFAD	Policier formateur antidrogue
PRAPS	Programmes régionaux d'accès à la prévention et aux soins
PRS	Programmes régionaux de santé
PRSP	Programmes régionaux de santé publique
RDR	Réduction des risques (politique de)
RECAP	Recueil commun sur les addictions et les prises en charge (OFDT)
RMI	Revenu minimum d'insertion
RSM	Ratio standardisé de mortalité
SAM	Enquête "stupéfiants et accidents mortel de la circulation routière" (DGS/OFDT/INRETS)

SFA	Société française d'alcoologie
SIAMOIS	Système d'information sur l'accessibilité au matériel d'injection et de produits de substitution (InVs)
SINTES	Système d'identification national des toxiques et des substances (OFDT)
SMPR	Services médico-psychologiques régionaux hospitaliers
SPIP	Service pénitentiaire d'insertion et de probation
TDI	Indicateur de demande de traitement [Treatment demand indicator]
THC	Tétrahydrocannabinol
TREND	Tendances récentes et nouvelles drogues (OFDT)
UCSA	Unité de consultations et de soins ambulatoires
UDC	Unité de coordination maternité et situations à risques
UDVI	Usage(ers) de drogues par voie intraveineuse (ou injectable)
UPS	Unité de soins pour sortants
VHB	Virus de l'hépatite B
