REPORT TO THE EMCDDA

by the Reitox national focal point of France,

l'Observatoire français
des drogues et des toxicomanies

FRANCE

DRUG SITUATION 2000

REITOX REF/ 2000

2000 REITOX core task 1 CT.2000.RTX.01-F

ANNUAL REPORT 2000

FRANCE - OFDT

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PART 1 NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS

1. DEVELOPMENTS IN DRUG POLICY AND RESPONSES

1.1 Political framework in the drug field

The three-year plan against drugs and for prevention of dependency (1999)

(please refer to Chapter 12.1 Part IV)

Following the policy proposals set out in a phase report (15 October 1998) by the Interministerial Mission for the Struggle against Drugs and Drug Abuse (MILDT), the government adopted its three-year plan for the struggle against drugs and for the prevention of dependency in the Interministerial Committee for the Struggle against Drugs and Drug Abuse (16 June 1999).

This plan raises certain findings:

- habits for consumption of psycho-active products are developing,
- users are resorting more and more to multi consumption habits (consumption of several substances: e.g. ecstasy and alcohol),
- care facilities are unequally distributed over national territory,
- with regard to drugs and drug dependency, there is no single, unifying culture,
- there is inadequate social and professional monitoring during care.

On the basis of these findings, the plan defines broad policy outlines. We are concerned with:

- setting out comments on these phenomena (studies and research),
- distribution of reliable data which is scientifically validated to the public at large,
- placing the emphasis on prevention for consumption of psycho-active substances (and no longer on products themselves),
- developing a common culture with prevention professionals,
- setting up, in advance, health and welfare care (before the consumers of psycho-active substances become dependent),
- improving integration or re-integration of users,
- placing priority, for users who have been interviewed by the police, on measures to enable organisation of effective consultation with doctors and social workers,
- provision of care for users in care or in prison,
- development of the risk reduction policy,
- improved law enforcement (law of 1996 concerning “proxenetism of drugs”),
- adaptation of instruments to provide effective counteraction of the massive influx of synthetic drugs,

- developing more effective co-ordination at national level,

- redefining the geographical priorities at international level by further adoption of development of activities to reduce demand and risk.

This plan was supplemented by a circular from the Prime Minister (13 September 1999) concerning the départmental (= County) organisation of the public policy for the struggle against drug dependency and for the prevention of dependency. This circular is intended to improve the definition of the functions of the departmental project leaders.

Coordination of Anti-Drug Policies

During the 1970s, public authorities in France were little concerned with coordinating public action on a central level. However, as early as 1971, anti-drug addiction liaison offices were established on a local level. These offices brought together prefects and local heads of the main government services concerned with this phenomenon (education, police, health, customs, justice). However, these structures would quickly become obsolete. The Pelletier Report recommended that a centralised coordinating structure be created for a limited amount of time.

National Structures

It wasn't until the beginning of the 1980s that this proposal was carried out. The Interministerial Committee for the Fight Against Drug Addiction, over which the Prime Minister presided, was created in 1982. Its mission included defining, organising and coordinating governmental policy on the fight against drug addiction. This committee met four times between 1982 and 1986, and approved two programmes in 1983 and 1985. This committee did not reconvene until 1993.

At the same time an administrative coordinating structure was created. This structure was responsible for preparing recommendations made by the interministerial council and ensuring they were enforced. This structure, renamed several times over the 1980s (Permanent Mission for the Fight against Drug Addiction, Interministerial Mission for the Fight against Drug Addiction, then General Delegation for the Fight against Drugs and Drug Addiction) was successively linked to the Ministry of Solidarity, the Prime Minister, the Ministry of Justice, and back to the Prime Minister. These frequent changes followed modifications in the direction that different governments wanted to take concerning anti-drugs and drug addiction policy.

From the beginning, this light structure was made up of a limited number of representatives made available by the administrations in the interministerial committee. Since 1987, it has used interministerial credits that for the most part are distributed amongst the different ministries. The Trautman[1] Report, published in 1989, provided an overview of ten years of fighting drug addiction in France. It cited identity and legitimacy problems experienced by the interministerial organisation that were linked to the change in the different ministries. Considering the difficulties involved in carrying out a mission of interministerial coordination, when an organisation is linked to a particular ministry, the report favoured a permanent link to the Prime Minister.

The General Delegation for the Fight Against Drugs (DGLD), created in December 1989 and headed by Georgina Dufoix, merged with the MILT in 1990, resulting in the DGLDT. The latter was linked to the Ministry of Social, Health and City Affairs in 1993. It was renamed MILDT in 1996, and its mission has since been under the authority of the Prime Minister. However, it has been "made available" to the Ministry of Employment and Solidarity and the Secretary of State for Health. This has led the National Audit Office to indicate in its report on anti-drug structures[2] that the there is some "ambiguity" in this situation.

[1] TRAUTMANN C., La lutte contre la toxicomanie et le trafic de stupéfiants, Report to the Prime Minster, la documentation française, February, 1990.
[2] National Audit Office, Le dispositif de lutte contre la toxicomanie, Rapport public particulier, Cours des comptes, Paris, 1998, 248p

Local Structures

Designed to serve as the extension of the MILT on a local level, Departmental Committees for the Fight against Drug Addiction were created in 1985 in a letter sent by the Prime Minister.

Their mission was to coordinate and organise actions against drug addiction on a local level, in conjunction with external State services and local authorities. The list of those participating in this committee was not limited and included external State services, local authorities, and associations. As soon as it was implemented in a large number of departments, this new structure was unable to find its place. New measures for local coordination were made in the 1990s.

The coordination of local actions was redefined in a letter written by the Prime Minister on July 9, 1996.[3] An assessment of departmental committees for the fight against drug addiction showed that only 30% of the departments still had one in 1994. It also showed that local participants had chosen departmental councils on the prevention of delinquency as a forum for discussing drug-related problems. Reform confirmed this development and provided for a new departmental framework for fighting drugs and drug addiction comprised of three levels: the prefect and a project leader responsible for implementing government policy (management level), a small committee on drugs and drug addiction which brings together the departmental heads of State services and legal representatives (coordination level), and departmental councils on prevention and delinquency (cooperational level) who are obligated to include a section on fighting drugs in each meeting. When possible, the departmental council on prevention and delinquency must develop a sub-group that deals with "the fight against drugs and drug addiction."

Anti-Drug and Anti-Drug Addiction Programmes

During the first interministerial committee, which met on February 2, 1983, the formulation of programmes was the central theme of its discussions. Several measures were planned for all of the concerned professions, but few had immediate consequences. A 1985 plan, which was developed by the president of the MILT and adopted by the interministerial committee, contained 31 measures relating to all areas involved in the fight against drug addiction. Amongst these measures were the creation of drug addiction treatment units in prisons, the creation of departmental committees for the fight against drug addiction, and the creation of a new law incriminating street dealers. Also included in the plan was the computerisation of the National Drug Addiction Documentation Centre (CNDT), which was followed by the creation of the Toxibase Association in 1986. The mission of Toxibase was to collect and disseminate specialised drug addiction documentation on a national level.

The assessment of these initial action plans has remained mixed. As recorded in a note from the National Audit Office in its report on the anti-drug system, many of the measures proposed in 1980 were never enforced. Some were never implemented until the 1990s.

Three programmes were approved during these years: the first plan containing 42 measures in 1990, the second triennial plan on fighting drugs in 1993, and a third programme with 22 supplemental measures for 1996 (passed in 1995). Each contains measures in the fields of prevention, treatment, repression and research. The key measures adopted will be covered in the following section and in the chapter that covers these different structures.

1.2 Policy implementation, legal framework and prosecution

Law Of 1970

A **law passed on December 31, 1970** constituted the legal framework surrounding French policy on fighting drugs for nearly 30 years. Two aspects, the repression of use and trafficking, are clearly

[3] Circular letter from July 9, related to the fight against drugs and drug addiction on a departmental level, NOR: PRMX9601580C, JO from July 10, 1996

distinguished in this law. The repression of drug trafficking has been intensified several times since 1970, by increasing the severity of punishment or creating new offences (supplying drugs, money laundering). On the contrary, the repression of use, which has been a constant source of debate, has never been changed in all of these years.

Although there has been little change on a legal level, this should not hide the fact that there have been important developments in the implementation of this law, as expressed in letters and other texts written by administrations in charge of justice and health.

The Law Of 1970 has been the object of many presentations and analyses. We will briefly state its objectives here without dwelling too much on its origins:

- To severely repress trafficking
- To prohibit the use of narcotics yet also propose alternatives to the repression of use
- To ensure free and anonymous care for users who seek treatment

First, it is important to note that that this law refers to narcotic substances based on a list determined by the commission of narcotics and psychotropic drugs in accordance with international regulations. A ministerial order has enabled the classification of a substance as a narcotic (formerly Chart B, but since the decree made December 29, 1988 the category of narcotic substances).

Punishment for **trafficking** is particularly harsh[4], and is more severe than for most of the other offences. The legal means available to police in these cases contrast sharply with common law. Time limits for custody range from 48 hours to four days, and searches may be conducted during the day or night.

The Law Of 1970 makes public or private **use** punishable by one year in prison and/or a fine[5], even if there has not been a perceptible negative impact upon those in the user's entourage. Another of the law's articles states that users should be placed "under the surveillance of health authorities."[6] However, this article is out of the realm of practicality even if it attests to the ambiguous legal status of users (both delinquent and ill).

Users may avoid proceedings by spontaneously seeking treatment. The provisions for anonymity guarantee that the Law will not ask for any explanations after treatment. It is also possible to escape proceedings if the prosecutor decides to close the matter or rules for a **court-ordered treatment programme**.

Court-ordered treatment programmes have been at the heart of many debates over the Law Of 1970. The following is a brief description of the process. When a user is arrested, the prosecutor may order the individual to undergo detoxification treatment or to be medically monitored. This ruling may not be forcibly carried out, and the prosecution is limited to simply informing health authorities such as Departmental Health and Social Action Organisations (DDASS) of the order. Then they must direct the user toward an appropriate method of treatment.

These health authorities are responsible for controlling the organisation and informing the prosecution if the user does not come in for treatment or prematurely stops. In such cases, the prosecutor recovers the power to re-open proceedings. It should be noted here that the prosecutor might choose not to order treatment and directly prosecute the user. **In fact, the prosecutor alone has complete liberty to decide the outcome of the situation.** It should also be noted that once the court has ordered treatment, it loses control over what becomes of the user. At this point, the prosecutor can only wait to be informed if necessary.

[4] According to article L-627 of the public health code imprisonment for importing, exporting, producing or making narcotics spans from ten to 20 years (until 1994 – it was then transferred to the new penal code).
[5] Article L-628 of the public health code
[6] Article 355-14 of the public health code

Lastly, it is important to mention other legal measures relating to the obligation of treatment that were provided for in the Law Of 1970. These measures empower the judge and court to force, and not simply order, a user to undergo detoxification treatment. If the user completes treatment, the judge may no longer inflict punishment. These measures are rarely used. The courts prefer to use common law measures that are not specifically aimed at drug users but are often used when dealing with them. Forced treatment may occur within the framework of legal restrictions on the initiative of the judge or the prosecution. They may also be pronounced by the court **within the framework of a suspended sentence with probation, or non-imposition of a sentence with probation**. Forced treatment may be used for incarcerated individuals. After a certain period of time, they may be **conditionally released with specific terms**, if the judge so decides.

To be thorough, it should also be noted that in both the past and present, narcotics trafficking might also be punishable as a **customs offence** (contraband and like offences). This offence is not specifically for narcotics as in the Law Of 1970. These offences are punishable by a maximum three-year sentence and by fines equalling two-and-one-half times the value of the illegal merchandise (value is estimated using underground market prices).

Legislative Measure Introduced Since the Law Of 1970

A new law, passed on January 17, 1986, instituted offences for selling or supplying drugs for personal use. The object of creating this new offence was so that minor drug dealers and users-resellers could be immediately brought before justice. For technical reasons, it was necessary to create this new legal measure that carries a less severe sentence than trafficking.

Measures designed to strengthen the repression of drug trafficking were written into a **law passed on December 31, 1987**. This law also incriminates drug-related money laundering for the first time. Those who facilitate false justification of the origin of resources held by perpetrators of trafficking-related infractions may be sentenced from two to ten years in prison. This law also makes provision for sentencing those who provide or supply drugs to minors in schools, or on administrative premises.

New legislation quickly completed this anti-laundering system. **A law passed on December 23, 1988** made money laundering a customs offence in cases when there are financial relations with a foreign country. A **law passed on July 12, 1990** on the participation of financial organizations in the fight against trafficking-related capital, created obligations for bankers and comparable professions in regards to detecting money-laundering circuits. Lastly, a **law enacted on November 14, 1990** introduced legislation from Article 5 of the United Nations Convention (December 20, 1988) into French law. This article targets the seizure and confiscation of trafficking-related income.

The **new penal code** that came into effect in 1994 (the **law passed on December 16, 1992**) reiterated most of the clauses written in the Law Of 1970, (originally written into the Public Health Code) except those related to use. New clauses “criminalize” offences committed within the framework of organised trafficking. Prison sentences reach thirty years for the production, fabrication, importation and exportation of narcotics for individuals who are part of an organised group.

A new **law enacted on May 13, 1996** made laundering income from any criminal activity a general offence. This law was passed as a result of difficulties encountered in applying the law on trafficking-related money laundering. In order to get around this law, the accused simply had to claim that the money came from a different infraction. This was no longer possible once the new law was enacted.

This law also made provision to meet conditions necessary for applying the Council of Europe Convention (November 8, 1990). It now became possible to carry out any research, identification, protective measures and confiscation of money from any infraction committed on the territory of a State that had signed the Convention.

This law also repressed drug trafficking by establishing two new offences (non-justification of resources for individuals maintaining a consistent relationship with dealers or drug users, and inciting a minor to transport, hold, supply or provide narcotics) and made it possible for anti-drug associations to take civil action.

A **law was enacted on June 19, 1996** regarding control of the production and sale of certain substance that could be used to make illicit narcotics or psychotropic substances. Substances that could be used as precursory products were classified into three categories by level of risk they presented for producing narcotic substances. In the first category only authorised individuals may produce, transform, and make substances available to others. Implicated individuals in activities involving substances have to make themselves known to the Ministry of Industry in the second category. Information about transactions involving substances from the first and second categories must be available to the administration. Any "unusual" transaction must be made known to the Ministry of Industry. Failing to meet these legal obligations is punishable by fine.

Lastly, we will cite a law enacted on **April 29, 1996** regarding narcotics trafficking on the high seas. This law allows for the boarding and inspection of any ship suspected of involvement in narcotics trafficking outside of territorial waters.

Lastly, the circular of **11th October 1999** concerns the intensification of struggle against use and local traffic. On one hand and regarding the struggle against use, it is to develop prevention in schools and run appropriate repressive action (arrests, holding for questionnement, judicial procedures, etc.). On the other hand, regarding local traffic, it is to further the dialogue between administrative and judicial authorities and to encourage the use of legal tools available to improve the effectiveness of the struggle against local traffic. This circular from the Minister of Intérieur come within the scope of policies defined for repressive and judicial action in the three-year plan of June 1999.

The new approaches in criminal policy

(Circular NOR JUS 9900148 C of 17th June 1999 concerning the judicial responses to drug addiction and **circular NOR JUS D of 17th June 1999** governing the battle against drug trafficking)

The Minister of Justice issued fresh directives in June 1999, to public prosecutors, concerning judicial responses to drug addiction and the battle against drug traffic. It should be noted that these new circulars were sent to the legal authorities at the same time as the MILDT three year plan was announced.

2.1.1 Judicial responses to drug addictions

2.1.1.1 ADULTS

The circular of 17th June 1999 starts from the principle of the need to individualise court rulings concerning the use of drugs, which means that it is essential to diversify the possible responses, in particular pursuit and imprisonment. Fixed imprisonment of a user who has committed no other related offence should only be used as a last resort.

In order to individualise court rulings it is first necessary to have a better understanding of the situation of the drug users up before the courts and to be able to refer to a more in-depth personal file. The circular therefore demands the development of faster social investigations, character assessments in the reports submitted to the courts and the improvement of the communication of information on personalities to the correctional establishment in custodial cases.

Faster social investigations, ordered on court appearances or when files are opened, could be started as soon as the subject is taken into custody. Information could be collected from the family, from schools or colleges and in the working environment, and also from the judicial services with previous

knowledge of the subject's situation. There should be a talk with a social worker as soon as the person referred arrives before the court.

As regards police questioning and custody, the circular stipulates that these should be reserved for people who might cause damage to others or themselves. The circular demands that police questioning should be ruled out in the immediate vicinity of "low threshold" structures.

The circular also demands that continuity of substitution treatments should be ensured during supervision arrangements.

▪ *DIVERSIFYING THE ALTERNATIVES TO PURSUIT IN THE INITIAL ENQUIRY PHASE*

▪ *CLASSIFICATION WITH WARNING*

A verbal warning and a caution may be issued by the police officer after a police interview, by a letter signed by the public prosecutor or preferably with a summons to attend before an authorised person or association.
The circular recommends that this type of classification be used for occasional users, above all those using cannabis.

▪ *CLASSIFICATION WITH GUIDANCE*

This kind of classification should be used for users with family, medical, social, professional or schooling problems and for those who use drugs for recreational purposes; more generally at the first interview with any user not under a compulsory therapy order. Classification with guidance should allow a preliminary contact with the care system.

▪ *CONDITIONAL CLASSIFICATION*

This measure is suitable for users who seem to require more stringent conditions. The user in this case is obliged to attend the designated structure and prove that he has done so.

▪ *COMPULSORY THERAPY ORDER*

The circular stipulates that the order should be re-focussed on its original purpose. This measure should be directed at heroin addicts and other users who use illegal substances massively or repeatedly, when it seems necessary to impose a coercive framework on them.
The circular stipulates that if the party does not attend a meeting or is served with a fresh summons, the public prosecutor may not revoke the current order if it seems to be having a positive effect.

▪ *PRE-SENTENCING PHASE*

Between the instigation of pursuit and the interview the party should be made aware of the value of starting placement or care procedures.

▪ *EXPERIMENTAL MEASURE TO PROMOTE CARE*

The aim is to allow the person prosecuted to enter a care scheme before attending court. But this entry is not an obligation. The reception scheme does not have to tell the judicial authority of the steps the user has taken.

- ***JUDICIAL CONTROL***

This measure is recommended for those on a warning whose life is too unstructured, very dependent and when one cannot justify placing them in provisional detention. Placing them under judicial control would be requested in order to get a care order.

- ***SENTENCE AND POST-SENTENCING PHASE***

- ***DEFERRAL WITH TRIAL PERIOD***

The circular recommends the development of measures to defer punishment with a trial period. This measure would set a specific period for those on a warning, help them to get a grip on time and involve them in the process of taking responsibility for their actions.

- ***SUSPENSION WITH TRIAL PERIOD***

This measure is the main “alternative sanction” proposed by the regional legal authorities. This measure should also take into account all the difficulties in integration which the offender encounters and is to be based on the implementation of socio-educational monitoring by the probation services.

- ***COMMUNITY SERVICE***

This measure is rarely applied to drug users who often find it difficult to adapt to the jobs usually allocated to the people subject to this measure. The circular stipulates that the period of work should be preceded by a preparatory period and that there should be educational or health back-up during the period of service.

- ***CONDITIONAL RELEASE SUBJECT TO A COMMITMENT TO CARE***

This measure is being used less and less. Nonetheless it allows better preparation for the release of those in custody. This measure should be prepared with the probation services during custody, in consultation with the offender, the family, the health services of the institution and outside partners (for example specialist care centres).

- ***OUTSIDE PLACEMENTS***

This measure allows an offender to be taken care of outside a correctional institution by a specialist association which will look after their socio-economic integration. The person also agrees to be supervised by a structure specialising in the care of drug users. The idea is to take advantage of the outside placement to contact the specialist care system, which may lead to therapeutic support.

- ***“PARTIAL LIBERTY”***

This measure does not seem to be applied to drug users, or only very rarely. The circular advocates its use. It allows the offender’s release to be prepared. In a first phase the offender may attend a social structure or a job with an escort. In a second phase traditional “partial liberty” is implemented. It would be helpful to be able to have drug users monitored by an educator who could continue to follow users after they are definitively released.

2.112 MINORS

As regards minors, the judicial response may be given in the context of criminal procedure or civil procedure with educational support. The criteria for choosing between the two procedures are not clearly defined in the circular.

- ***CRIMINAL PROCEDURE***

- minors without personal or social difficulties involved in straightforward use or casual sale should be cautioned and conditionally classified, the conditions being notified to the parties concerned and their legal representatives.
- minors are only subject to compulsory therapy orders in exceptional cases
- repeated offences and/or involvement in drug trafficking justify the systematic involvement of the juvenile court or the examining magistrate specialising in juvenile cases in the context of the Decree of 2nd February 1945.

The circular recalls that numerous educational responses may be given in the context of the above-mentioned order: supervised freedom, judicial protection orders, placement in educational or health establishment.

- ***CIVIL PROCEDURE***

The juvenile courts are invited by the circular to ask to be kept informed as a matter of course of situations where addictive behaviour develops which puts young people at risk, in particular with products such as alcohol and medicines.

- ***THE BATTLE AGAINST DRUG TRAFFICKING***

The circular deals first of all with the conditions for improving the coordination of public action, in recalling the central role which the OCRTIS should play and inviting the preventive services to implement coordination arrangements at local level.

The circular then deals with the question of measures intended to affect the assets of the dealers. It recalls that confiscation covers the whole of the dealer's assets and not just the product of the crime. It also recalls that the public prosecutor has the power to adopt restraining measures in order to ensure that it will be possible to confiscate the assets of the person under investigation.

Noting that if it is not possible to identify the assets of dealers and if there are no prior restraining measures, confiscation usually only covers the assets seized on arrest, the circular invites the courts to use the law on drug procurement (law of 13th May 1996 - Art. 222-39-1 of the new Criminal Code) which makes it an offence for a person in a regular relationship with a user or a dealer not to be able to justify the origin of his resources or his way of life.

Finally the circular clarifies a certain number of points relating to cooperation with international courts on the subject of identifying, seizing and confiscating illicit assets.

1.3 Developments in public attitudes and debates

Thirty or so surveys relating at least partly to the topic of drugs and drug abuse were performed in France between 1988 and 2000. Most of them were commissioned either by the Comité français d'éducation pour la santé (CFES) in order to prepare or to measure the impact of preventive campaigns, or by Press organisations wishing to perform occasional monitoring of public opinion. The last opinion poll with regard to drugs was conducted by OFDT in April 1999 (2000 people from the ages of 17 to 75 were selected by the quota method and interviewed by telephone). Here, we summarise the main results, whilst setting the relevant developments which they reflect with regard to the relevant decade.

Substances

Approx 95 % of polls are able to refer spontaneously to a drug, with an average of 3.7 products being mentioned, primarily cannabis and its derivatives (78%). The other substances most often identified are cocaine (54 %), heroin (45 %), ecstasy (39 %), LSD (27 %), tobacco (21 %), alcohol (20 %) and crack (12 %). An ever increasing minority spontaneously refers to alcohol as included in the category of drugs (20 % in 1999 as opposed to 14% in 1997). This is probably connected to the press campaigns summarising the findings of the Roques report on the danger of products which place alcohol at the same level as heroin. Thus, an increase in spontaneous comments about tobacco is slightly lower (21 % in 1999 as against 17% in 1997). A 1993 enquiry conducted by CFES reveals that, where these products are expressly offered, there is fairly widespread agreement with regard to the drug status of alcohol and tobacco (84% and 77 % respectively).

Legal substances are more and more coming to be considered as drugs, in the same context as illegal products.

Perceptions of hazard to health

Heroin and cocaine are associated with immediate danger by a very high majority (approx 85 %). Experimentation with ecstasy is perceived as relatively less dangerous (76 %). For more than one half of the pool, cannabis is perceived as dangerous if sampled, but one third consider that its regular consumption poses no hazard. The percentage of individuals who believe that the consumption of cannabis is not very injurious to health also increased between 1990 and 1996, but remains in the minority (38%). In 1999, this trend was confirmed, since only 12% believed that occasional smoking was dangerous to health.

The risk of dependency is judged to be far more serious for heroin and cocaine (56% and 58% respectively with regard to experimentation) than for cannabis (38 %). With regard to alcohol and tobacco, more than three quarters of French people believe that they are more dangerous to the health than over and above a certain daily consumption expressed in terms of numbers of glasses or of cigarettes. The consumption of tobacco appears to be dangerous if experimented with, for 21% of individuals consulted, as against only 6% holding that belief in respect of alcohol. On average, the health risk is situated as starting with 9 cigarettes a day and 4 glasses per day.

If we are concerned with setting up a hierarchy of products, designating the most dangerous as heroin, cocaine, ecstasy, alcohol, cannabis, tobacco and "medicines for the nerves", a fairly high relative majority chooses heroin (41 %), with cocaine and ecstasy supplementing the category of products mentioned most intensively, at 20% and 17% respectively.

Fears experienced

In 1999, more than 80% of persons interviewed feared illegal drugs other than cannabis (68% only feared cannabis). 55 % feared "medicines for the nerves" and approx one third feared tobacco and alcohol. For all products, women declared worse fears than men, with particular reference to cannabis and alcohol. Major splits between fears also emerged depending on the age of the interviewee. For alcohol and tobacco, and also for substances relating particularly to younger people (ecstasy, inhaled products and hallucinogenic mushrooms), the proportion of those who expressed fear is found to increase with age over 18 years. For cannabis, this development is even more marked. Other products, such as heroin, LSD, medicines for the nerves, amphetamines or – again – stimulants – generate less differentiated fears depending on the age category.

Although the number of French people in favour of **drawing a distinction between "hard drugs" and "soft drugs"** is slightly on the increase, taken over the 1990's, this is not really significant. Above all, we find that **a fairly clear majority is still opposed to them** in 1997 (61%). In 1999, the distinction between these two groups of substances was maintained, but become more complicated because of the more hazy distinction between legal and illegal. Questions regarding perceived hazard of products, furthermore, reflect the possible representation of hard or dangerous utilisation of soft drugs (cannabis) or of legal substances (alcohol and tobacco).

Risk of escalation from soft drugs onto hard drugs

The concept of escalation from cannabis to "harder" drugs appears to be firmly based in public opinion in 1992, although the question was the subject of very marked differentiation between consumers and non-consumers of cannabis (who accepted and rejected the concept in the approx proportions of 80% respectively). In 1999, seven French people out of ten expressed their agreement with this theory, 13% tended to disagree and 14% were not at all in agreement with it. The contrast between cannabis consumers and non consumers, on the other hand, appears to have lessened, whilst the question of contact with consumers or the level of general knowledge with regard to drugs may also play a part. The concept of escalation consequently appears less deeply rooted in public opinion than at the beginning of the decade.

Habits and users

French people, where interviewed with regard to the main hazards confronting young people, often mentioned drug abuse as the top hazard, including in the context of surveys which are not based on that topic. Amongst the causes which may result in a young person taking drugs, and the perceived vulnerability factors, there are mentioned the search for a sense of well-being which is absent (academic or professional failures, various problems, escapism, etc), mentioned by a majority of interviewees, very markedly takes priority over the effect of being led astray (18%). The concept of transgression, which could be put forward as a possible encouraging factor, is very seldom mentioned (2%). The concept of pleasure, which was put forward in 1997 for the first time in a survey, was mentioned by 7% of interviewees. At the beginning of the decade, the legalisation of experimentation with drugs was greatly opposed (the proportion of those opposed to such a concept increased from 80 to 90% between 1990 and 1992).

Between 1990 and 1996, drug addicts were considered by the very large majority of people to be ill. This opinion did not prevent six people out of ten, in the mid-1990's, from considering them to be "aggressive and dangerous". Thus it is found that the concepts of illness and delinquency, provided that there is no counter-indication by protocol, can coexist : **the conventional divide between illness and delinquency therefore does not adequately precisely reflect the perception which the public may have of drug addicts**. Where an interviewee has additional circumstances (family problems, social difficulties, etc) which encourage him to characterise drug addiction as escapism, the divide loses its unchangeable nature.

Occasional smokers of cannabis are not considered to be drug addicts other than by a minority: in 1997, only 29 % of interviewees considered that anyone who occasionally enjoyed smoking a joint from time to time was a drug addict; in 1999, 22% believed that such behaviour made the consumer dependent. The concept of drug addicts being responsible for what happened to them was shared by less than one half of French people in 1995, a trend which is slightly on the decrease since 1992. As above, this problem raises the question of the arbitrariness of all definitions and that of the range of choices left open to the interviewee in the formulation of his reply. An individual wishing to draw the distinction between drug addicts and regular users of cannabis would thus find it difficult to take up a position in respect of this question.

Overall, the most tolerant opinions and attitudes with regard to the consumption of drugs is found amongst younger people who are politically less conservative, and those with a higher level of education, and inhabitants of more urban areas, and women. This category also comprises people who have had contact with drugs with particular reference to consumers. These trends are confirmed throughout the 1990s, although the greatest tolerance generally observed amongst young people is not found in all surveys.

Information

In 1999, a consensus was defined (86%) with regard to the value of education for young people. The proportion of individuals who believed that it was better not to talk about it too much was on the decrease during the 1990s. And education for young people was perceived as adequate by 71% of individuals, but dangerous by 15%.

Although no more than 8% of French people believe that they are very well informed about drugs, there is **a total of 58% of them who believe that they are well informed.** More than two-thirds (68%) of people between 18 and 24 believe that they are well informed, whilst only 48% of people between 65 and 75 believe that they are well informed. The perceived level of information also increases regularly hand-in-hand with the level of education (from 43% for those without higher

education qualifications to 74% for individuals whose higher education exceeds bac+2 and with the fact of having already consumed cannabis in one's life. (76% as against 54%). The latter result confirms the hypothesis that experimentation is an important factor in legalisation.

Prevention and care

Public information is increasingly a key tool in prevention, especially at school. This is the subject of approval from 86 % of French people in 1999, although 15% believe it to be dangerous (as was the case for one third of interviewees in 1992). Preventive action perceived as being the most effective thus combine the possibility of setting up dialogue with a certain proximity factor (local politics).

Amongst measures approved of, in common with preventive actions and primary education, there is the obligation for care and access to the best medical treatment for drug addicts. **Recourse treatment by heroin substitute medicines is deemed effective by approximately 70% of French persons in 1996 and in 1997; eight out of ten people confirm their approval of it in 1999.** Programmes for medically-controlled distribution of heroin, without benefiting from the same popular approval, and therapeutic use of cannabis are nonetheless amongst the highest (and growing) levels of approval (39 % for the first case and 55% for the second in 1997, and in 1999 the respective figures are 81% and 67%).

In 1996, it was found that the approval of French people with regard to personal commitment with regard to the struggle against drugs and drug dependency (where 68% are prepared to participate in informational meetings on the topic), reduce where the proposed action relates to users (59% would have consented to participate regularly in support groups, 56 % were prepared to give up two hours per week free of charge to help an association).

Public policy

In polls before 1999, the majority view which appeared to be defined is that **prosecutions and legal penalties should be imposed on consumers** of heroin and of cocaine (85% in favour), of cannabis (70 %) or of alcohol (approx 50 %). However, polling of such opinions is very sensitive to the way in which questions are put: three quarters of interviewees **in this way, were not in favour of the idea that drug addicts should be punished.** Likewise, if the person and his individual freedom are emphasised rather than the legal aspect of the question of utilisation, then one third of interviewees, as in 1999, will be induced to express their consent for the proposal according to which the prohibition of smoking cannabis is an infringement of the right for free utilisation of one's own body.

In 1999, the majority of French people believed that prohibition of usage was legitimate, although not very effective. Approx one half of people categorically reject the idea of **regulation** of cannabis (as against three quarters for heroin). **Legalisation** (unrestricted sale) of cannabis is the subject of very marked opposition: only 17% are in favour. Thus, controlled use is what most people in favour of revision of legislation would approve of. The concept of **conditional sale** of cannabis attracted more than one third of French people in 1999 (as against 12% for heroin), whilst the concept of unrestricted sale remained in the minority, although it had lost its marginal-opinion status (17% in 1999 as against 10% in 1992). The persons most often favourable to free unrestricted sale are men and young adults. Finally, it can be commented that although questions concerning vetoes on cannabis consumption bring up relatively marked divisions, those relating to heroin are much more unanimous.

The obligation for care in the context of official investigation is very widely accepted (hardly one individual out of ten came out against). Only one quarter of French people, more of the older and less educated people, believe that it is possible to achieve a world **without drugs.** Although recourse to **substitute products** is considered favourably by 81% of French people, the **sale of syringes without regulations** does not enjoy the same level of acceptance (63% in favour). **Controlled distribution of heroin** is a far less widely accepted step than the previously mentioned ones, but the majority of French people are nonetheless in favour (53%). The level of agreement with the latter three propositions markedly increases amongst those who have already consumed cannabis, and decreases with age. Finally, **medical use of cannabis** is approved by more than two-thirds of interviewees (and more often by men than by women). Overall, since the beginning of the 1990s, actions in connection with policies to reduce risks seem to be more and more accepted by French people. However, the majority remains favourable to prohibitive measures, except where authorisation is envisaged in a medical context: not only products but also their consumption habits are what motivate the opinions polled with regard to public policies.

The existence of a campaign on the part of the authorities to help dependent users is recognised by approx two thirds of interviewees (66%). Nonetheless, 63% believe that it should increase and 21% believe otherwise. A very high, majority (86 %) believe that it is useful to inform young people, with a proportion of individuals believing that it is better not to talk about it too much on the decrease during the 1990s.

During the year 2000 a parliamentary debate took place concerning the national report into the conditions for detention in penitentiary establishments in France:

The first report deals both with consumption of drugs in prison and the care of drug addicts by substitution treatments. The debate concerning prisons has acquired fresh importance in the debate about drug addiction, and the problems of care in a prison environment have shown, according to the report's authors, the need for improved co-ordination of the policy in the fight against drug addiction:

"Drug addicts do not as such belong in prison. The mere consumption of narcotics should not attract prison sentences. With regard to delinquent drug addicts, the commission wishes to see a situation where substitute treatments are made general practice throughout the UCSA. On coming out of detention, it is essential that such treatments should not be interrupted. Drug addicts need support, time, care and accompaniment through the substitution programme, and this should not be limited to mere consumption of a "product". At the same time, "in a free environment", there are not enough places in care centres; the problem is not so much the amount of cash available as the diversity, which has been the subject of criticism on many occasions, of the various parties involved in the fight against drug addiction. This question also raises a public health issue."[7]

1.4 Budget and funding arrangement

The expenses invested by the government either at the level of government budget or at the level of a different budget financed by local government, are set out. Certain structures and certain activities may be clearly identified as relating to the policy for the fight against drugs, but other activities cannot be readily differentiated in terms of structures or financing, and raise problems of evaluation.

Specific collective expenditures

Specific credits

The budget of the minister of employment and solidarity covers 2 chapters which specifically deal with the fight against drugs. These are the expenditures mentioned in chapter 45-15 of the budget of the minister of employment and social affairs, the interministerial credits of chapter 45-17, that can be supplemented with the credits in connection with AIDS prevention amongst drug users mainly corresponding to the precautions for risk reduction.

Specific credits in connection with the policy for the fight against drugs (credits voted under initial finance legislation) millions of francs

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Interministerial credits	250	250	246 ,9	246,9	237	215,5	230,5	230,5	294,5	236,3	278,2
Health and municipal credits	352,6	438,9	439,9	461,1	484,5	619,1	690,4	751,4	779,7	815,73	867

[7] HYEST Jean-Jacques, Chairman, CABANEL (Guy-Pierre) , Reporter. *Prisons : Shame on the Republic*. 29 June 2000, n°449, Volumes 1 and 2.

Total	602,6	688,9	686,8	708	721,5	834,6	920,9	981,9	1074,2	1052,03	1145,2

Sources : -The resources for the fight against drug addiction, accounts office, 1998

-MILDT. Finance legislation 1999, 2000

Specific credits in connection with the policy for the fight against drugs (credits voted under the initial finance legislation) in millions of Euros.

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Interministerial credits	38,1	38,1	37,6	37,6	36,1	32,8	35,1	35,1	44,8	36	42,4
Health and municipal credits	53,7	66,9	67	70,2	73,8	94,3	105,2	114,5	118,8	124,3	132,1
Total	91,8	105	104,6	107,8	109,9	127,1	140,3	149,6	163,6	160,3	174,5

Sources : The resources for the fight against drug addiction, accounts office, 1998

MILDT. Finance legislation 1999, 2000.

Interministerial credits have remained stable since 1992, with a major increase in 1998. In 1999, interministerial credits exhibited a reduction given the importance of the reports from the previous year. In the year 2000, 39.77 million francs corresponding to envisaged expenditures were transferred to the ministerial colleagues of MILDT under initial finance legislation. Health and municipal credits, on the other hand, increased by 32% between 1992 and 1996. This increase is far more rapid than that for all of governmental expenditures, which were progressing by a little less than 10% (apart from breaking down the deficit) between these two years.

AIDS division credits

Credits in connection with AIDS prevention amongst drug users broadly correspond to the system for risk reduction. These expenditures were assessed as 40 million francs in 1995, 53.5 million in 1996 and 66.3 million in 1997. They were 78.5 million in 1998 and 100.7 million in the year 2000.

Distribution of interministerial credits for the year 2000 (initial finance legislation) Francs

	1992	1994	1996	1998	1999	2000
Health, social affairs	59.5	45.9	68.1	47.9	66.2	21.9
National education and research	11.9	12.9	12	19.5	22.5	19.5
Youth & sport	10.1	9.2	17.2	13.7	16.9	14.9
Interministerial urban delegation	2.8	9.2	10.5	13.2	_	_
Justice	22.8	18.4	18.4	18.9	20.7	4.7
National (police)	23.8	27.6	19	18.5	16.5	8.6
Defence (gendarmerie)	9.8	11.5	8.8	10.7	9.6	7.2
Economy and finance (Customs)	24.1	22.5	16	15.6	16.3	6.7
Foreign affairs	10.8	9.2	6	5.8	12.2	9.5
Collaboration	2.5	2.7	2	1.6	_	_
Others	0.8	0.9	-	6	2.2	1.8
MILDT's own activities	55.1	48	52.5	77.7	110.6	183.3
Total	234	218	230.5	249.1*	293.7	278.2

Source : Relationship with interministerial activity of DGLDT, MILDT

*The difference between this figure and that in the preceding table is explained by a report of credits voted under the initial finance legislation, of more than 45 million francs.

Distribution of interministerial credits for the year 2000 (initial finance legislation) Euros

	1992	1994	1996	1998	1999	2000
Health, social affairs	9.07	7.00	10.38	7.30	10.09	3.34
National education and research	1.81	1.97	1.83	2.97	3.43	2.97
Youth & sport	1.54	1.40	2.62	2.09	2.58	2.27
Interministerial urban delegation	0.43	1.40	1.60	2.01		
Justice	3.48	2.81	2.81	2.88	3.16	0.72
National (police)	3.63	4.21	2.90	2.82	2.52	1.31
Defence (gendarmerie)	1.49	1.75	1.34	1.63	1.46	1.10
Economy and finance (Customs)	3.67	3.43	2.44	2.38	2.48	1.02
Foreign affairs	1.65	1.40	0.91	0.88	1.86	1.45
Collaboration	0.38	0.41	0.30	0.24		
Others	0.12	0.14		0.91	0.34	0.27
MILDT's own activities	8.40	7.32	8.00	11.85	16.86	27.94
Total	35.67	33.23	35.14	37.98	44.77	42.41

Expenditures on the part of public authorities with regard to drugs (in 1995):

In a study published recently by OFDT, Pierre KOPP proposed an assessment of the "social cost" of drugs. Thus, the data set out below summarises only the public costs in connection with the consumption of drugs (alcohol, tobacco, illegal drugs) and – more specifically – the expenditures incurred by public administrations in relation to drugs.

On the table below, public departments' expenditures in relation to drugs are traced as a function of their duties: duties for enforcement (justice, police, gendarmerie, Customs), welfare/health duties and those oriented towards prevention. However, as summarised by the authors, "this sharing of functions between enforcement agencies and others should not allow us to forget that the departments of justice, police and gendarmerie spend a proportion – which is sometimes a high proportion – of their activities on prevention".

Public administrations' expenditures in relation to drugs (in millions of francs)

Nature of expenditure (Minister)	**Expenditures (own budget)**	**Expenditures (interministerial credits)**	**Total expenditures**
Justice	**1,541.12**	**16.56**	**1557.68**
Including: - Judiciary services	225.98	-	
- Penitentiary administration	1,315.14	-	
- Judiciary protection of young people	nd	-	
Customs	**532.29**	**20.25**	**552.54**
Gendarmerie	**459.32**	**10.35**	**469.67**
Including: - Judiciary police	311.62	-	
- General public safety	109.50	-	

- Other expenditures	38.20	-	
Police	**1,235.87**	**24.84**	**1260.71**
Welfare, health and municipal affairs:	**748.62**	**50.13**	**798.75**
Including: - DGS	696.32	26.10	722.42
- DAS	14.00	14.58 (or 16.2 ???)	28.58
- DIV	22.00	9.45	31.45
- DDASS and DRASS	16.30	-	16.30
MILDT	**nd**	**45.36**	**45.36**
National education, higher education and research	**43.68**	**12.33**	**56.01**
Including: - National education	2.00	9.90	11.90
- Research	41.68	2.43	44.11
Youth & sport	**8.80**	**8.28**	**17.08**
Foreign affairs	**14.00**	**7.2**	**21.20**
Collaboration	**42.60**	**1.80**	**44.40**
France's contribution to the UE drugs budget	**30.87**	-	**30.87**
Work in terms of professional employment and training	-	**0.81**	**0.81**
***Total* =**	**4,657.17**	**197.91**	**4,855.08**

Sources : Kopp, P., Fenoglio, Ph. . The social cost of legitimate drugs (tobacco and alcohol) and of illicit drugs in France. OFDT study N° 22, September 2000, 277p. *In millions of francs. 1995 data.* (own budget and interministerial credits)

The expenditures of the Ministry of Justice are organised into three groups (in 1995)

The expenditures of "judiciary departments" comprise personnel costs (magistrates, bailiffs and clerks of courts) the costs for operation of jurisdictions, court costs and legal aid costs.

Expenditures in connection with custody of prisoners on remand and convicts (penitentiary administration).

The expenditures for court protection of youth.

Each of these groups has been allocated a proportion of the budgets set aside for treatment of persons having been the subject of proceedings for ILS (French abbreviation for offences against narcotics legislation). Thus, the total expenditures come to 1541 million francs.

Expenditures of the general Customs and indirect rights department (in 1995)

Upon assessment of the percentage of activity of customs officers and the number of agents allocated to duties for surveillance and the fight against all trafficking (as a function of quantities seized and offences confirmed and investigations performed) it is found that 2250 customs officers spend part of their working time in the fight against trafficking in drugs and that 500 customs agents are entirely

employed on the fight against drugs. In total, the annual expenditures incurred by customs come to 532.29 million francs.

National gendarmerie expenditures (in 1995)

The national gendarmerie expenditures are added to by three types of action: judiciary police duties (311.62 million francs), public safety duties (109.5 million) and other expenditures (38.2 million francs), giving a total of 459.32 million.

National police expenditures

The total working budget of the national police was 25 billion francs in 1995, with 21 billion francs going to personnel costs. Amongst the employees of the national police force (132,626 persons), 2,195 officers are devoting all of their time to the fight against the drugs trade. With regard to public security staff (82,000), 4,336 officers are working full time on ILS (infringements against narcotics legislation). Taking account of operating costs and calculating the annual mean cost per officer, the national police force is spending 1,235.87 million francs on ILS.

Expenditures of the Minister for social affairs, health & municipal matters (in 1995)

Expenditures are broken down into four groups: treatment and prevention of drug dependency are covered by the general health department (696.32 M.F.), social treatment and prevention are covered by the social affairs department (14 M.F.) and the interministerial municipal delegation ("DIV", 22 M.F.) covers co-ordination and leadership of health and social activities covered by DDASS and DRASS (16.3 M.F.). In total, this ministry devotes 748.62 M.F. to the struggle against drug dependency.

Other ministries' expenditures

The Ministries of National Education, Research, Youth & Sports, Foreign Affairs and Collaboration are spending a total of 140 M.F. on the fight against drug dependency.

In total, public administrations' expenditure in the fight against drug addiction is assessed as 4.8 billion francs in 1995, supplemented by interministerial credits.

Local authorities' expenditures

Local authorities, regional authorities, general councils and municipal bodies are providing, or sharing the provision of, financing of activities in the fight against drugs, essentially in the field of prevention.

For example, the Nord-Pas de Calais region spent 4.7 million in 1994-1995 for the section of "prevention" in the governmental regional planning agreement[8]. In conjunction with the Government, the Ile de France cofinanced the installation of care flats for AIDS patients. 10.4 million was spent in 1994-1995[9].

The expenditures incurred by the general council of the *département* of Seine Saint-Denis in connection with the struggle against drugs came to 5 million francs in 1996[10]. However, it is not easy to assess the expenditures of local authorities. Expenditures are probably concentrated on a limited number of towns, *départements* and regions most affected by the use of drugs.

Expenditures financed by social security

[8] Accounts, The weapons in the struggle against drug dependency, qv
[9] Ditto
[10] Kopp,P., Palle, C., Towards an analysis of the cost of illicit drugs, OFDT report, May 1998

- Hospital expenditures

The circular from the hospitals department dated 27 December 1995 sets at 0.06% the entirety of hospital-sector expenditure allocated to care of drug addicts, viz an envelope of 150 million francs in 1996. This envelope was finally limited to 76.3 million for this year[11].

Care expenditures for drug users by emergency services are not included in this figure.

- Expenditures in connection with urban substitution

The cost of substitution with Buprénorphine for sickness insurance can be assessed – according to the report mentioned above from the Accounts office, as being between 500 and 600 million francs in 1997.

To that expenditure, there should be added the costs of urban-prescribed methadone, not assessed at present but which – given the low number of substitutes for methadone in cities in 1997, should be fairly low.

[11] Accounts, Weapons in the struggle against drug dependency qv.

PART 2 EPIDEMIOLOGICAL SITUATION

2. PREVALENCE, PATTERNS AND DEVELOPMENTS IN DRUG USE

2.1 Main developments and emerging trends

Overview

1999 saw the confirmation of the main trends observed in previous years with regard to development in consumption of psychoactive substances:

- Deaths due to drug consumption continued to decrease over the last five years;
- Consumption of heroin has experienced a significant downturn. It is possible to back-up such an assertion in particular in the context of development in the decrease in relation to 1998 and previous years in terms of the three indicators provided by police investigations for heroin trading, quantities seized and overdose deaths. This situation is explained by several hypotheses: heroin is acquiring an increasingly negative image amongst young people and, in particular, it has suffered from the increase in potency of substitution treatments since 1995. However, certain counter-trends are being set up, which – although they are not enough to deflect the main trend - could nonetheless be an indication of changes in the forthcoming years. And observations on the ground indicate a minority development in heroin consumption in the technological environment;
- The significant development in consumption of stimulants (ecstasy, speed, cocaine) because of festival settings in connection with “techno” music. This trend appears to affect, furthermore, populations in contact with traditional care structures, where it appears that consumption of legal and illegal drugs have tended to be replaced by consumption of stimulants with particular reference to cocaine;
- Cannabis consumption is becoming more and more commonplace. This is apparent from the regular yearly increase since 1995 in the number of individuals investigated for consumption and consumption/sale and the increasing success (which is also confirmed by surveys amongst the general population) enjoyed by this product with young people and particularly by the 15-16 years age groups.

Recent trends

In terms of fresh consumption and fresh products, it is undeniable that today, the festival environment which has evolved around techno music is an unrivalled factor in distribution, essentially that of hallucinogens and stimulants. Some of these products, such as DMT, ketamine, and nitrogen protoxyde are characterised by a rising trend. Furthermore, it is possible to observe, again within festival environments, a marked trend in the development of multiple consumption. This is far from recording the development of an anarchic practice in the use of drugs, but rather appears to originate from practices intended to ensure regulation of effects between different products. These regulatory habits, which are rendered possible by the increase in the number of products available on the marketplace, fulfil the perceived requirement for management of multiple substance effects.

Another notable characteristic in the general development in the use of psychoactive substances in France, is the reciprocality of influences which is set up between the conventional environment of

users employing conventional care structures and the environment of users developing in festival environments, essentially “techno”. Comments from the “field” report on increasing influences between these two areas, with particular reference to circulation of products. Although the two areas have their own characteristics in terms of consumption, the relatively sealed-off boundary between the two which still existed just a few years ago, is in the process of collapsing. Accordingly, there is to be seen the emergence, as yet restricted, in “techno” festival environments, of substances such as crack, heroin, medicines such as high-dosage buprenorphine (Subutex®) or Rohypnol®, most commonly associated with urban environments. On the other hand, it seems that products such as cocaine, ecstasy and LSD, previously consumed in festival environments, are appearing in environments which are habitually the preserve of narcotics consumers.

The emergence of these new products and of these new habits cannot fail to raise numerous problems. Starting with the absence of information concerning the effects and the risks in connection with utilisation of new substances which are constantly appearing on the synthetic drugs marketplace: the increasing practice of multiple consumption raises the problem of pharmacological interactions between substances, which are mostly unknown, and the public-health consequences.

Analysis of trends in relation to social contexts

“NO INFORMATION AVAILABLE"

2.2 Drug use in the population

Main results

Assessment of the extent of drug consumption

Before answering the questions raised with regard to the number of consumers and their characteristics, it is necessary to define what is meant by consumption. It is often possible to see juxtaposition of figures relating to different consumption concepts, and which cannot actually be compared. Consumption is characterised by two fundamental aspects: the fact of it and the frequency of it.

It is therefore necessary to specify “consumption levels” in order to obtain perspective on the amount of consumption of the various drugs. Four levels have been adopted here:

- Experimentation (fact of having taken a product at least once).
- Occasional usage.
- Regular usage.
- ”Problem” usage which has a direct link with damage caused by consumption.

These four categories establish a graduation of seriousness or potential seriousness of consumption. The first three are established on the basis of indicators currently employed at international level: consumption of a product at least once in a person’s life, at least once per year, every day or every evening. These indicators overlap with each other.

These various groups are not mutually exclusive: regular consumers represent a subgroup of occasional consumers, who are themselves a part of the category of experimental users. The concept of “problem” users is more transverse, although this type of user is often found amongst regular users.

Nonetheless, available indicators are sometimes somewhat different from these categories (refer below). The fourth category is the trickiest one to define. It relates simultaneously to the definitions of harmful usage and dependency, whilst set out in a very pragmatic way (possibility of measurement) and a subjective way (for example, the "10 cigarettes per day" threshold for tobacco). Consequently, comparisons between products are very difficult for the latter category.

This exercise provides orders of magnitude with a high margin of error. This data must be taken as a simple framework for the extent of various modes of consumption of the main psychoactive products and their relative density in consumption as a whole.

Alcohol is the psychoactive product which is the most firmly rooted in society and in consumption habits. It is the product must frequently experimented with and consumed on an occasional basis. With regard to regular consumption, it is exceeded by tobacco which – for two experimental users – will have an "active" user who is almost always a regular smoker (at least 1 cigarette per day) and a heavy smoker in two cases out of three (10 cigarettes and more per day).

Alcohol and tobacco consumption levels are by far those which cause the most serious extent of damage, either on the health or social level, or with regard to potential dependency.

Levels of consumption of psychoactive medicines partly correspond to therapeutic usage and partly to similar consumption to that of other drugs. The border between the two is difficult to establish. In the absence of criteria by which they can be demarcated, we can only refer to the isolated figures in existence with regard to overall consumption. Therefore, it is necessary to take account of developments in these figures.

Estimation of the number of drug users in mainland France (extrapolation to the 12-75 year age group, i.e. approximately 48 million person in 1999)

Estimation of the number of consumers :	Alcohol	Tobacco	Psychotropic medicines	Illicit drugs Total	Inc cannabis
> Experimental users (1)	46 millions	32 millions	/ / /	10 millions	10 millions
> Occasional users (2)	44 millions	16 millions	/ / /	3.6 millions	3.6 millions
> Regular users (2)	10 millions	14 millions	5,4 millions	/ / /	/ / /
> "Problem"(3)	4.2 millions	9.4 millions	/ / /	142 to 176 000	/ / /

> Experimental users (1)	alcohol	Once in a person's life
	tobacco	Once in a person's life
	medicines	Once in a person's life
	illicit drugs	Once in a person's life
> Occasional users (2)	alcohol	Once in the year
	tobacco	Admit to being smokers
	medicines	
	illicit drugs	Once in the year
> Regular users (2)	alcohol	One glass in the evening
	tobacco	1 cigarette per day
	medicines	
	illicit drugs	
> "Abusive users" (3)	alcohol	Deta test (refer "methodological indices" on the alcohol section)
	tobacco	At least 10 cigarettes per day
	medicines	
	illicit drugs	Users of narcotics

Sources :		
	Alcohol	"Health barometer" 2000, CFES ESPAD 1999
	Tobacco	"Health barometer" 2000, CFES ESPAD 1999 (Survey of household conditions, INSEE)
	Medicines	Adult "health barometer" 95/96, CFES Young people's "health barometer" 97/98, CFES (Health survey 91/92, INSEE, CREDES, SESI)
	Illicit drugs	"Health barometer" 2000, CFES ESPAD 1999

Consumption of illicit drugs is measured according to a scale which differs from that of the products mentioned above. Although their experimentation has a tendency to expand, the number of declared or "countable" users of these products is incomparably lower than for other substances.

On the basis of this framework data, which should be given no greater importance than that of indicating orders of magnitude, the following chapters in this report set out to provide a clearer statement of levels of consumption and to define trends with regard to development of preferences, product by product. With a view to aiding decision-making, priority should be given to seeking a satisfactory assessment of developments rather than the (often illusory) search for precision in terms of measurement of variables.

According to a survey conducted in 4 French prisons over 1,212 detainees in 1997 and 1998, it was found that drug users who had already experienced a VIH or VHC screening test were more numerous. On the other hand, coverage in terms of hepatitis B vaccine is approximately equal amongst users and non-users and is shown to be quite inadequate. Secondly, levels of prevalence of VIH and VHC, obtained from a voluntary saliva test, are higher than amongst the general population, and are particularly alarming amongst drug users.

General population

Consumption of illicit drugs amongst adults

Only by surveys conducted from a representative pool of French adults is it possible to assess the level and habits of consumption of such products throughout the population. In fact, there is no other reliable method for assessment of quantities of illegal drugs distributed in France.

These surveys, based on declarations, encounter several difficulties. With regard to an illicit product, it is possible to perceive that people's replies are not totally honest and that they are influenced by the respective social acceptability of their consumption.

Furthermore, these surveys can barely take account of markedly minority consumption patterns in relation to the overall population of France. Utilisation of cannabis over a year is adequately high to be picked up by these surveys, but this is not the case for products such as heroin, cocaine or ecstasy. Where the number of individuals admitting to being consumers of these drugs over a year becomes too low, it is no longer possible to draw statistically significant conclusions as to the level of consumption of these products throughout the population. And marginalised population sectors, which probably occupy a significant position amongst drug users, evade conventional telephone or home channels of consultation. This is why other methods have to be used in order to gauge the number of consumers of narcotics or of cocaine.

Since the beginning of the 1990's, numerous surveys using various methodologies have broached the question of consumption of drugs with particular reference to cannabis (refer methodological indicators). We selected those which appeared to us to be capable of giving the most reliable results and providing the best context for assessment of trends.

Measurement of declared consumption

In 1999, 21.1 % (1) of individuals from 12 to 75 years old stated that they had already consumed an illegal substance in their lifetime and 7.6% (1) over the last 12 months.

Stated prevalence for consumption of illegal drugs amongst adults between the ages of 12 and 75 years.

Product	During one's life	During the year

Cannabis	21.1 %	7.6 %
Cocaine	1.3 %	0.2 %
Heroin	0.6 %	0.1 %
Amphetamines	1.3 %	0.1 %
Ecstasy	0.7 %	0.2 %
LSD	1.5 %	0.2 %
Hallucinogenic mushrooms*	0.3 %	-
Medicines used "for intoxication"	0.6 %	0.1 %
Inhaled products	1.5 %	0.2 %
Opium, morphine*	0.2 %	-
Poppers *	0.1 %	-

Source : Baromètre santé adulte (Adult "Health barometer")2000, CFES

* Products marked with this symbol were not explicitly suggested in the same way as other products but appeared in reply to the question relating to "other drugs" for which only prevalence over a lifetime was enquired into.

** Precise wording of the question.

This declared consumption of illicit drugs relates almost exclusively to cannabis and deals above all with those under 45 years of age. This is why it is, furthermore, valuable to relate declared consumption levels to the population of those between the ages of 18 and 44. In 1999, approximately one third of that population had already experimented with cannabis and approximately 1 person out of 10 was consuming it more frequently, occasionally or regularly (refer table). Declared experimentation with drugs other than cannabis appears to be fairly marginal, even amongst those between the ages of 18 and 44.

Surveys (2) conducted amongst servicemen in selection centres indicate that a high proportion of young men between the ages of 18 and 23 are affected by drug consumption. Whilst cannabis remains the most frequently consumed substance, the 1996 survey indicates a high level of usage of ecstasy during one's lifetime.

Biological tests have made it possible to investigate the correspondence, in this survey, between stated and actual consumption of cannabis. For consumption which is stated to be over the past month, under-declaration was set at 40% of cases and over declaration in 50% of cases (individuals stating consumption whereas their tests are negative). This characteristic is probably due to the particular context of selection days on which some of them are trying to conceal their consumption whilst others invented in order to try to reform. Overall, over-declaration more than compensates for under-declaration, therefore a slightly over estimated figure is arrived at.

Stated prevalence levels amongst men of the ages 18-23 consulted at a national service selection centre in 1996

Product	During one's life	During the past month
Cannabis	40.0 %	14.5 %
Cocaine	2.5 %	0.4 %
Heroin	1.5 %	0.3 %
Ecstasy	5.1 %	1.2 %

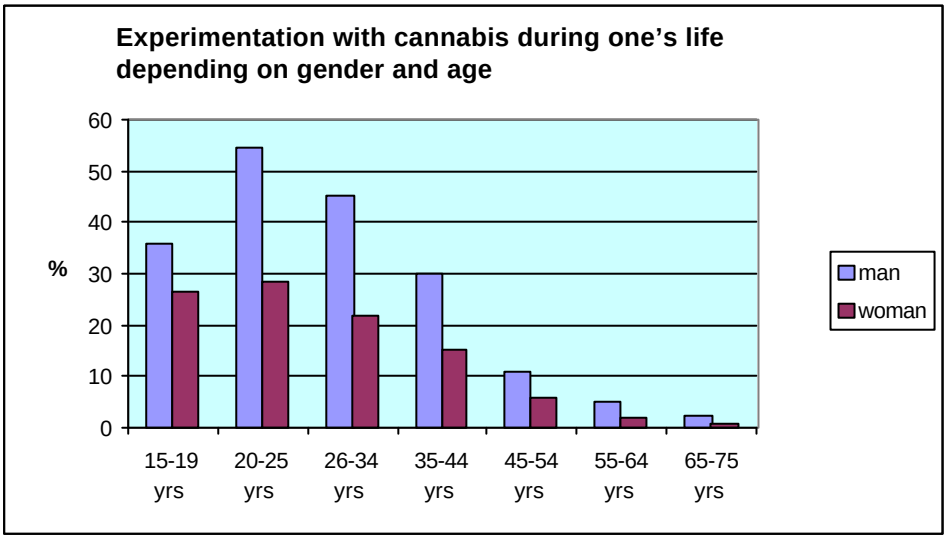
Source : DCSSA, Enquête toxicophile (Drugs enquiry) 1996

Development in stated consumption

According to Adult "health barometer" surveys, cannabis consumption significantly increased between 1992 and 1999. Surveys conducted amongst young people, particularly in a school environment, confirmed this development, which is also reflected in the 1998 young people's "health barometer" (refer the section on young people's consumption). All of these surveys tend to confirm the comments made on site: the usage of cannabis is becoming more commonplace.

Discriminating factors in consumption

Usage of cannabis during one's life is strongly linked to age and gender, with young people and men most often admitting to being consumers of illicit drugs than older people and women would admit. The following graph, taken from the year–2000 "health barometer", is an effective illustration of these facts:



Source : Baromètre santé ("Health barometer") 2000, CFES

School environment and young people

Consumption of illicit drugs amongst adolescents in 1999: levels and trends

The onset of consumption habits comes most often during adolescence, and consequently it is of prime importance to have effective observation of consumption habits amongst young people.

This consumption can be observed in the form of two types of survey. The first surveys are performed amongst the general population and are conducted by telephone, as is the case for adults. The second type is performed in a school environment, where the pupils themselves fill out an anonymous questionnaire. Consequently, the context and the interviewed population will differ. In particular, school-environment surveys are deficient in terms of young people not at school and in terms of absent pupils. Furthermore, it is likely that the family context of the telephone survey will be the cause of some reticence, but conversely the presence of class mates in a school environment could give rise to over declaration of certain consumption patterns. The results obtained by these methods of investigation are – then – not necessarily in agreement, but more likely to complement each other than to clash: it is likely that the "actual" prevalence is between the figures gathered by the two types of survey.

The most recent data is that obtained from a school environment, ESPAD (European School Survey on Alcohol and Other Drugs), performed in 1999 by INSERM, in partnership with OFDT and the national education ministry. The results are set out here in respect of 14 –18 year olds.

Whatever the consumer's age and whatever the product, experimentation (the fact of having already consumed a product at least once during one's life) is always more frequent for boys than for girls. Experimentation with cannabis experiences a marked increase with age and is always more common for boys, its prevalence changes from 14% to 59% for boys during the age from 14-18, and from 8% to 43% during the same age span for girls.

For the other illicit products mentioned in the questionnaire, the levels of experimentation are low: they are still less than 5% apart from inhaled products (glues, solvents…) and, to a lesser degree, for hallucinogenic mushrooms (amongst older boys). Although this experimentation does indeed increase with age for hallucinogenic mushrooms, it levels off amongst boys and even decreases slightly amongst girls with regard to inhaled products. The explanation for the latter finding is the fact that experimentation in these substances tend to take place more before the age of 14 years, such that its prevalence hardly develops any further during one's lifetime. For girls and for boys, three quarters of experimental users took an inhaled product for the first time before the age of 15.

Illicit drugs : prevalence during one's lifetime, according to gender and age

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

Source : ESPAD 1999, INSERM-OFDT-MENRT.

The 1999 figures can be compared with those for the school-environment survey by INSERM in 1993, also in respect of the 14-18 year group. For cannabis, the increase is very marked, with the prevalence for consumption over one's lifetime experience doubling from one survey to the next (15% to 33%). To look at the details of this increase per age group and per gender, it appears that it is particularly strong at 18 years old: at that age, in 1999, 59% of boys and 43% of girls stated that they had already taken cannabis, as against no more than 34% and 17% respectively in 1993. For other psychoactive products, the low levels of prevalence observed sometimes meant that comparisons were tricky. Nonetheless, the level of experimentation appears to experience a global increase between the two surveys, with particular reference to inhaled products. At a more refined level of analysis, it would appear that this increase particularly relates to the younger boys.

Usage of illicit drugs during one's life amongst 14-18 yr olds 1993-1999

Product	INSERM 93 (n = 6518)	ESPAD 99 (n = 9657)
Cannabis	14.6 %	33.1 %
Cocaine	1.1 %	1.6 %
Heroin	0.8 %	1.1 %
LSD or hallucinogens	1.7 %	3.6 %

Amphetamines	2.3 %	2.%
Inhaled products	6.0 %	10.7 %

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

Measurement of higher levels than mere experimentation is very difficult for products other than cannabis and inhaled products: for other substances, recurrent consumption is very rare, although the majority of those to have tried one of these products do not repeat the experiment. The choice of indicators for recurrent usage is dictated, here, by the data available in 1993, with regard to enabling comparison with 1999. In 1993, at the age of 18, 15% of boys had consumed cannabis ten times or more during their lifetime. In 1999, that proportion was exceeded over and above the age of 16 (19%) and came to 35% at the age of 18. For girls, usage was at a lower level of prevalence, but trends are similar: in 1993, at the age of 18, 6% of girls had taken cannabis 10 or more during their life, and in 1999 that level of prevalence is exceeded over and above the 8 or 15 (6%), reaching 22% at 18. The increase in the everyday use of cannabis is, therefore, not limited to experimentation alone.

On the other hand, for inhaled products, the increase is far more subtle, with particular reference to girls: at the age of 18 in 1999, 5.4% of boys and 3.5% of girls had consumed an inhaled product at least 3 times during their lifetime, as compared with the 1993 figures of 2.5% and 2.3% respectively.

Cannabis and inhaled products: usage during one's lifetime broken down according to gender and age, 1993 - 1999

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

Source : INSERM 93, ESPAD 99.

Specific groups

"NO INFORMATION AVAILABLE"

2.3 Problem drug use

National and local prevalence

Estimate of the Number of "Problem" Drug Users

The use of drugs such as heroin and cocaine are difficult to detect in general population surveys. Over the last few years, the Observatory has resorted to using indirect methods to improve estimates of the number of these users (mainly for opiates).

The preceding estimate, published in the 1996 edition of this report, was derived by using a demographic method based upon health care data from 1993. It used an estimate which cannot be clearly dated, but was applicable to the first half of the 1990s to target the number of heroin addicts.

The new estimate presented here is the result of work undertaken on a European level. A group of experts, in which the OFDT participated, analysed the various methods used throughout the European Union. They were then applied and studied. The report from the European group is in the process of being published. This exercise made it possible to apply four different methods in France, and resulting in a range of estimates.

A summary of the results of this study is presented in the following chart. The group targeted by the different methods is "problem opiate users." The notion of "problem" refers to drug use that may result in treatment in the health and social system and/or contact with law enforcement agencies. The range of estimates, applicable to the second half of the 1990s, ran from 146,000 to 172,000 users.

The four methods are described in detail in the technical report cited in the references. They are possibly biased because of the hypotheses and data used. No method should, in itself, be considered the ideal method. The study is mainly interesting because different methods are used and cross validated. Thus, estimates obtained are strengthened by the convergence of results derived from using these different methods.

Assessment of the number of "problem" users of narcotics

	Method	Prevalence
1	Extrapolation of police data	164000
2	Multiplicative demography	176000
3	Extrapolation of processing data	156000
4	Retroactive calculation from AIDS data	142-176000

The OFDT will soon attempt to consolidate this work by cross-referencing national estimates with others established at a local level. This is why it is currently supporting the use of the capture-recapture method in several French cities (Toulouse, Marseille, Nice, Lille, Lens).

Risk characteristics

Intravenous injection

Over the category of persons in care with the health/welfare system in November 1999, a 14% proportion is currently resorting to intravenous injection as the means of consumption. Utilisation at present or pre-dating injection is mentioned in 54% of habits. Information with regard to injection techniques is not, however, included (no reply or don't know) in 15% of cases.

Figures concerning overall habits exhibit marked disparities, with the proportion of injectors amounting to two thirds in specialised establishments as against one quarter in community establishments. The proportion of "no reply" and "don't know" answers is particularly high in the latter structures.

Proportion of persons in care in November 1999 resorting to intravenous injection

	Specialised establishments		Hospital establishments		Community establishments		Total	
	1997	1999	1997	1999	1997	1999	1997	1999
Yes, of which :	**69%**	**62%**	**59%**	**49%**	**26%**	**25%**	**59%**	**54%**
Yes, previously	50%	46%	43%	37%	15%	15%	43%	40%
Yes, currently	19%	15%	16%	12%	11%	10%	17%	14%
No	**31%**	**38%**	**41%**	**51%**	**74%**	**75%**	**41%**	**46%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
NR + NSP*	9%	8%	16%	16%	24%	36%	14%	15%

Source : DREES

* NR = no reply ; NSP = don't know

In specialised establishments and in hospital establishments, the proportion of injectors is in a downward trend, as is also the proportion for people who previously injected themselves and those who declare that they are currently using the same technique.

Characteristics of persons resorting to intravenous administration amongst persons in care in specialist centres

Recourse to injection is admitted in a little less than 44% on first request for treatment at specialised centres as against 71% in other forms of recourse. The decline of the part of injectors is general between 1997 and 1999, whether it relates to a first request for treatment or not. However, it is a little more rapid for the latter category, and particularly so for those who have already experienced injection (30% in 1999 as against 36% in 1997). This development has to be seen in the context of a downturn in the proportion of narcotics and heroin in admissions, a category in which the use of injection is the most widespread. However, the downturn in the proportion of injectors is equally high amongst heroin users (74% in 1999 as against 80% in 1997) and particularly amongst users of narcotics practising injection currently (26% in 1999 as against 36% in 1997). On the other hand, amongst persons admitted for use of cocaine, a category where numbers are limited, the proportion of injections has, on the other hand, remained stable between 1997 and 1999 (approx 60%).

In 1999, persons having recourse to specialised centres using injection are on average, 31.8 years old as against 28.7 years for non-injectors. Those who did not reply were of intermediate age.

Development in the proportion of injectors in admissions for November

	1993	1995	1996	1997	1999
% of users of drugs by intravenous means, all establishments (in proportion to “yes” or “no” replies)	63.1	59.1	57.3	59.2	54
Absence of replies (all establishments)	15.4	11	9.1	14.1	15
% of users of drugs by intravenous means, specialised establishments (in proportion to “yes” or “no” replies)	72.1	70	67.1	68.7	62
Absence of replies (specialised establishments)	9.3	7	5.9	9.4	8.2

Source : DREES, November survey

3. HEALTH CONSEQUENCES

3.1 Drug treatment demand

Users of drugs progressed by health and welfare institutions

Recourse to health and welfare system in November

In November 1999, approx 26,600 recourses to health and welfare structures which had responded to the survey where gathered, which corresponds to a 5% increase in relation to 1997. This global mean figure covers an increase of 12% in instances of recourse in specialised establishments and a downturn in health establishments of almost 10%. The latter development, however, appears to be – at least partially – connected to a downturn in the number of health establishments which replied to the survey.

Over all of the recourses that were had to specialised centres in November, 34% were counted as the first recourses in 1999, which is a slightly downward proportion in relation to the 1997 trend (36%).

Recourse to specialised centres over the year

During 1999, more than 65,000 drugs users were taken into care in specialised centres. The increase in the number of admissions surveyed over the year (8%) is higher than in 1997 (3.7%) and is the result of an increase by approximately 10% between 1995 and 1996.

Approx 46% of annual admissions are first-time recourses. This proportion is on the decrease in relation to the 1997 value.

Origin of admission

In 1999, users stated that they had come for consultation in specialised centres and health establishments on their own initiative in somewhat less than one half of cases (45%). These are

followed by the following reasons for entering into care: family (11%), doctor (10%), specialised centre (9%), or court order (9%). These figures are mainly the same as those for 1997.

Development in admission modes

The distribution of users according to the various types of admission experienced a marked development in connection with the introduction of substitute treatments, which constitute a condition of admission. In specialised centres, substitute treatment represents 32% of admissions in 1996 as against 1.2% in 1993, whereas the proportion of persons coming off drugs has gone down by 30 to approx 9%. A similar trend is noted, albeit less clearly, in hospitals, where the percentage of users admitted for substitution treatment has increased from 0.7 to 12%, with the proportion of persons coming off drugs decreasing from 39 to 27%.

Since 1997, the question with regard to the nature of admissions is no longer asked, but one question was introduced with regard to substitution treatments, as mentioned in 51% of all recourses during November 1999 (Subutex® 30%, methadone 19%) and 63% of recourses to specialised centres (Subutex® 35%, methadone 26%, others 2%). The proportion of persons under substitute treatment has continued to increase markedly in specialised centres (+ 6 points) and more moderately in other structures (+2 points).

Distribution of drugs users admitted during November 1999, according to establishment category

	Number of establishments having replied to the survey in November	Number of drugs users admitted in November
All specialised structures	275	17 124
All health establishments, of which:	462	7 321
Regional hospital	52	1691
Public hospital	239	2700
Hospital specialised in psychiatrics, and private psychiatric hospital operating as a public hospital	104	2640
Mental health clinic	67	290
Regional medical/psychological department*		
All welfare establishments	440	5 229
Total		29 674
Total excluding duplicated counts		26 635 **

Source : DREES, November 1999 survey

* Hospital departments providing care in penitentiary institutions

** Double counts (persons progressed both in a specialised centre and in a health/welfare establishment) are deducted from the previous total

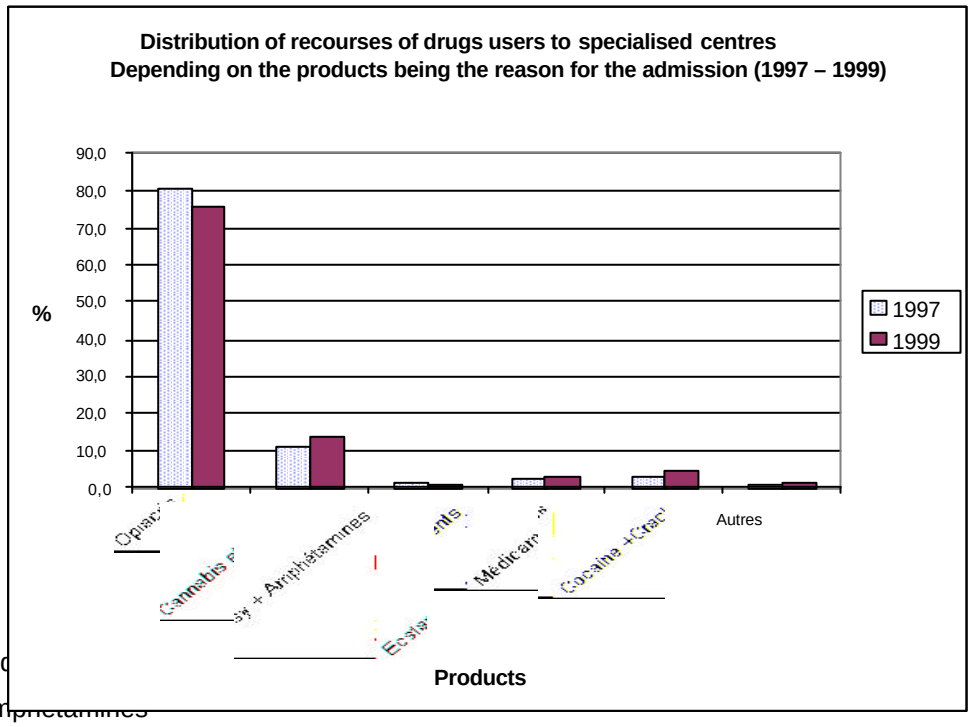
Any double-counts within each category of establishment are not – however – eliminated. A user who has frequented several specialised centres or several hospital departments during November will have been counted several times.

Products originating the admission

Narcotics are the reason for admission to specialised centres in almost 76% of recourses in November 1999. These include drugs users following a substitution treatment who are admitted to specialised centres because of their dependence on a narcotic, but who are not consumers of illicit narcotics such as heroin, or only to a slight extent. Cannabis is involved in almost 14 % of admissions, with cocaine and crack representing nearly 5%. Cannabis and cocaine are, however, traditionally often cited as associated products. Data in respect of associated products is not yet available for 1999.

Development between 1997 and 1999 is characterised by a downturn in the proportion of narcotics in favour of cannabis and cocaine. Amongst narcotics, there should be noted the increase in the number of recourses in connection with consumption of Subutex® not prescribed (4.3% in 1999 as against 1.5% in 1997). This development should be seen in the context of the high number of persons following substitution treatment on Subutex® , and ease of access to such treatments.

Distribution of recourses of drugs users to specialised centres



Keys:

Narcotics

Cannabis and

Ecstasy + amphetamines

Medicines

Cocaine + crack

Others

Source : DREES

Medicines : benzodiazepines, antidepressants, barbiturates and other hypnotic drugs, other tranquillisers

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

During the 1990s, the proportion of narcotics in admissions fell to the level reached at the beginning of the period, after having increased during the first half of the decade; a symmetrical development is seen for cannabis. For narcotics, this development is probably the development of the epidemic peak in the consumption of heroin which was reached at the end of the 1980s, and which is reflected by an increase in admissions by a delay of a few years.

Over the ten years under consideration, the only permanent development in the distribution of products giving rise to a reason for admission will finally be seen to be the downturn in the proportion of medicines and an increase in cocaine and crack. The latter increase is consistent with the increase in cases of investigation by police for usage of cocaine and information provided by the supervisory body for recent trends (TREND system) installed by OFDT. The downturn in the proportion of medicines is more surprising. One possible theory could be that this drug dependency on a legitimate product presents the advantages of problems of detection. In the context of the increase in admissions in connection with narcotics, there may be less prompting to record cases of dependency on medicines. It is also possible that recording of problems in connection with this type of product may be performed via different structures. Finally, it should be taken into account that sales of tranquillisers have had a downward orientation since the beginning of the 1990s, which does not contradict the development in admissions.

Development in recourses of drugs users to specialised centres depending on the product which is the reason for the admission (1989 – 1999)

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

Source : OFDT, according to DREES data

Age of users

From the point of view of age, the distinction can be drawn between two groups which are emerging amongst persons consulting the health and welfare system (and also users interrogated by the police):

– **Users of narcotics,** essentially heroin, are of an average age of around 31 and increasing from year to year. Cocaine and crack users who have recourse to care, although lower in number, are of an age which relates them with narcotics users. It is also possible to note the higher average age of persons admitted to hospital for use of medicines (other than narcotics).

– **Cannabis users** whose age is around 25 years for recourses. The average age of ecstasy users is comparable to that of cannabis users.

Age of users depending on products being the reasons for admission to specialised centres in 1999

First product being the reason for admission	Specialised establishments	Health establishments
Heroin and other narcotics, including		
Heroin	31.4	30.9
Codeine derivatives	34.3	33.7
Morphine, opium and other narcotics	33.4	35.7
Methadone at the beginning of a prescription	34.0	31.5
Buprenorphine other than as prescribed	30.1	30.0
Cannabis	25.0	26.2
Psychotropic drugs, of which		

Antidepressants	34.0	34.3
Barbiturates	30.9	33.6
Benzodiazepins	30.2	34.4
Other hypnotic drugs and tranquillisers	30.2	38.6
Cocaine	30.1	30.5
Crack	32.2	32.7
Synthetic drugs, including:		
Amphetamines	31.0	34.5
Ecstasy	24.3	23.2
LSD and other dysleptics	28.3	28.3
Glues and solvents	29.7	31.2
Other substances	32.8	32.2
Alcohol	33.8	
Total of respondents	30.6	30.2
No reply	32.0	32.1
Overall	30.6	30.9

Sources : DREES, November 1999 survey

Users who first had recourse to specialised centres in November 1999 were younger (28.5 years) than those who had already entered into contact with such institutions (almost 32 years).

Development in age of users admitted to specialised establishments and health establishments

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

Source : DREES, November 1999 survey

The trend for ageing in users admitted to specialised centres and health establishments is continuing in 1999. It relates to all types of users, whatever the product consumed, with the exception of cannabis users admitted to hospital, who are slightly younger. What are the elements which can explain the increase in average age of users of products other than cannabis to specialised centres

and health establishments? First of all, it has to be stressed that between 1987 and 1999, the number of recourses increased in all age categories, including the youngest, where growth is nonetheless strongest amongst the oldest. It is interesting to note that between 1997 and 1999, the number of recourses in the 20 – 24 year age group decreases and remains identical for 25 – 29 years, and increases relate either to the youngest or to those over 30.

The increase in the number of oldest users may partly be the consequence of ageing in users admitted previously and who continue to be admitted (grouping effect). It is nonetheless possible to note an increase in age amongst first recourses, and this tends to indicate that entrance to the care system is also taking place later. Two hypotheses, which are not mutually exclusive, can be put forward to explain this development: the period between the start of using drugs and recourse to the care system has extended in time; a proportion of admitted users tends to enter consumption later.

Gender of users

The population of users using the care system is traditionally more predominantly masculine. This proportion is at 77 % of recourses in 1999, a figure which has been on the increase since the end of the 1980s, when it was around 73%. In specialised centres, the proportion of women amongst first recourses was slightly lower (20% in 1999 as against 23% in all recourses to specialised centres).

Admission of drugs users by general practitioners

Until the beginning of the 1990s, little information was available about the treatment of drug users by regular doctors. An initial survey conducted in four regions in 1992 gave a glimpse of this type of treatment that proved to be more widespread than believed. The second survey, conducted in 1995, was based upon a cross-section of all doctors who provided the first information about drug addicts being treated by general practitioners on a national level. This survey was conducted again in 1997. Its results could be introduced into the regular indicators used to monitor changes in certain aspects of drug use (in the same way as the November survey).

The results presented here are based upon statements made by a sample of doctors. These individuals are professionals who were informed about the survey and agreed to participate. Their answers may be considered reliable. The extrapolation of the observed results from the sample to all general practitioners might (as with any survey) may cause a considerable margin of uncertainty.

Each doctor was questioned about the number of users seen during the year and whether it was only once or several times. It is not possible to exactly determine the number of different users seen by all doctors as an individual may have seen several doctors during the year. The gap between the number of all users seen by doctors and the number of different users depends on “medical nomadism” (consecutive appointments with several doctors) and multiple prescriptions (simultaneous treatment by several doctors).

The number of general practitioners who treated drug users remained stable between 1995 and 1997. On the other hand, on average, each doctor treated a higher number of users. In 1997, as was the case in 1995, 61% of the general practitioners surveyed stated they has seen at least one drug user during the year. Yet, on average, the increase in the number of users seen by each of these doctors led to a 50% growth in the number of drug users who went to a doctor between 1995 and 1997. This result is based upon the hypothesis that user “nomadism” and multiple prescriptions remained stable between these two dates.

Drug users were more frequently regular patients in 1997 than in 1992. All the same, regular patients only represented from 42%-46% of the users who saw a general practitioner in 1997.

The number of prescriptions for substitute substances increased between 1992 and 1997 while the number of prescriptions for tranquillisers, hypnotics and analgesics decreased. On average, general practitioners prescribe Subutex® to around one-third of the drug users who seek treatment from them. However, there are strong differences between doctors. Some very frequently prescribe Subutex® to drug users, others do so very little or not at all. Half of the doctors prescribe an average daily dose of 8 mg, 23% prescribe less than 8 mg and 26% prescribe over 8 mg.

It may also be noted that in 1997, general practitioners treated drug users in a more global manner. There was a particular increase in the percentage of doctors who stated they often treated somatic problems (98% in 1997, compared to 71% in 1995).

Better-trained doctors, some of which become specialized in this area.

Compared to 1995, more doctors have received training, consider themselves trained and are familiar with the existence of networks. Doctors who treat many users (over 10) most often practice in PACA regions, Ile-de-France and Nord-Pas-de-Calais. They more often consider themselves trained, know the networks better and have a drug addiction-related activity outside of their office. They represented 22% of the sample in 1997.

There are two particular types of general practitioners distinguished from the others because they see more drug users (on average): network doctors (10% of the sample in 1997) who treat 25% of the users and 44% of the users taking Subutex® ; and doctors from medico-social centres whose attitude toward prescribing substitute treatment is, on the other hand, identical to that of other general practitioners. It should be noted that doctors who do not consider themselves sufficiently trained to treat drug addiction care fore 37% of the users but only 20% of the users taking Subutex®.

In 1997, 31% of the drug addicts seen by general practitioners tested seropositive for the Hepatitis C virus and 17% for HIV. It may also be estimated that around 23% of the users seen by general practitioners tested positive for Hepatitis B in 1997. Tuberculosis was diagnosed amongst 2% of the users, and 4% of them were found to have a sexually transmitted disease. Eight percent had been emergency hospitalised, 7% had had an accident on public roads, and 1.4% had overdosed.

One-third of the general practitioners stated they had encountered new problematic drug addictions. Sixty-two percent of them took note of emerging difficulties linked to substitution, including trafficking, misuse, and addiction to the substance and polydrug addiction.

General practitioners are beginning to have a better understanding of users. Forty-six percent of them feel that users have changed and have become more responsible in the face of possible risks.

Moreover, doctors consider it easier to treat users because they have received related training and are more involved and motivated. On the other hand, it is also difficult to care for users because of their lack of availability, isolation and a lack of motivation. However, the opinion of general practitioners toward the possibility of treating users did not change between 1995 and 1997.¤

3.2 Drug-related mortality

Mortality in relation to use of illicit drugs

In the absence of a background study, it is not possible to obtain global knowledge of mortality amongst drugs users. The main causes for mortality in this population which can now be examined are mortality by overdose where it was the subject of court proceedings, mortality due to pharmaceutical dependence and finally AIDS in intravenous drugs users.

Death by overdose is defined as a violent and suspicious death which gives rise to a police investigation which has to reach a conclusion as to the context of drugs usage. OCRTIS data is probably under-estimated, since there are cases where the doctor giving the reason for death chooses to avoid court proceedings in order to cause less suffering to the victim's family and friends and authorises burial without the police having been able to perform an investigation. INSERM provides annual data into deaths related to drugs usage recorded in France and identified by doctors as such. The level of under-estimation of these deaths, however, is dependent on how the doctor filled in the death certificate. Data into AIDS related deaths in connection with drugs usage gathered by the national public health network are also under-estimated, by approx 20%.

Thus what we are describing is a partial vision of a phenomenon.

Between 1994 and 1999, the number of fatal overdoses greatly decreased, from 564 to 188. This decrease follows a virtually constant rise since the beginning of the 1970s, which continued up until 1994. Amongst the factors providing some explanation for this development, it is possible to refer to the introduction of substitution and risk-reduction policies and the trend for migration of drugs users away from heroin.

Number of deaths by overdose

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Total	350	411	499	454	564	465	393	228	143	118
Of which Heroin	302	368	460	408	505	388	336	164	92	69
Medicines	27	31	31	44	50	68	49	56	41	39
Solvents	12	6	6	1	6	4	1	1	1	0
Cocaine	5	5	0	1	2	4	6	6	9	7
Ecstasy	0	0	0	0	0	0	0	0	0	2
Indeterminate	4	1	1	0	1	1	1	1	0	1

Source : OCRTIS (*Use of and trade in narcotics – 1999 statistics*)

The average age of persons whose death follows overdose was 31.5 years in 1999 as against 25 in 1986.

In the majority of cases, fatal overdose follows heroin intake, but deaths in connection with multiple consumption (combined consumption of heroin, alcohol and medicines in particular) represent an ever-higher proportion of overdose death. Overdose deaths in 1999 are attributed to heroin in 59% of cases and to medicines in 33% of cases, with the latter proportion exhibiting a clear increase in relation to the beginning of the 1990s (approx 7% in 1990 and 19991).

Deaths caused by intake of medicines mostly result from intake of several medicines. However, it is frequently possible to note the presence of Subutex® (11 cases), Rohypnol® (6 cases), Tranxène® (4 cases), Skénan® (3 cases), and Methadone® (6 cases for each). Currently there is controversy as to the level of hazard of Subutex, particularly where it is intravenously injected or consumed with other medicines, with particular reference to benzodiazepins or alcohol.

What are currently referred to as "drugs-linked deaths" essentially covers deaths due to pharmaceutical dependence (code CIM 304)), which also exhibit a marked downturn since 1994. Only deaths whose causes were reported in the death certificate by the doctor who recorded the death and are registered as the main cause of death (i.e. illness or trauma which directly led to death) are included in the following table. However, one of these causes may have contributed to the death without being the main cause. This will be seen in the INSERM file as an associated cause.

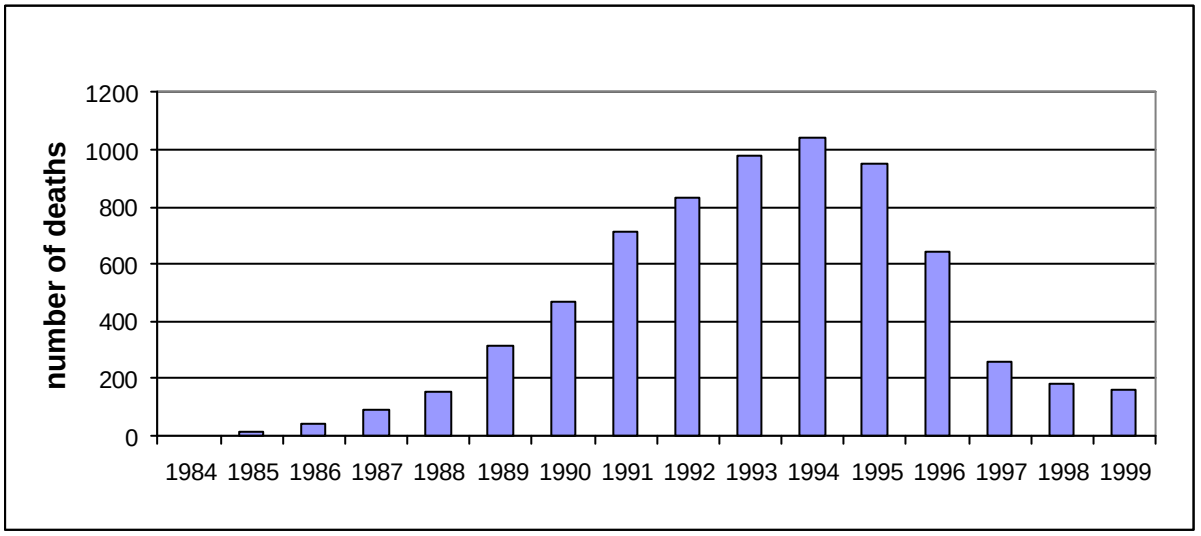
Deaths in connection with drugs usage

	Pharmaceutical co-dependence (CIM 304)
1990	241
1991	297
1992	384
1993	404
1994	428
1995	406
1996	346
1997	181

Source : INSERM-SC8

Number of deaths due to AIDS amongst drugs users, having exhibited a continuous growth between 1986 and 1994, was divided by more than 6 between 1994 and 1999 (1 040 in 1994 and 163 in 1999). A similar development is noted for all AIDS deaths, whatever the mode of contamination.

Deaths by AIDS of drugs users



Source : Institut de Veille Sanitaire (=health monitoring institute)

New AIDS treatments are the main explanation for the downturn in AIDS' related deaths which is observed in the same proportions for all categories of patients.

3.3 Drug-related infectious diseases

See chap.14 part IV

3.4 Other drug-related morbidity

The other aspects of morbidity among drug users are less well known and have been measured either to a limited extent or in a very heterogeneous manner. The doctors questioned in the EVAL study reported cases of tuberculosis in 2% of their drug-using patients and sexually transmitted diseases in 8%. Septicemia was mentioned by 5% of users in the IREP survey, venous infections in 14% of cases in the ARES92 study, and more general antecedents of infection in 23% of cases in the GT69 study.

Dental problems were the preoccupation most frequently mentioned by users met in the street in the IREP survey (52% of cases).

Overdoses, suicide attempts and psychiatric problems are important morbidity traits in the most dependent drug users, and we are not able to measure these in a precise and consistent manner. ¤

4. SOCIAL AND LEGAL CORRELATES AND CONSEQUENCES

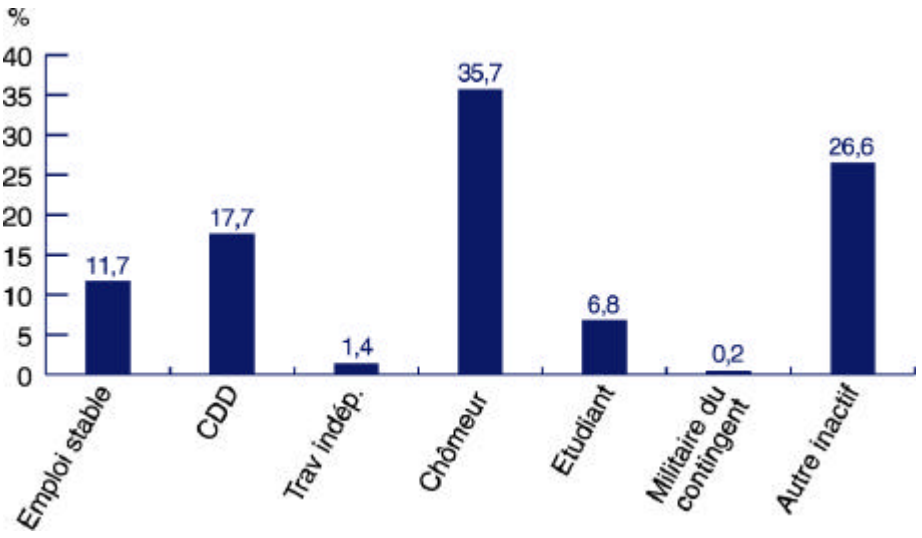
4.1 Social problems

Employment

Of the people provided with assistance by health and social services in November 1997[12], 69% were "economically inactive"; depending on the nomenclature used in the survey, this category included the unemployed, students, and others. This breakdown has remained fairly stable since the late 1980s. The breakdown between economically active and inactive people in November 1989 and in November 1992 was identical to that in 1997.

[12] The 1999 results are not yet available

Occupations of users having recourse to the health and welfare system in November 1997



Stable

Employment

Fixed-term contract

Self-employed

Unemployed

Student

Military service

Other inactive

Source: DREES

Among users having recourse to specialist centres for the first time in November 1997, the proportion of schoolchildren, students and unpaid trainees was higher than among users for whom it was not the first contact (9% and 2% respectively). However, the proportion of unemployed people who had previously had a job was lower among the former (26% compared to 30%). Apart from these differences, the breakdown by occupation is fairly similar for both groups.

Of the arrested users, using the same definition as in the November survey, 67% were “inactive”; 41% of these were unemployed and 26% were students. The breakdown between active and inactive people was therefore quite similar in both sources, but students were much more highly represented among the users arrested.

Between 1997 and 1998, the proportion of unemployed people fell from 58% to 41%, and that of students increased from 18% to 26%. The main reason for the increase in users arrested between 1993 and 1998 was the growth in the number of students arrested (+ 19,000), manual workers (+ 11,000), unemployed (+ 4,266) and non-manual workers (+ 3,224).

Welfare cover

In 1997, as in a number of previous years, just over 6% of persons having recourse to the health and welfare system did not have any welfare cover, and of these a high proportion (44%) were aged under 24. The proportion of people receiving the minimum wage increased from 26% to 27.5% between 1995 and 1997. Because of the fluctuations in the number of responses to this question, the significance of this small increase must be treated with caution.

Nuisance to the community

In France, the problems caused by the concentration of users and dealers in certain districts date back to the early 1980s. One consequence of the emergence of Aids in terms of drug addiction has been to place the concentration of drug users in cities in a new light. During the period before the epidemic, users simply needed to be dispersed, and the formation of other drug scenes prevented, to avoid causing a nuisance to the local people and create a secure climate. Since the advent of Aids, the issue has become more complex because it is no longer purely one of public order; it is now a health matter which is more difficult to manage. The authorities have confronted the epidemic by setting up low-threshhold schemes such as syringe exchange programmes and drop-in centres within these open drug scenes. These are seen by some local people as helping to keep users “corralled” within the local area and to attract others.

Over the past two years, this situation has resulted in three new developments:

The first is that the inhabitants of particular areas have set up associations either to *oppose* low-threshold schemes or to *support* them.

The second is that local people are opposing not only the presence of users and dealers in their area, but also the organisations which look after them, particularly low-threshhold ones.

The third is that people are now having recourse to the courts in disputes of this kind. At least two court cases have been brought against four organisations in Paris and Montpellier with a view to shutting them down or moving them elsewhere.

4.2 Drug offences and drug-related crime

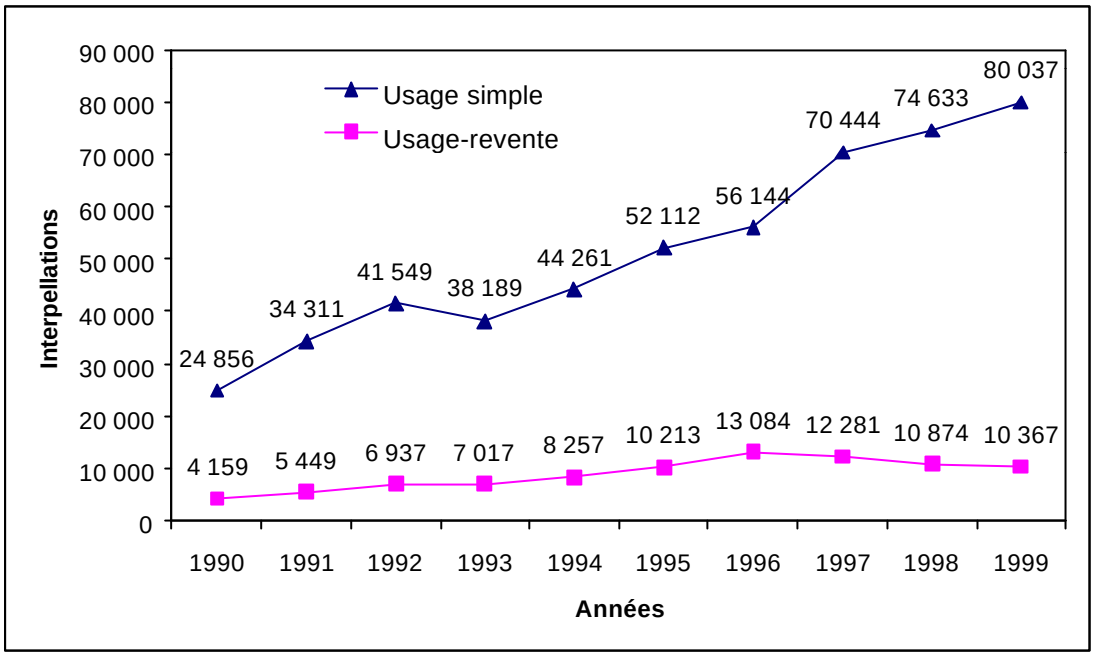
Arrests for drug use

The police and gendarmerie act quite independently in dealing with drugs offences. It is therefore very difficult to determine how much of the observed change results from changes in the population of users and how much from changes in levels of activity by the law enforcement services. If the police particularly concentrate their efforts on drugs, this can result in an increase in the number of arrests, even though the number of drugs users remains constant. It is therefore important not to be too hasty in drawing conclusions about the number of users based on the arrest figures.

There was a moderate increase in the number of users and users/dealers arrested in 1999 (5.7%), and also in 1998 (3.4%) following a particularly sharp rise of 19.5% in 1997. The number of use-only arrests doubled between 1993 and 1999.

Arrests of users are growing more rapidly than those of users/dealers. The share of users/dealers as a proportion of total arrests has slightly decreased since 1993, and stood at around 11% in 1999. Conversely, the number of users as a proportion of total arrests has grown from 74.6% in 1993 to 83.5% in 1999.

Arrests for use only and use/dealing (all products)

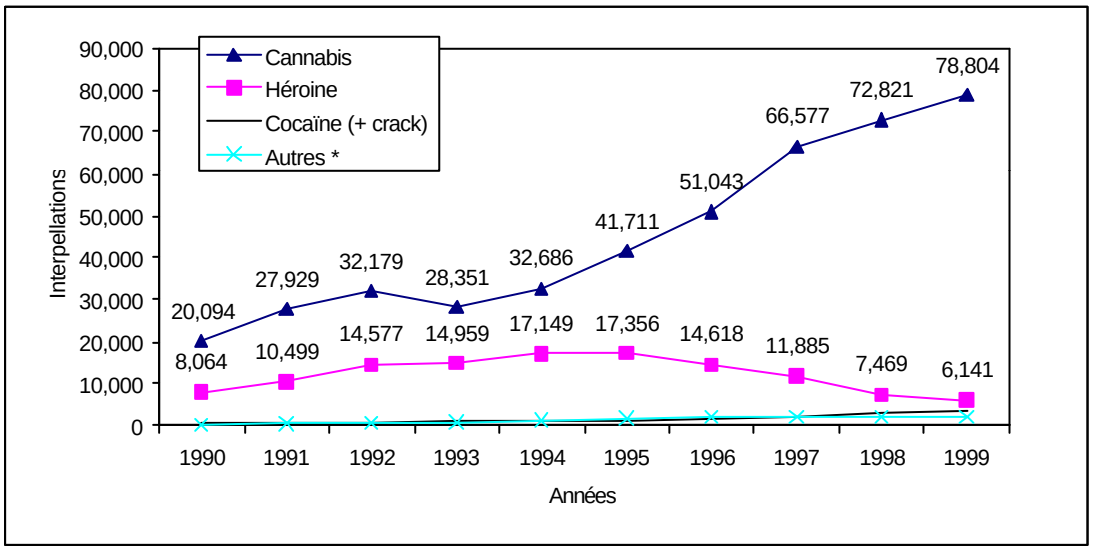


Source: OCRTIS (*Usage et trafic de stupéfiants – statistiques 1999*)

Interpellations = Arrests

Années = Year

The growth in the number of arrests of users between 1998 and 1999 is essentially due to an increase in the number of arrests for using cannabis, and to a lesser cocaine, while arrests for heroin use are falling sharply. Between 1993 and 1999, the number of cannabis users increased by a factor of 2.8, while for heroin it decreased by a factor of 2.4. Cannabis users represent 87% of users arrested compared to 63% in 1993. Arrests of cocaine users grew considerably in the 1990s. In terms of numbers, they exceeded the number of arrests for heroin use in a number of departments of France. However, they accounted for only just under 4% of arrests for use in 1999.



Arrests for use and use/dealing, by product

Arrests

Year

Cannabis

Heroin

Cocaine

Other

* Other products comprise ecstasy, LSD, opium/morphine, and psychotropic/pharmaceutical products

Source: OCRTIS (*Usage et trafic de stupéfiants – statistiques 1999*)

There is no simple explanation for the rise in arrests over recent years, though broadly speaking there are two main causes. The first is possible changes in the behaviour of the police and gendarmerie. For example, according to the review of the implementation of the 1995 Justice Ministry circular on therapeutic injunction, nearly all public prosecutors' offices instructed the police and gendarmerie to use standard descriptions for users. The implementation of these instructions may have led to a rise in the number of recorded arrests. Internal reorganisations within the police services may also have helped to increase the number of arrests, and particularly the tendency to grant the public security services greater autonomy in relation to narcotics.

The second main factor concerns the increasingly common nature of cannabis consumption and major changes in the context in which it is used. Given the state of current knowledge, it would be presumptuous to say that one or other of these explanations is the more likely.

The rapid increase in the number of people receiving substitutes since the beginning of 1996 appears to be one of the most plausible explanations for the fall in the number of arrests for heroin use.

As far as police procedures are concerned, ordinary users are less often held for questioning and more often released than they were previously.

Statistics produced by the Police Judiciaire 13 give an idea of what happens to drug users after arrest. In this respect, it is important to differentiate between ordinary users and user/dealers, since according to the Justice Ministry circulars the judicial response should not be the same in both cases..

Generally speaking, during the 1990s the police arrested far more users but the number of ordinary users held for questioning was more or less stable. The proportion of user/dealers cautioned is always higher than that of ordinary users: the figures in 1998 were 83% and 53%. But the number of people held for questioning rose in 1998: the number of users only was up by 16%, user/dealers by 17%, and traffickers by 9%.

Of the total number of ordinary users implicated in 1998, 97.4% were released compared to 92.6% in 1993. The word "released" covers a large number of situations, and does not mean that the investigations were discontinued. Some people may be sentenced later on after being summonsed to court.

Characteristics of arrested users:

[13] Ministère de l'Intérieur, Direction Générale de la Police Nationale, and Ministère de la Défense, Direction Générale de la Gendarmerie Nationale, *Aspects de la criminalité et de la délinquance constatées en France en 1998 par les services de police et de gendarmerie*, Paris, La Documentation Française, 1999.

The proportion of minors among arrested users is increasing. The share of people implicated in use and use/dealing rose from 6.6% to 20.2% between 1993 and 1998, for the first category, and from 5.7% to 20.3% for the second.

According to the OCRTIS figures, the annual growth in the number of minors arrested for use and use/dealing is considerably higher than for adults: since 1990, it has averaged 25% for the former and 12% for the latter.

Another significant trend is the fall in the proportion of foreigners among those implicated in use and using/dealing. Between 1993 and 1998, the number of foreigners as a total of users fell from 13.7% to 8.0%, and of users/resellers from 19.0% to 10.4%.

Persons arrested

The above figures are the annual number of arrests recorded by OCRTIS. However, it is possible for one person to be arrested a number of times within the same year. The OCRTIS database has been used to establish the exact number of individuals arrested between 1990 and 1997 and the number of times they came into contact with the police for using narcotics during this period[14].

Between 1990 and 1997, 348,652 different people were arrested for drug use: 76% for cannabis, 23% for heroin, 2% for cocaine and 1.3% for ecstasy. Arrests for drugs other than cannabis and heroin represent only a very small proportion of total arrests.

During this period, each individual was arrested an average of 1.3 times. The differences between products are significant: each heroin user was arrested an average of 1.4 times compared to 1.2 times for cannabis users and just over once for users of cocaine.

Although these figures confirm the generally accepted view that heroin users have more frequent contact with the police, it is worth noting that three quarters of the 82,000 arrested heroin users were arrested only once, and only a core of 7,000 was arrested three or more times for narcotics offences.

Multiple arrests in a single year are fairly rare. A heroin user is arrested an average of 1.1 times a year, compared to 1.05 times for a cannabis user.

Finally, it is interesting to note that three quarters of the 19,361 cannabis users arrested in 1990 had no further contact with the police services between 1990 and 1997. The number of individuals arrested for heroin use after a first arrest for cannabis use was 1,443, or just over 7% of cannabis users arrested in 1990 and 40% of those arrested more than once.

Arrests for trafficking

Number of arrests for trafficking

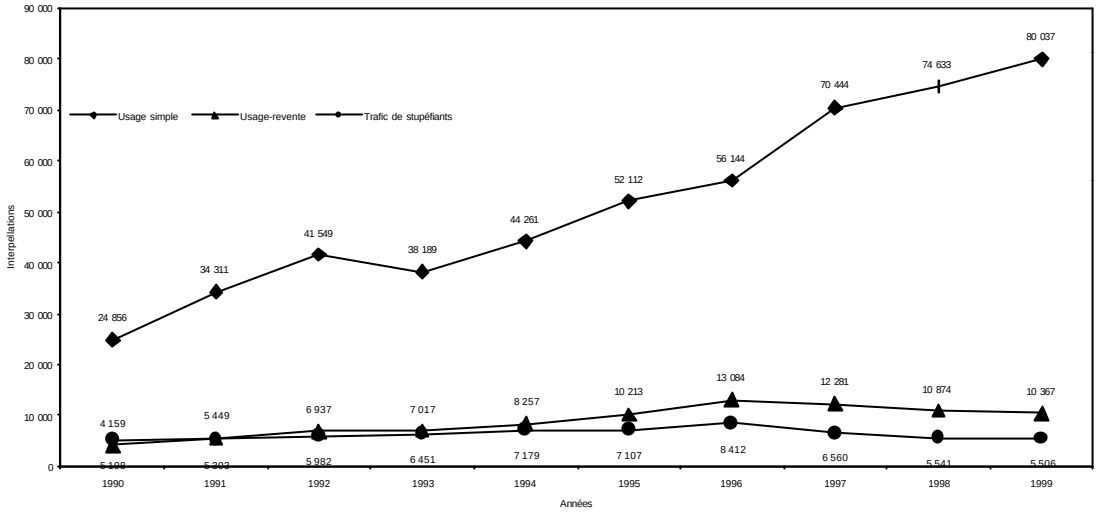
The number of arrests of traffickers fell fairly sharply between 1996 and 1998 but stabilised in 1999, decreasing from 8,412 in 1996 to 5,506 in 1999. The number of arrests in 1999 was more or less the same as in 1991/1992.

[14] ENSAE Junior Etudes, *Etude du fichier FNAILS des interpellations pour usage de stupéfiants au niveau de l'individu*, Paris, Observatoire Français des Drogues et des Toxicomanies, 1997.

Arrests for trafficking represented around 6% of the total arrests for narcotics offences in 1999, compared to 23.5% in 1993.

Interpellations = Arrests

Nombre = Number



Usage simple = Use only

Usage-revente = Use/dealing

Trafic... = Narcotics trafficking

Arrests for narcotics use, use/dealing and trafficking

Source: OCRTIS (*Usage et trafic de stupéfiants – statistiques 1999*)

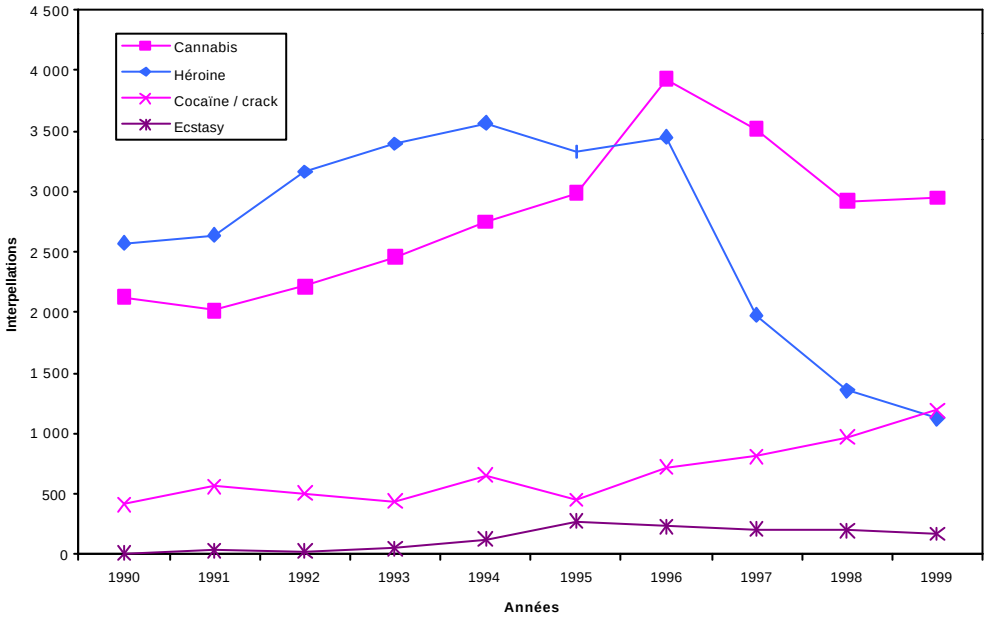
Arrests by type of trafficker

Of the traffickers arrested in 1999, 23% were international and 77% local. The proportion of local traffickers has been fluctuating between 75% and 85% since the mid-1980s. However, nearly all of the fall in arrests of traffickers from 1996 to 1999 was due to the fall in local trafficking.

Arrests of traffickers by product

In 1999, cannabis traffickers represented 54% of traffickers arrested, a similar proportion to those of 1997 and 1998. The proportion of heroin traffickers has been falling since 1992 (it dropped from 53% to 20% in 1999), while the proportion of cocaine and crack traffickers rose from 8% to 22% between 1992 and 1999. Arrests of ecstasy traffickers accounted for a much smaller proportion of total arrests, at only 3% in 1999.

The trend between 1992 and 1999 has been characterised by a sharp diminution since 1997 of arrests of heroin traffickers. Arrests of cannabis traffickers also rose between 1992 to 1996 and then fell significantly. Arrests of cocaine traffickers, which have been fluctuating between 200 and 500 since the mid-1980s, have recently started to rise. Arrests of ecstasy traffickers have been relatively stable since 1995.



Arrests for trafficking by product

Source: OCRTIS (*Usage et trafic de stupéfiants – statistiques 1999*)

Arrests

Year

Cannabis

Heroin

Cocaine/crack

Ecstasy

The contraction of the heroin market, which has been apparent in the number of user arrests since 1995, has also been very obvious in terms of trafficker arrests since 1997. This trend appears to have continued in 1999. The fact that traffickers are probably switching to other products such as cocaine is starting to be reflected in the number of arrests for trafficking in this product.

Convictions for use

Apart from receiving treatment orders, arrested users may either be released without charge, cautioned (this is the most common) or prosecuted. Since prosecutions are only instigated if there is sufficient evidence for a charge, most users who are prosecuted receive convictions.

Court appearances may take place in a number of different ways:

- Immediate appearance

In most such cases, the arrested person is held until their trial, which takes place very soon afterwards.

- Summons by officer of the *police judiciaire*

The person is released after arrest, whether or not they have been held for questioning and the case is referred to the public prosecutor's office. The court summons is served direct by an officer of the *police judiciaire,* so the person cannot claim ignorance of the date of their court appearance.

- Direct citation

Here again the person is released, but subsequently receives a summons from a *huissier de justice*, or process server.

- After preliminary investigation

Preliminary investigations are generally carried out in trafficking cases. They usually involve a relatively large number of users.

Court statistics use a different nomenclature to those drawn up by the police. They distinguish between many different types of offence, which can be grouped into seven main types[15]. There is no exact correspondence between the two nomenclatures, so it is difficult to compare the figures for arrests and convictions.

When the public prosecutor's office decides to prosecute a person arrested for a narcotics offence, it also has to decide which offence or offences they have committed. In the majority of prosecutions, public prosecutor's offices use several offences simultaneously. In 1996 (the last year for which figures are available), prosecutions and convictions involving three or four offences were very common, and the number of offences associated with one conviction has been tending to rise since the early 1990s. From magistrates' point of view, using multiple offences makes it easier to decide on the facts of the case. However, it also makes it difficult to observe trends, especially since different public prosecutor's offices use different definitions. Although three simple categories are used in the arrest statistics, convictions may involve many different combinations of offences: for example, use may be combined with possession/acquisition, transport or trafficking.

The annual statistics published by the courts usually describe convictions in terms of the main offence involved[16]. However, statistics of this kind give only a very partial picture of convictions for narcotics use, and an analysis of the associated offences provides a more detailed view.

[15] Possession/acquisition; illicit use; trafficking (import, export); trading, transport; offer and dealing; abetting use by another person; other.

[16] The main offence is the first one mentioned if all the descriptions are in the same category (crime, offence or contravention); if the descriptions are in different categories, it is the first one mentioned in the most serious category.

Convictions as the principal offence

There were 6,686 convictions for use as the principal offence in 1998. Although this figure fluctuates from year to year, it is relatively stable in the medium term.

The table below suggests that the number of narcotics convictions is relatively stable, unlike that of arrests for use. The fall in convictions in 1995 was the result of a presidential amnesty, whose effects were also felt to a lesser extent in 1996.

Convictions for use represent 28% of total convictions for narcotics offences, which is a decrease compared to 1992.

Arrests and convictions for use (main offence)

	1992	1993	1994	1995	1996	1997	1998
Arrests for narcotics use only	41,549	38,189	44,261	52,112	56,144	70,444	74,633
Convictions for illicit use of narcotics	7,374	8,157	6,201	4,670	6,751	6,530	6,686
Total convictions for narcotics offences	21,851	22,530	20,580	20,661	23,840	23, 980	24,081

Source: OCRTIS (*Usage et trafic de stupéfiants – statistiques 1999*) & Ministère de la Justice (*Annuaire statistique de la Justice – édition 2000*)

As we have already noted, the statistics for main offences give only a very partial picture of the offences to which convictions relate. In fact, the offence of “use” appears more often in convictions than the figures in the above table indicate.

Convictions for associated offences

Here, we have examined all convictions including at least one offence of use. There were 15,168 of these in 1998, which was a similar number to 1997 but a significant increase compared to 1991. Does this mean more users are being convicted? To answer this question, we need to distinguish between cases where the conviction was simply for an offence of use, and those where use was associated with other offences.

Convictions for use only

There were 3,452 convictions for use only in 1998. Compared to 1991, these decreased both in number and most importantly as a proportion of the total convictions including at least one offence of use. However, convictions for use only remained fairly stable between 1996 and 1998.

Non-suspended prison sentences were imposed in 19% of convictions for use only in 1998, compared to 24% in 1991. The average length of non-suspended prison sentences (including partially suspended ones) decreased from 3.5 to 2.4 months between 1991 and 1998. A study[17] relating to 1991 looked at non-suspended sentences for use only. Half of these people had already been convicted during the previous two years, often for theft or receiving stolen goods. Users with no previous court record were convicted in 9% of cases; in half of these instances they were not present at the court hearing.

[17] Timbart O., L’usage des stupéfiants dans les condamnations, *Infostat Justice*, n°38, July-August 1994.

In 29% of cases, drug users were sentenced to a suspended term of imprisonment, frequently combined with a probationary period during which they were required to undergo detoxification or medical supervision; this was the case with 70% of suspended prison sentences in 1995.

Fines were imposed in a third of cases, community service in 8% of cases, and education in 5%.

Convictions for use and other narcotics offences

This information requires particular caution. We are awaiting new data, and the latest we have available dates from 1997.

In 1997, there were 10,075 convictions combining use and other narcotics offences. Of these, the number of convictions combining use and offences relating to trading in narcotics is rising very rapidly. The number of convictions combining use and trafficking and use and transport approximately quadrupled between 1991 and 1997. The number combining use and dealing doubled.

The proportion of non-suspended prison sentences was higher for these convictions than those for use only, at 21% of convictions compared to 14%. However, the main difference in convictions is the proportion of partially suspended sentences, which stood at 0.6% for use only compared to 37% for use and trafficking and 21% for use and transport.

Since 1991, there has been a trend towards more severe sentences for use combined with transport or trafficking. The proportion of non-suspended prison sentences is increasing, and the average length of imprisonment was 16.8 months in 1997, compared to 18.3 in 1996 and 16 in 1991.

Convictions for combined use and dealing probably refer to the users/dealers category in the police statistics. In these cases, the average length of imprisonment is around 10.8 months.

Convictions for use and trafficking or use and transport probably often relate to smugglers who try to cross frontiers with limited quantities of narcotics. The penalties are much less severe than those for trafficking alone or trafficking combined with offences other than use.

Unlike the previous group, the number of convictions for combined use and possession/acquisition is increasing fairly gradually. The structure and length of penalties for possession/acquisition in 1997 were fairly similar to those for use only. Significantly, the average length of non-suspended sentence fell from 10 months in 1991 to 4.8 in 1997, though this may have been increased by a few cases involving very long sentences. It is therefore possible that convictions for use only and for use and possession/acquisition often relate to similar forms of behaviour and groups of people.

Convictions for use and other offences not linked to narcotics

Finally, there were 2,242 convictions combining use and non-narcotics-related offences in 1997. The number of these convictions is rising, but they have decreased as a proportion of the total since 1991. In 1995, nearly two thirds of cases involved use combined with theft or receiving stolen goods.

The proportion of non-suspended prison sentences was particularly high for convictions combining use and misdemeanours in 1997, at 33%, though this was a distinct decrease on 1996. The percentage was increased by the number of convictions for use and illegal immigration, which are automatically subject to a non-suspended prison sentence. However, the proportion of non-suspended sentences has been declining since 1991, and the average length of sentences has been increasing since that date; it stood at seven and a half months in 1996.

Essentially, the increase in the number of convictions involving at least one offence of use is a result of the increase in convictions for use combined with trafficking, transport or dealing**,** in other words offences where users are normally involved in narcotics trading. Convictions for use only in the broad sense, or use combined with other misdemeanours, remain fairly stable.

Here again, it is difficult to know whether the explanation for this trend lies in the fact that more users are involved in the narcotics trade (by being used to transport narcotics and cross frontiers) or whether public prosecutor's offices have changed their definitions by using two offences, use and trafficking, where in the past they would have used only the offence of use.

Convictions for offences of use and combined offences

	1991		1996		1997 (1)	
	actual gross convictions	%	actual gross convictions	%	actual gross convictions	%
Use	11,505	100	15,493	100	15,685	100
use only	4,242	36.9	3,019	19.5	3,368	21.5
use and ILS	5,063	44.0	10,081	65.0	10,075	64.2
use and trafficking	475	4.1	1,741	11.3	1,501	9,6-
use and transport	761	6.6	3,109	20.0	3,478	22.2
use and dealing	1,431	12.4	2,505	16.2	2,377	15.1
use and possession	2,242	19.5	2,683	17.3	2,677	17.1
use and other narcotics	154	1.4	43	0.2	42	0.2
use and non-ILS	2,199	19.1	2,393	15.5	2,242	14.3

Source: SDSED, Ministry of Justice

(1) provisional data

Convictions for use as a proportion of convictions for narcotics offences

In 1997, there were a total of 27,483 convictions involving at least one narcotics offence. Just over half of this total, 15,685, were for at least one offence of use.

Use-only represented around 12% of these 27,483 convictions, use combined with offences linked to narcotics trading accounted for 36%, and use combined with other misdemeanours, around 9%.

The number of arrests for use as a proportion of convictions including an offence of use was 21% in 1997. This was a decrease on 1991, when the figure was around 8%.

Convictions relating to narcotics trading

As with convictions for use, the nomenclatures in police and court statistics are different, and there is no way of knowing exactly what penalties were imposed by the courts on those arrested for trafficking.

In the court statistics, the term “trafficking” refers only to the import or export of narcotics. Traffickers arrested by the police may also be convicted for offences of trading, transport, offering and dealing, obtaining, acquisition or use of narcotics. In most cases, an arrested trafficker will be convicted for multiple offences, and there is a trend towards using an increasing number of offences in each conviction. Between 1991 and 1996, the average number of narcotics offences covered by convictions including at least one ILS increased from 1.8 to 2.6. We saw in the section on convictions for use that an offence of trafficking may also be combined with an offence of use. Charging practices are not standardised and may differ widely from one public prosecutor’s office to another.

Convictions in principal offences

The fastest-increasing offences are trading, use and transport of narcotics and, to a lesser extent, trafficking. We have already seen this trend in terms of offences combined with use.

The figures for principal offences give only a partial picture of the offences relating to trading in narcotics to which convictions relate. Many convictions relate to offences of combined use, as the following table shows.

Number of convictions for principal offences linked to narcotics trading

	1992	1993	1994	1995	1996	1997	1998
Convictions for narcotics trafficking (import/export)	2,196	2,128	2,450	2,706	2,427	2,193	1,977
Convictions for trading, use, transport of narcotics	2,182	2,284	2,173	2,652	3,298	4,016	3,512
Convictions for offering and dealing of narcotics	2,272	2,034	2,307	2,595	2,862	2,523	2,447
Convictions for possession/acquisition	7,563	7,699	7,294	7,910	8,183	8,592	9,343

Source: Ministry of Justice (*Annuaire statistique de la Justice – édition 2000*)

Convictions for narcotics offences other than use

The data available for this type of conviction is not as detailed for combined offences as for convictions for use.

However, we can attempt to evaluate the number of convictions for trafficking by comparing the total convictions comprising at least one narcotics offence in 1997, namely 27,483, to the total convictions in 1997 comprising at least one offence of use, which was 15,685. The difference, 11,798, comprise at least one narcotics offence, but not use.

The figure for convictions other than use is greater than the 8,000 arrests of traffickers recorded by OCRTIS in 1995-1996. This means that the 11,798 convictions for offences other than use consist not only of traffickers recorded by OCRTIS but also other categories, users/dealers, users only, or persons arrested for other misdemeanours.

Convictions for narcotics offences in 1991, 1996 and 1997

	1991	1996	1997
Number of convictions comprising at least one ILS	22,699	27,426	27,483
Number of convictions comprising at least one offence of use	11,505	15,493	15,685
Number of ILS convictions not including an offence of use	11,194	11,933	11,798

Source: SDSED, Ministry of Justice

Apart from use, convictions comprising at least one narcotics offence increased only slightly between 1991 and 1997. As the table below shows, most of the increase in the number of convictions comprising at least one ILS was due to the rise in the number of convictions including use.

Imprisonment for use

Imprisoned persons fall into two distinct categories: those held on remand pending a judgement and those imprisoned after being convicted.

A distinction is also drawn between statistics measuring incoming and outgoing prisoner movements during a given year and those measuring the size and characteristics of the prison population on a given date, 1 January.

When it comes to calculating the number of individuals imprisoned for one offence of use, we only have statistics for principal offences. This means that persons imprisoned following one offence of use can also be imprisoned for other offences. Conversely, those imprisoned for other offences (narcotics-related or otherwise) can also be prosecuted or convicted for an offence of use. As with convictions, this approach based on the principal offence gives only a partial view of imprisonments for offences of use. However, we do not have figures for the number of persons imprisoned based on the different combinations of offences.

There has been a constant decline in the annual number of imprisonments for offences of use between 1993 and 1999, from 1,200 to less than 500.

Number of persons imprisoned for principal offence of use

	1993	1994	1995	1996	1997	1998	1999
Number of persons imprisoned during the year	1,213	1,034	892	870	700	-	471

Source: PMJ1, Ministry of Justice.

The number of persons entering penal institutions for other narcotics offences is declining slightly.

As at 1 January 2000, there were 290 people in prison whose principal offence was use, and 471 people in this category entered penal institutions during 1999. It is not known how many of them were convicted for use only and how many for use combined with other offences. The number of persons imprisoned following prosecutions for trafficking who were also convicted for use is also unknown. In the absence of a study on combined offences by persons in prison, it is difficult to gain a precise idea of imprisonments for use. However, there is a filtering effect in operation, with 75,000 people arrested in 1998 for narcotics use only, compared to around 7,000 convictions where the principal offence was use. There were 471 imprisonments for principal offence in 1999, but the number of people imprisoned following a conviction including use is unknown, though it was somewhere between 500 and 7,000.

Number of people imprisoned for principal offence of use as at 1 January 2000

Number of prisoners (remand and convicted)	290

Source: PMJ1, Ministry of Justice

Imprisonments for trafficking

Prison statistics in turn use a different nomenclature to those of the courts, and the term “trafficking” is defined in a general sense.

The figures relating to imprisonment show only the principal offence. A person imprisoned for trafficking can also be prosecuted or convicted for use, and it is also possible to be imprisoned following a conviction for theft and use. If “use” is not the first offence cited in the conviction, this person will not be counted as having been imprisoned for ILS.

The figures for imprisonments cover both periods on remand and imprisonments following conviction (with some people not being held on remand prior to sentencing). The figures show both incoming and outgoing prisoners, and the prison population on a given date.

Flows of prisoners

In 1999, 9,125 people were imprisoned for a narcotics-related principal offence, with two thirds of these being sent to prison for trafficking. The number of imprisonments for trafficking fell sharply in 1997 after having remained very stable between 1993 and 1996. This may be related to the decrease in the number of arrests of traffickers.

Imprisonments for offences related to narcotics trading

Type of offence	1993	1994	1995	1996	1997	1998	1999
Trafficking	7,845	7,726	7,991	7,842	6,869	-	5,867
Dealing	686	1,140	1,053	987	910	-	491
Other ILS (except use)	2,091	2,158	2,653	2,244	2,115	-	2,296
Use	1,213	1,034	892	870	700	-	471

Source: PMJ1, Ministry of Justice

Number of prisoners on a given date

At the beginning of 2000, 8,600 people were in prison for narcotics offences, divided roughly equally between convicted and remand prisoners. The number of prisoners convicted for narcotics offences is decreasing. They represented 21% of the total number of convicted prisoners as at 1 January 1994, and less than 18% on 1 January 2000.

For the great majority of convicted and remand prisoners, the principal offence was trafficking. But as we have already pointed out, with some of the people held for trafficking, dealing or other offences, there may also be an offence of use involved.

Number of people in penal institutions as at 1 January 2000

	Number of prisoners (remand and convicted)	%
Trafficking	6,187	71.9
Dealing	402	4.7
Other ILS (except use)	1,721	20.0
Use	290	3.4

Total ILS	8,600	100

Source: PMJ1, Ministry of Justice

4.3 Social and economic costs of drug consumption

Estimation of the social cost of drugs

Social costs

Apart from the cost to the public, a study recently published by the OFDT[18] attempts to measure the total social cost of illicit drugs, alcohol and tobacco. It calculates social costs using the **"cost of illness"** defined by international experts (see box below).

Illicit drugs have a social cost of 13,350 million FF, which is 111 FF per capita and 0.16% of GDP. Some 46% of this cost results from lost productivity; of the total of 6,099 million FF, 5,246 million FF relates to ILS imprisonments and 852 million to early mortality. Because these substances are illicit, the second largest cost (accounting for 29.3% of the total, or 3,911 million FF) is that of law enforcement. This is followed by the cost of care, at 11.4% or 1,524 million FF, divided between the cost of outpatient hospital treatment (924 million FF) and general practitioners (600 million FF). In fourth place (7.1%) are prevention and research costs of 948 million FF, and last of all comes lost taxes and other levies at 6.5%, or 866 million FF.

[18] : Kopp, P., Fenoglio, Ph. . Le coût social des drogues licites (tabac et alcool) et illicites en France. OFDT, étude n° 22, September 2000, 277 pp.

Social cost of drugs in France, 1997 (million FF)

	Illicit drugs
1. Direct cost of care	**1,524.51**
1-1 – Outpatient hospital treatment	*
1-2 – Outpatient hospital treatment	924.51
1-3 – General practitioners	600.00
2. Direct research and prevention costs	**948.88**
2-1 – Public sector and C.N.A.M*.: total	948.88
2-1-1 - CFES* campaign	*
2-1-2 - C.N.C.T*	*
2-1-3 - C.N.A.M.* prevention campaign	*
2-1-4 - Financing of ANPA by C.N.A.M.*	*
2-1-5 - C.N.A.M.* accident at work benefit	*
2-1-5 – Ministry of employment and welfare	*
2-1-6 – social affairs, health, local councils	798.75
2-1-7 - M.I.L.D.T.*	45.36
2-1-8 – Education	56.01
2-1-9 – Youth and sport	17.08
2-1-10 - Contribution to E.U.* budget	30.87
2-1-11 – Work, employment and professional training	0.81
2-2 – Private sector	n.a
3. Direct cost of law enforcement	**3,911.46**
3-1 – Public sector (gendarmerie, police, justice, cooperation, foreign affairs, P.N.U.C.I.D.*)	3,906.20
3-2 – Public sector, prevention of cigarette trafficking	*
3-3 – Fines paid by private-sector bodies	5.26
4. Direct cost of lost taxes and other levies	**866.24**
4-1 – premature death	100.25
4-2 – hospitalisation	n.a
4-3 - imprisonment for road traffic offences, I.L.S.*	765.99
5. Other direct costs	*
5-1 – Public sector fire prevention	*
5-2 – Traffic accidents (insurance companies' costs)	*
6. Indirect costs: lost income and productivity	**6,099.19**
6-1 – loss of income, private-sector operators	1,774.73
6-1-1 – premature death	205.39
6-1-2 - hospitalisation	n.a
6-1-3 - imprisonment for road traffic offences, I.L.S.*	1,569.34
6-2 – companies' loss of productivity	4,324.46
6-2-1 – premature death	646.88
6-2-2 – hospitalisation	n.a
6-2-3 - imprisonments (road traffic offences, I.L.S.*	3,677.58
TOTAL	**13,350.28**

Notes: n.a = not available; * = insignificant; * = see list of initials
Source: OFDT 1999

These calculations allocate all the costs to society of consumption of the various substances, without making any distinction between "normal" and "harmful" consumption. The study is limited to the "tangible" monetary costs (such as lost income) and excludes the "intangible" monetary value of subjective damage such as pain and suffering.

The social cost measured here covers* all tangible costs borne by society, *i.e. both by the private sector (*private costs*) and the public sector (*public costs*), and caused by consumption and trafficking, with the exception of the cost of buying the substances.

Private costs ***include not only those*** **directly borne by consumers of substances** ***(consumption costs, loss of income due to premature death and other factors, certain non-reimbursable medical costs etc), but also*** **indirect or external private costs** ***borne by private-sector individuals and organisations who are not consumers of substances. This second category includes the costs inflicted by consumers of substances on other private non-consuming areas of the private sector (for example, companies pay the costs of lost production caused by the absence of employees hospitalised due to their consumption of alcohol, tobacco or illicit drugs). It also includes the expenses directly incurred by the private sector (principally charities).*** ***There are three types of*** **public costs** ***incurred as a result of the*** **consumption and trafficking of drugs by the private sector.** ***The first is public spending as laid down in the budget, and includes the costs of the various ministries. The second are the resources expended by regional, departmental and local authorities. The third consists of social transfers, mainly in the health sector, which are shown here as public expenditure. This is not the case in the accounting systems of France and most European countries, because these costs are financed by the whole of society, including households and private-sector companies. However, in order to make it easier to make international comparisons between studies, we will follow the American and British practices of including all social transfers within public expenditure.***

This is also a ***prevalence study*** because it estimates the cost of problems occurring during a given year, 1997.

Lost income and productivity due to premature deaths are estimated using the "human capital" method and the present value of future income. This is the most common approach, and differs from the "***willingness to pay"*** approach (Hodgson & Meiners, 1982) which assesses the value of human life based on the amount which individuals are willing to pay to change their life expectancy. As a rule, the results obtained using the human capital method are lower than those using the willingness to pay technique.

The human capital method calculates the present value of future lost income caused by premature death due to drug use. The results below are calculated using an actualisation rate of 6%.

The cost of illness method

The *cost of illness* (COI) method is well established in the scientific community. The key idea is that an illness or social problem incurs costs because it results in the use of resources which could have been used for a different purpose.

It assumes two hypotheses: firstly that the factors of production are fully employed (i.e. that all existing resources are being used to produce goods and services) and secondly that a reallocation of the resources used in drug prevention would not affect the level of welfare benefits. Using these two hypotheses, all the consequences of drugs are treated as a "social cost" that results in a loss of collective well-being.

This reasoning is based on the concept of *opportunity cost,* which is the ability to make alternative and more advantageous use of the resources allocated to a particular activity. We will therefore refer to a "*counter-factual" scenario,* which is an alternative state of affairs.

The COI methodology was formalised as a set of guidelines following work done by the US Public Health Service task force under Dorothy Rice (Rice *et al*, 1986; Hodgson & Meiners, 1979). It has been the subject of numerous theoretical developments (Single *et al.*, 1995) and discussions (see, in particular, the comments made by Harwood *et al.,* Reuter, Kopp, Kleiman and Cohen in the May 1999 issue of *Addiction*).

Estimate of total drug consumption/demand/expenditure

Expenditures for purchasing illicit drugs

It is only possible here to attempt to define the parameters of these expenditures by using plausible assumptions. It is tempting to not even try to measure this because of the difficulty of doing so. However, this does not appear to be satisfactory because it would give free reign to subjective

representation of totals estimates for " drug money." The OFDT thought that it would be preferable to fuel the debate over this question by proposing to make this measurement by using plausible and reasonable assumptions. When these elements are clearly defined, it is possible to discuss the assumption and measure variations in the figures obtained when certain parameters of the calculation are modified. We will limit ourselves to making an assessment of expenditures for cannabis and heroin. It is not possible to make a reasonable assessment of expenditures for cocaine and synthetic substances due to a lack of necessary information.

Two methods for assessing expenditures may be used:

- The total amount for interior use may be extrapolated from assumptions made concerning the proportion of seized substances coming into the territory destined to supply the interior market. This very simple method is based upon rates of seized substances that may seem arbitrary and likely to vary, depending upon the efforts made by those involved in the fight against drug trafficking.

- Quantities used are assessed upon the basis of the number of users and assumptions made concerning quantities of drug used according to the type of user. This calculation, which is based upon many assumptions, becomes even more complex. However, this approach is much more sound than the first approach, and is the one selected.

Cannabis

This assessment of expenditures is limited to the use of cannabis resin.

The calculation presented here is supported by a study conducted by P. Cohen and A. Sas on cannabis use in Amsterdam[19] (refer to boxed section at the end of this text) and certain data from the study conducted by R. Ingold and M. Toussirt on cannabis use in France[20].

A study conducted on cannabis users in Amsterdam, using results from a general population survey, provides information on the frequency of use amongst experienced cannabis smokers over the last year. These individuals have used cannabis at least 25 times in their lifetime.

According to information from surveys conducted in France, the estimated number of individuals who smoked cannabis during the year was 2.2 million in 1995[21]. We will assume that there is a relation between those who smoked cannabis during the year and experienced cannabis smokers.

By using frequency of use, which differs little between France and the Netherlands, in making assumptions about the distribution of users over the year, we can calculate quantities used and corresponding expenditures for the different types of users. The calculation presented in the chart situated below is also based on other assumptions:

– The average price of cannabis resin was 35 francs per gram, as observed by R. Ingold in his survey about cannabis in France;

– Average use amongst daily smokers was 0.5 grams per day. According to the same survey, the monthly budget for very regular users of cannabis ranged from 500 to 600 francs. These figures closely correspond to the calculation based upon daily use of 0.5 grams at 35 francs per gram;

– Average weekly use amongst individuals using cannabis at least once per week, but not daily, was assumed to be equal to 1.5 grams;

– Monthly use amongst those who smoked once per month was assumed to equal 0.5 grams;

– Average use amongst individuals who smoke less than once per month was assumed to be equal to 0.5 grams every other month.

[19] COHEN (P.), SAS (A.), Cannabis use in Amsterdam, Cedro, 1998
[20] INGOLD (R.), TOUSSIRT (M.), Le cannabis en France, ed. Anthropos, Paris, 1998 173 pgs.
[21] Measurement of the scope of drug use in chapter « Les consommations de drogues en France ».

Calculation of estimated cannabis sales in France

Annual frequency of use	*% of users during year*	*No. of users*	*No. of grammes used each time*	*No. of times used per year*	*Tonnes used*	*Expenditure (FF million)*
Daily	17	374,000	0.5	365	68.26	2,388.9
Once a week or more, but not daily	31	682,000	1.5	52	53.20	1,861.8
Once a month	15	330,000	0.5	12	1.98	69.3
Less than once a month	37	814,000	0.5	6	2.44	85.4
Total	**100**	**2,200,000**			**125.87**	**4,405.5**

Therefore, the assumptions retained led to an estimated 125 tons of cannabis resin used, which corresponds to expenditures equalling 4.4 billion francs. This figure may be overestimated, as the structure for consumption in Amsterdam was used in making the calculation. Of all the individuals who used cannabis over the year, the percentage of those who used it on a daily basis, or at least once per week, could be lower than in the Netherlands where this substance is much more easily obtained. It is possible that the 2.2 million figure for individuals who used cannabis during the year is underestimated because some of the individuals surveyed by phone did not wish to reveal that they used an illicit substance. These two factors play against each other, which would tend to reduce the margin of error for the figure of 4.4 billion francs. Surveys that include questions about cannabis use within the preceding day or week would make it easier to find very regular users who are at the origin of nearly all of these expenditures (as seen in the following chart).

Lastly, we would like reiterate that of the 51.6 tons of cannabis resin seized in 1997, 8.7 tons were headed for the French market. The amount of cannabis seized seems rather small, but is not unlikely.

Heroin

It is possible to calculate expenditures for heroin in two steps. First, we will use figures on the number of syringes sold to estimate heroin use that corresponds to the use of these syringes. Second, we will try to estimate the number of non-injecting heroin users.

An estimated 13.8 million syringes were sold or distributed to drug users in 1997[22]. Prevention messages encouraged drug users to not share and re-use syringes. A survey conducted amongst users frequenting syringe exchange programmes showed that 18% of the users continued to share syringes. According to the Ingold Survey[23], a large majority of users recycle their syringes. Assuming that they use one syringe per day, with 13.8 million syringes sold, a total of 38,000 syringes are used per day.

Various factors play in favour of increases or decreases in this figure. A syringe may be used longer than just one day, which causes an increase in the number of syringes used per day. Yet, some users may not re-use their syringes at all (decrease in the number of syringes). There are still users who share syringes (increase). Lastly, a certain number of syringes may be used to inject substances other than heroin (cocaine, Subutex®), which would decrease the number of syringes used to inject heroin. We finally assumed that each day, around 30,000 syringes are used to inject three doses of heroin.

The price of heroin has been dropping for several years. We may consider that the average cost per dose is 100 francs. With the assumptions retained, the result is an average expenditure of around 3.3 billion francs.

[22] Section relating to harm reduction indicators.
[23] R. INGOLD, op.cit.

The number of non-injecting heroin users was estimated from the total number of problem opiate users. It is possible using different methods of estimation to situate the number of these users between 142 and 176,000 (refer to the section on illicit drugs). A large share of these users is currently undergoing substitute treatment (daily use of substitute substances). Quantities of methadone or Subutex® sold correspond to approximately 60,000 patients undergoing substitute treatment. On the basis of 150,000 problem users, we can assume that 90,000 individuals completely or mostly use heroin.

The use of injection was mentioned by 80% of the heroin-addicted individuals treated during the month of November. Recent heroin users who have not yet been in contact with the treatment system, or have just done so, use injection less. We assume that the percentage of injectors, out of all heroin users not undergoing substitute treatment, is around 60%. Thus, non-injectors represented 40% of the 90,000 individuals not receiving substitute treatment (or 36,000 users). By assuming that on average non-injectors use less heroin than injectors, we retained the assumption that these users take one dose per day at 100 francs. Thus, we come up with an additional expenditure of around 1.3 billion francs

In total, expenditures for heroin use in 1997 could be calculated at around 4.6 billion francs.

It is currently not possible to measure the extent of cocaine and synthetic drug use. Information on these substances may not be found in general population surveys (except for amongst young people), or administrative statistics produced by health and social, or law enforcement services, where these substances do not even appear in 2%-3% of the cases. Despite this, we can mention the Padieu Report in which turnover for cocaine was estimated at 3 billion francs in 1994.

The determinable turnover for illicit drugs (cannabis and heroin) using the assumptions retained could reach nearly 9 billion francs. By modifying certain parameters in the plausible margins, one may likely obtain variations in expenditures that could double. The assumptions made here and the reasoning used lead us to consider that **the turnover for cannabis and heroin should not be over 20 billion francs or go under 4 billion francs.**

5. DRUG MARKETS

5.1 Availability and supply

Availability of drugs/trends and explanation

The following are the main trends in relation to the availability of the principal psychoactive substances:

- The supply of heroin appears to be falling. Between 1996 and 1999, arrests for trafficking fell by 67.4%, and the number of seizures by 67% (OCRTIS). Observers on the ground have also found that the product is less easily available. This appears to be due to the disorganisation of local trafficking networks which have fallen victim to the greater availability of substitution products, which have made street dealing less profitable.

- Cocaine is becoming more easily available. In 1999, arrests for use only increased by 8.42% after rising by 49.53% in 1998. Volume seizures increased by 251% compared to the previous year. Observations on the ground, and statistics on the social background of those arrested for use only, show that the profile of consumers is becoming more diverse and the drug is being used by new segments of the population. In the past, cocaine was available privately to those who knew where to find it; today, it is becoming increasingly accessible in public places.

- The availability of ecstasy and amphetamines is also rising. Seizures of the two categories of drugs increased by 62.88% and 41.07% in 1999. The availability of speed has significantly increased over the past two years, particularly at techno raves.
- Anaesthetics such as GHB and ketamine are becoming increasingly available at raves, according to observers. GHB has been sporadically noted a number of times during the past year in the Paris region, the South of France and, at the end of the year, in the west of the country. Ketamine, too, is becoming increasingly available at illegal techno raves.
- The availability of LSD and other hallucinogens varies from one part of France to another. LSD began appearing at raves at the beginning of the 1990s. Since then, although its availability has been limited to such events, consumption has continued to rise.

Sources of supply and trafficking patterns within country

The number of arrests for local and international narcotics trafficking remained relatively stable during 1999. However, arrests for cocaine trafficking rose by 22.2%, and for psychotropic products excluding ecstasy by 110%.

Cannabis

3,382 kg of cannabis herb was seized in France during 1999, a fall of 3.97% on the previous year. 40% of the seizures came from the Netherlands (1,374 kg), 26% from Belgium (878 kg) and 5.3% from France. Since 1996, when 90% of seizures came from Asia and South America, an increasing proportion has come from Europe and this is now the main region of origin.

68% of the cannabis herb was destined for England and Ireland. France, with 20 percent of seizures intended for domestic consumption, was the second most important destination region.

Cannabis resin seizures of 64,096 kg represented a 22% increase on the previous year. If we include the quantities with Spain as their country of origin, 95% of resin seized in France came from Morocco. Poland and France were the two most important destinations, with 37% and 24.8% of total identified seizures.

Heroin

For the ninth year running, the Netherlands was the largest source of heroin seizures, at some 35% of the total (71 kg of the 203 kg intercepted). Next came the Golden Triangle countries (Burma, Thailand, Laos) with 6% of the heroin seized (12 kg), followed by Southwest Asia with 3.5% of the total. 37% was of unknown geographical origin.

Cocaine

There was a big increase in the volume of seizures, from 3,687 kg in 1998 to 1,050 kg in 1999. However, they should be interpreted with caution, as they mainly consisted of a few exceptional seizures. If we disregard these, the increase was around 21%.

The main country from which cocaine was exported direct to France in 1999 was Colombia, which accounted for some two-thirds of the amount seized ; South America represented around 81%. The main transit regions for cocaine being transported to France were, in order of importance, South America, Central America and the Caribbean. Spain was the leading transit country within the European Union, with 62% of seizures, followed by the Netherlands at 28%.

Ecstasy

Ecstasy seizures increased by 835% between 1997 and 1999, from 198,941 to 1,860,402 tablets. Most of this was transit traffic destined for Great Britain, Ireland, Spain, Canada and the United States. Seventy-nine percent came from the Netherlands, and 16% from Belgium, which appears mainly to be a transit country for drugs made in the Netherlands.

Amphetamines

In 1999, the law enforcement agencies seized 232 kg of amphetamines, a 41% increase on 1998. Sixty-eight percent was of unknown origin. However, it is suspected that as with the ecstasy, most of the amphetamines seized came from the Netherlands and were in transit, mainly to Great Britain.

5.2 Seizures

Narcotics seizures depend both on the availability of the products concerned, and on the activities of the police, gendarmerie and customs services. A few very large seizures can create significant fluctuations from one year to the next, which makes it very difficult to analyse them over time.

Volume cannabis seizures increased in 1999 compared to the previous year. The number of seizures is also continuing to increase, particularly for small quantities. However the quantity and number of heroin seizures decreased, continuing a trend which began several years ago. The number of cocaine seizures was smaller than that of heroin, but is increasing from year to year.

Narcotics seizures

		1997		1998		1999	
	Unit	No. of seizures	Quantity seized	No. of seizures	Quantity seized	No. seizures	ofQuantity seized
Cannabis *	kg	34,266	55,117	40,115	55,698	44,068	67,479
Heroin	kg	3,924	415	2,964	344	2,684	203
Cocaine	kg	1,317	844	1,354	1,051	1,460	3,687
ack	kg	228	16	334	25	405	11
Amphetamines	kg	163	194	158	165	141	233
Ecstasy	doses	628	198,941	608	1,142,226	649	1,860,402
LSD	doses	171	5,983	154	18,680	143	9,991

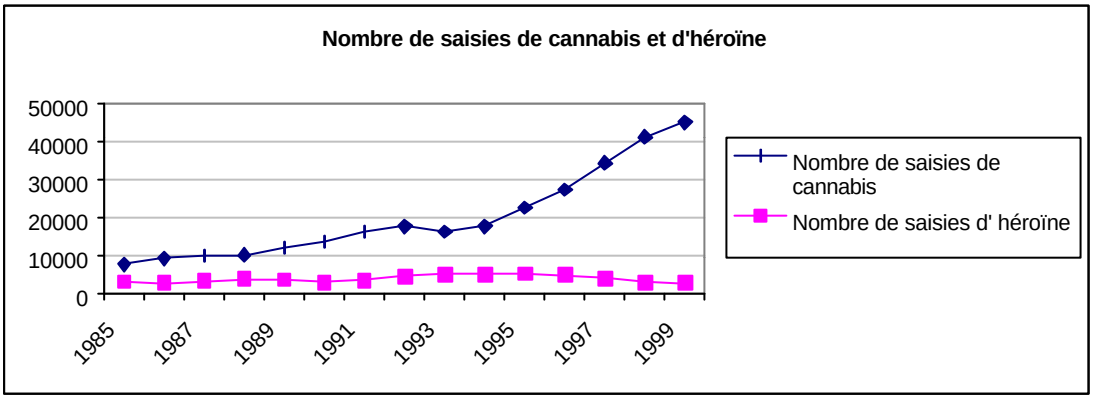
* Seizures of cannabis resin and herb, respectively 64,097 and 3,382 kg in 1999

Source: OCRTIS

In the long term, disregarding annual variations, the quantities of all substances seized are tending to increase. However, the increase is larger for cannabis than for heroin. Between 1985 and 1999, the average annual growth in heroin seizures was 5%, compared to 15% for cannabis (herb and resin).

Heroin seizures fluctuated between 200 and 300 kg a year between the mid-1980s and the early 1990s, and since then have been between 400 and 600 kg. In the last few years, they have returned to 1980s levels. Cannabis seizures varied from 10 to 20 tonnes in the first of these two periods and from 40 to 70 tonnes in the second. The amount of cocaine confiscated was low in the mid-1980s, but expanded rapidly until 1990. Apart from an exceptional seizure in 1994, levels have varied between 800 and 2,000 kg a year, though three more exceptional seizures in 1999 brought the total for that year to some 4,000 kg.

The increase in the quantities seized in France may have something to do with drugs transiting the country. Around 16 tonnes of the cannabis resin seized in 1999 was intended for the domestic market; this was a similar level to that which occurred between 1992 and 1995. **The origin and destination of the drugs seized have remained more or less unchanged over recent years.** Since the beginning of the 1990s, drugs have increasingly been acquired from countries other than those where they were produced.



Number of cannabis and heroin seizures

Number of cannabis seizures

Number of heroin seizures

Number of cannabis and heroin seizures

Source: OCRTIS (*Usage et trafic de stupéfiants*)

Most cannabis seizures are of resin, which nearly always comes from Morocco, either direct or, increasingly, from Spain, which is the first EU country from where cannabis resin is redistributed. Three-quarters of quantities seized in 1999 were in transit, primarily to Poland as part of an exceptional seizure, and then to the more traditional countries of the Netherlands, the United Kingdom and Italy.

Seizures of cannabis herb in 1999 were quite unusual, because 74% came from European countries, mainly the Netherlands and Belgium, compared to 36% in the previous year. The main destinations in

1999 were the British Isles and France. Cannabis seizures increasingly have a known origin or destination, which makes it easier to monitor the routes by which the drug is being traded.

Heroin still mainly comes from southeast Asia, and Afghanistan and Pakistan in particular. The main transit country before it enters France is the Netherlands, which accounted for 35% of the quantities seized in 1999. Other countries which regularly appear on the list are Belgium (11 kg in 1999), Thailand (12 kg) and Turkey (9 kg). Unlike previous years, there were a limited number of seizures with Spain as the country of origin, reflecting the existence of small-scale smuggling between the two countries. However, there were exceptional seizures of heroin from Germany and Ivory Coast.

Unlike cannabis, half of the quantities seized are destined for the French market. The other main destination countries in 1999 were Spain (45 kg), Germany (9 kg), Cameroon (6 kg) and the Netherlands (5 kg). The regions for which the drugs are destined also depend on the major seizures made each year.

South America has traditionally been the main source of cocaine. In 1999, 80% of seizures came from that region, mostly direct from Colombia (2.5 tonnes). Spain and the Netherlands were once again important transit countries in 1999; Spain is often used as an entry route to Europe by South American traffickers, and the Netherlands as a redistribution country.

5.3 Price, purity

Products seized:

The analysis of seized products has provided some information concerning the composition of the various products currently in circulation. The results cannot be regarded as representative of all products in circulation, nor even of the products seized.

The samples of heroin analysed since 1995 have been increasingly diluted; the smaller the quantities seized, the lower the purity. They are most often cut with caffeine, which is found in some 90% of samples, and paracetamol. Most samples of heroin chlorhydrate 97 contained between 80% and 90% caffeine. The proportion of caffeine in base 98 heroin is lower at between 30% and 40%. Paracetamol is being used in increasingly strong concentrations.

The average purity of analysed samples of cocaine is very high, in most cases exceeding 70%. Mannitol is the main cutting product, together with saccharose, lactose and lidocaine.

The police scientific laboratory at Lyon has received too few samples of ecstasy and amphetamines to provide results on these products.

Products on the SINTES – OFDT database

The SINTES database is a combination of four others. It contains a physical and chemical description of samples of synthetic substances. Some of these were confiscated by the law enforcement agencies and analysed by the scientific laboratories operated by the police, customs and IRCGN (gendarmerie nationale). Others were collected in various locations (raves, private parties, nightclubs) by prevention or treatment professionals, and analysed by the toxicology laboratories at the Hôpital Fernand-Widal in Paris and the Hôpital Salvator in Marseille.

In 1999, analysis of this data showed that:

- MDMA and amphetamines were undoubtedly some of the most commonly used synthetic substances in 1999;
- Toxicological analysis has found a very wide range of psychoactive substances;

- A large part of the immediate toxicity of the substances in circulation is due to medicines added without the user's knowledge, so that they take it more often because they are disappointed by its effects;
- Many of the samples are compounds, and some of the substances they contain are consumed unintentionally, causing potentially dangerous pharmacological interactions.

Street prices of products

(TREND – OFDT project)

The following are the street prices of nine illicit substances in 1999. They have been converted from francs to euros, which is why they contain decimals.

Cannabis resin (1 g): 4.5 euros

Cannabis herb (1 g): 6.1 euros

Brown heroin (1 g): 65.6 euros

White heroin (1 g): 115 euros

Cocaine (1 g): 81.5 euros

Crack: 7.6 euros

Amphetamines (1 g): 15.2 euros

Ecstasy (1 tablet): 15.2 euros

LSD (1 dose): 7.6 euros.

6. TRENDS PER DRUG

Information from various sources and indicators + explanation of trends

France has three main sources of information concerning the main trends in the use of psychoactive substances:

- Surveys of the general population by the Observatoire Français des Drogues and des Toxicomanies;
- OCRTIS statistics on drug seizures and arrests;
- The TREND project, which has been operational since 1999 and is based in ten locations in France. It is seeking to identify trends in drug use.
- The November survey by DREES.

Analysis of cannabis, synthetic drugs, heroin/opiates, cocaine/crack, multiple use

Cannabis

All the data indicates that cannabis consumption is becoming more common. Repeated consumption among young people aged 14 to 18 significantly increased between 1993 and 1999. In 1999, 59% of 18-year-old males and 43% of females said they had taken cannabis, compared to 34% and 17% respectively in 1993 (ESPAD 99). There was also a 15% increase in the number of young people aged 15 to 20 arrested for using and using/dealing cannabis. According to the arrest statistics, the

average age of cannabis users is constantly decreasing; in 1999 it was 21.6 years, which was significantly lower than for other substances (ecstasy 22.7; heroin 27.8; cocaine 29.4; crack 31.4). Also, according to a survey of perceptions and opinions on drugs and drug addiction carried out in 1999, 17% of French people were in favour of the legalisation of cannabis (a considerable increase on surveys carried out earlier in the 1990s), while 68% were in favour of its use for therapeutic purposes. This survey was carried out in April 1999 on 2,002 members of the general public aged 15 to 75.

Synthetic drugs:

There was a substantial increase in the consumption of ecstasy by young people in France during the 1990s. Surveys of young men aged 18 to 23 found that stated consumption rose from 0.5% in 1995 to 5.1% in 1996. The increase was also apparent in a survey of Paris secondary schools in 1983, 1991 and 1998, which found that 3% of pupils had tried ecstasy in 1998 compared to 0.1% in 1991, while 1.7% had tried LSD compared to 0.4% in 1991 and 0.5% in 1983. A national survey of secondary school pupils in 1997 found that 3.4% of those aged 15-19 said they had consumed ecstasy or LSD during the year, and 2.1% had used amphetamines.

According to OCRTIS arrest statistics, the average age of ecstasy users is 22.7, and 87.76% of arrested users are in the 18/30 age band.

In 1999, although it is difficult to assess trends in ecstasy consumption from one year to the next, it is clearly very common in the younger age groups and affects people from very different social and cultural groups.

The national TREND project has reported on the emergence of new synthetic products such as DMT, DOB, and 4-MTA, which are so uncommon that their consumption cannot be measured by surveys of the general population. Others, such as GHB and ketamine, are more widespread.

Heroin/opiates:

The first signs of disaffection towards heroin became apparent in 1995. Since then, a number of indicators have shown that this is a very definite trend:

- The average age of users arrested rose from 24.1 years in 1986 to 27.8 in 1999;
- Substitution treatments have become much more common: the number of beneficiaries was evaluated at 64,300 in 1999 compared to 64,000 in 1998, 45,000 in 1997 and 30,000 in 1996;
- Deaths from heroin overdoses fell by 79.50% between 1996 and 1999;
- Arrests for trafficking fell by 67.40% and seizures by 67% between 1996 and 1999.

Also, observers on the ground have reported that the quality of heroin as perceived by consumers has been constantly deteriorating, and this is confirmed by laboratory analysis of heroin seized in France from 1991 to 1997. This diminution in quality seems to have caused disaffection among former consumers. Apart from those who have stopped using heroin, either because they are satisfied with substitution or because they have given up opiates altogether, the large-scale growth in prescription of substitutes over recent years has changed the traditional profile of the heroin addict. Today, people are starting to combine heroin with substitutes and even stimulants such as cocaine and crack.

However, although heroin consumption has declined among “traditional” users, it is now being used on a small scale as a regulatory sedative at techno raves.

As far as medically prescribed opiates are concerned, observers report that Subutex® has a strong presence on the parallel market. Most of the supply comes from consumers who sell part of their prescription or exchange it for other products such as cocaine and crack. Observers are increasingly noting cases of Subutex® being used for the first time by young consumers of alcohol, cannabis and ecstasy for whom it is the first opiate on which they become dependent and their introduction to intravenous injection. The reduction in prescription of morphine sulphates (skenan/moscontin) in favour of Subutex® has reduced their availability on the parallel market and thus their consumption.

Cocaine/crack:

See section on this subjet (chapter 13 part IV)

Multiple use:

Multiple addictions to more than one licit or illicit product have become frequent. The TREND project, which uses observations by people in the field, has shown that the number is increasing partly as a result of the increased number of products both in traditional addiction environments and at raves. In 1999, some forty different combinations were listed.

However, multiple use should not simply be seen as an unthinking process of consuming whatever substances happen to be available. The combinations listed often serve very specific purposes in the management of substance use. The common concept of multiple consumption is not sufficiently precise to describe this type of behaviour, and it should really be referred to as regulation. The designers of TREND describe this as: “any form of combined use of two or more psychoactive substances deliberately adopted by a consumer to modify the effects of one or more substances already taken or to be taken. This use may be concomitant or spread over a period of a few minutes to a few hours, but not exceeding the total duration of the specific effects of each of the substances consumed.”

The ESPAD survey of use by adolescents aged 14 to 18 of psychoactive substances (alcohol, tobacco, cannabis), shows a significant proportion of 18-year-olds making repeated use of at least two of these products (28% of males, and 15% of females), and particularly a combination of tobacco + cannabis, which applies to 15% of 18-year-old males.

7. DISCUSSION

7.1 Consistency between indicators

There are many different indicators of trends in drug use and its effects. These are based on three main types of source:

- Surveys of the general population (or a subset of it) which use statements by individuals to obtain data about the scale and frequency of use and perceptions of it;

- National databases or registers providing data on the health consequences of drug use, such as mortality and morbidity;

- Government statistics, which mainly relate to public-sector health and welfare activities and law enforcement. These give an indirect indication of the scale and nature of drug use and availability.

Information gained from these indicators can be consolidated or complemented by qualitative data based on field observation. This is the case with data obtained using the TREND project set up one year ago to monitor recent trends. Each source of data reflects only part of the situation from a very specific angle, so general trends can be identified by comparing them. The trends described above have therefore been identified by cross-analysis of the different indicators. Among the most obviously apparent are the following:

- The decline in heroin consumption;

- The corresponding rise in cocaine use;

- The decrease in the incidence of certain problems related to drug use;

- The increasingly common use of cannabis and synthetic drugs.

7.2 Implications for policy and interventions

A periodically updated national review of the drugs phenomenon is of general interest to decision makers. The trends described in this annual report may also have numerous implications for public policy, but it is not our task to reflect on these. The French government has set up an autonomous public-sector body, the OFDT, to observe the overall drugs situation and assess the implications of the above trends in terms of public policy.

7.3 Methodological indications and data quality

One of the main gaps in the provision of information about drug use in France has been largely filled by a long-term survey of drug use and perceptions among the general population. However, this has its limitations. Some are common to this type of survey, such as the fact that people are asked about their own drug use; for example it is interesting to compare what people claim to consume in terms of legal drugs with those that are actually sold. Some aspects of the methodology used can also induce bias, most importantly the way in which the questionnaire is administered (see the remarks in previous chapters).

One of the main methodological problems we will have to confront in this area over the coming years is that of telephone research, including such factors as statement bias, coverage: the development of ‘red lists’ and the spread of mobile phones.

The existing indicators concerning the health consequences of drug use are still not robust enough, so we still do not have a global approach to drug-user mortality. Although the three available indicators are evolving in the same direction, we still do not have a full overview of mortality trends. Also, the observation of a decline in HIV incidence among users needs to be consolidated using data which is not based on statements by users.

Finally, we should not attribute too much importance to minor economy-led fluctuations in these indicators because each of them has its own limitations. If we are to identify trends, these must be based on a number of indicators and confirmed by other data of a similar nature.

Main sources used in part II:

Baromètre Santé 2000, initial results: This data is provisional in that it has been adjusted only for the probability of selection within households. It may therefore change slightly once it has been adjusted to take account of the usual socio-demographic variables.

Baromètre Santé adultes 95/96, CFES: This telephone survey was carried out in 1995 on a representative sample of 1,993 individuals aged 18-75 living in France. It was adjusted to closely reflect the total population in terms of structure (age, sex, region and type of home). The Baromètre Santé provides information about behaviour, knowledge and attitudes in relation to health.

Survey of drug user behaviour in military service selection centres in 1995 and 1996, DCSSA.

This survey was carried out on 10,870 individuals in 1995 and 2,698 in 1996. It was based on an interview with a doctor on the subject's use of psychoactive substances, and on a urine analysis which enabled the truth of the responses to be tested. The sample used was highly representative because 95% of young Frenchmen underwent selection tests for military service. The survey was discontinued in 1997 because of the planned abolition of compulsory military service.

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

Since 1997, the OFDT has been setting up a long-term project to observe drug use and attitudes based on national surveys of the general population. The participation in the ESPAD 1999 European schools survey forms part of this project. It is being carried out by the adolescent health team at INSERM by M. Choquet and S. Ledoux, who have been involved in the ESPAD project since 1993, in partnership with the OFDT and the education ministry.

ERROP (Enquête sur les Représentations, Opinions et Perceptions sur les Products Psychoactifs), OFDT, 208 pp., April 2000.

"Evolution de la prise en charge des toxicomanes, Enquête auprès des médecins généralistes en 1998 et comparaison – 92-95-98", November 1998, EVAL, OFDT report.

SIAMOIS system: Système d'Information sur l'Accessibilité au Matériel Officinal d'Injection et à la Substitution, initiated by the Direction Générale de la Santé and developed by the Institut de Veille Sanitaire. This was designed in 1996 to monitor accessibility to sterile injection equipment available in pharmacies, and to substitute medicines. The data is provided by the Groupement pour la Réalisation et l'Elaboration d'Etudes Statistiques pour l'Industrie Pharmaceutique. By relating this data to the population aged 20-39, which comprises 80% of drug users, it is possible to obtain indicators enabling comparisons between regions and departements. These in turn can be compared to new cases of Aids, deaths from overdoses and arrests for narcotics offences in the same age group.

National database of narcotics offenders, OCRTIS.

OCRTIS receives figures from the police and gendarmerie, as well as a large part of the ILS procedures drawn up by the police. The procedures are used to recategorise certain data provided by the police, which is why there are differences between the two sets of statistics. The Gendarmerie Nationale and the police services of Paris and the inner suburbs supply data direct to the FNAILS, and it is not possible to carry out the same recategorisation as for the other data. These latter sources probably tend to overestimate the proportion of trafficking. As with the statistics produced by the *police judiciaire*, the FNAILS does not generally take account of customs offences where no statement has been taken. The substance mentioned is the main one used by the arrested person. Prior to 1993, there were big differences between the figures for arrests for use and use/dealing provided by

OCRTIS and the *police judiciaire*. The gap gradually narrowed between 1988 and 1993 and may have led to a "catching up" process which artificially increased the growth in the number of arrests. Since 1993, the difference between the two sets of statistics has been very small.

National prisoners database, SCERI.

This database shows the number of people who entered penal institutions between 1 January and 31 December of a given year. Only the first offence mentioned on the imprisonment warrant is recorded; as with convictions, this is not necessarily the most serious one, and may simply be the first one to be identified.

The national prisoners database also records the number of people in penal institutions on any given date, based on the number entering and leaving during the current and previous years.

November drug addiction study, DREES

This records the drug addicts who made use of the health and social services system during November. It covers those taken on by specialist drug addiction centres, hospitals, and non-specialist welfare centres before or during November. These addicts were regular consumers of illicit products or abusers of legal ones. One addict can use the same establishment more than once, or different ones, sometimes simultaneously.

INSERM unit SC8 (national register of causes of death)

Since 1968, unit SC8 of INSERM has been recording all causes of death in France, using information from death certificates and coding based on CIM-8 (from 1968 to 1978) and CIM-9 (until 1997). Death certificates mention three causes: immediate cause, principal cause, and contributing morbidity. There are three codes in CIM-9 relating to drug addiction: drug dependence, drug abuse, and drug-induced psychosis.

Institut de Veille Sanitaire (deaths from Aids).

Deaths from Aids must be reported. The Institut de Veille Sanitaire records these by the year in which they occur, as well as the cause of infection. The data is adjusted to take account of the fact that a grace period is allowed for deaths to be reported. Also, some 20% of deaths are not reported.

OCRTIS (death by overdose where inquest has occurred).

Inquests are held for suspect or sudden deaths such as those due to crimes, accidents, suicides and overdoses, which often affect young people. If the death is suspected to be due to an overdose, OCRTIS is sent a telex as soon as the inquest is opened and cases, including the names of those affected, are recorded on a database. OCRTIS is then sent an inquest report later on.

PART 3 DEMAND REDUCTION INTERVENTIONS

8. STRATEGIES IN DEMAND REDUCTION AT NATIONAL LEVEL

8.1. Major strategies and activities

See the chapters on this subject (chapter 1.1 part I and chapter 12 part IV)

8.2 Approaches and New Developments

9. INTERVENTION AREAS

9.1 Primary prevention

During the 1990s, primary prevention was based on a listening approach which involved re-establishing dialogue between adults and young people in increasingly difficult environments as part of the wider issue of preventing delinquency and alienation.

The measures taken at the time by central institutions to prevent drug use and dependence made listening a priority. They were as follows:

- **In schools:** Comités d'Education à la Santé et à la Citoyenneté (CESC). These bodies are responsible for coordinating preventive action, and took over from Comités d'Environnement Social (CES) in 1998.
- **Locally:** "Points Ecoute", local centres providing guidance to young people and parents with social or relationship problems;
- **Nationally:** a telephone helpline, Drogues Info Service, with local helplines in some regions. In 2000, a "questions and answers" area was set up on the MILDT website, drogues.gouv.fr.

Apart from these general provisions, primary prevention is still mainly the responsibility of the private sector and charities. There are specific campaigns for specific groups of people or areas, such as young children, women drug addicts, ethnic groups and the workplace, though these do not gather information on a formal basis.

However, these projects are coordinated by departmental prevention plans and umbrella organisations reporting either to the justice ministry or the local council (cf. 9.4).

9.1.1 Infancy and Family

This area is not the subject of centralised action by government bodies. Local initiatives by charities are not currently listed, and it is therefore difficult to gain a clear overview of them.

Young children are given only very indirect information about the problem of drug addiction, in the form of health education projects and in many cases nutritional education, which deal with the subject of orality and the dependence which can result.

9.1.2 School programmes

Projects administered by the Ministry of Education are required to cover the prevention of all forms of dependency. They are implemented by coordinating bodies set up within primary and secondary schools in 1990 and known as Comités d'Environnement Social (CES), mainly in areas identified as ZEPs, or Zones d'Education Prioritaire.

Circular no. 98-108 of 1 July 1998 renamed these bodies Comités d'Education à la Santé et à la Citoyenneté (CESCs), and marked the beginning of a more global approach to the problems encountered by young people. The circular also laid down principles for the development of CESCs throughout the country. Since 1995, these coordinating bodies have been jointly financed by the MILDT and the Ministry of Education. They are run by the head of the educational establishment, and comprise members of the educational profession and local associations, institutions and other bodies. They draw up prevention policies to create proper links between the school and the local area, set clear operational objectives for the projects they carry out, and ensure that these are suited to locally identified health problems. A review of the projects carried out is submitted to the respective education authorities. Primary and secondary teachers prepare pupils for the transition between primary school and college, and regular meetings are held to define protocols designed to prevent violence and drug addiction among pre-adolescent pupils about to leave primary school.

- The current Three-Year-Plan encourages schools to focus their prevention campaigns on both legal and illicit products. This approach reflects the preventive role which schools carry out by helping young people to become well integrated members of society, and the teams involved therefore need to be multidisciplinary.

The experimental "Elèves, acteurs de prevention" programme

Between 1997 and 1999, the education ministry implemented an experimental programme designed to prevent high-risk behaviour, entitled: *"Elèves, acteurs de prevention"*. There are plans to extend this programme and make it a long-term one.

It began in July 1997 with the first meeting of a steering group consisting of the DESCO B 4[24] office, five representatives of schools, two school paramedical representatives, one trainer from MAFPEN[25], one professor of literature and one child psychiatrist.

The purpose of the campaign

The programme aimed to do the following:

- explain the concept of peer prevention and validate the relevance of this approach
- gain a better knowledge of adolescents' problems and their use of psychoactive products
- develop tools to help pupils get the message across to their peers

[24] Direction de l'enseignement scolaire, bureau B4
RMI: minimum income of insertion
[25] MAFPEN: Mission Académique de Formation des Personnels de l'Education National

- involve schoolchildren in managing prevention campaigns
- educate children so that they have a full knowledge of the issues involved

How the programme works

Invitations to take part were sent in September 1997 to five education authorities with a particular awareness of the problem. As a result, 14 educational etablishments became involved: three in Aix-Marseille, two in Créteil, three in Lille, two in Lyon and four in Versailles. These had to meet two criteria:

- They had to be taking active steps to involve pupils in the running of the school, possibly with delegated responsibilities, and in particular in thinking about prevention.
- They were required to set up a team of four adults (one member of management, one member of educational staff, one member of medical/social staff, one teacher) to take part in the training session in November 1997 that marked the first stage of the project.

Programme evaluation

At the request of the education ministry, an evaluation[26] was carried out of the schools that took part in this experimental programme.

The pupils involved received adult guidance in organising campaigns and spreading the word about prevention. Their involvement in the management of the programme earned them the recognition of their peers. The experiment proved a success for half the schools involved, and even where it did not, it attracted a great deal of interest from pupils in all schools. Its impact on the atmosphere and quality of life in schools was very positive, both in terms of their external reputation and in the way pupils perceived them.

Although the programme has not in itself led to a decrease in violence and truancy or an improvement in academic results, it has made an important contribution because it lies at the heart of these schools' policies for preventing academic failure, exclusion, and risk behaviour. The experiments were judged to be positive, and pupils showed a greater level of responsibility in relation to the issues involved.

This indicates that the programme should be used on a wider scale, taking into account the limitations and key success factors identified by the programme evaluation.

In particular, pupils must be trained to act as organisers and put across the message of prevention by listening to and helping their peers. They can never replace competent adults when it comes to dealing with the difficult problems faced by their colleagues, and schools must not expect them to become guardians of law and order or treat the programme as a way of pacifying an unruly school. Other adverse effects, such as competition between pupils who are appointed to help manage the programme or as EAPs, or pupils developing too much of a fascination with human suffering, must also be taken into account.

Finally, the success of the programme will depend on the environment in which it takes place. If it is to be extended, the following requirements must be met:

- The project must involve the whole school, it must have an overall policy on health education and citizenship, and the team that runs it must be well organised;
- The head of the school must be closely involved;

[26] Ballion (R.), *Les élèves acteurs de prevention* , Centre d'Analyse et d'Intervention Sociologiques, EHESS-CNRS, February 2000.

- The membership of the steering group must be as wide-ranging as possible, with adult advisers being closely involved in the community and taking an active part in the programme;
- The adults must have a clear perception of the important role played by pupils in prevention.

New guidelines

In November 1999, the Direction des Lycées et Collèges at the Ministry of Education, and the MILDT, published a new set of guidelines for the prevention of risk behaviour in schools and in elementary schools.

Police campaigns in schools

Police campaigns in schools are carried out by the following bodies:

- The Mission de Lutte Anti-Drogue (MILAD):

This reports to the office of the Director-General of the Police Nationale, and is responsible for coordinating the policy of directorates and departments of the Ministry of the Interior in combating the use and trafficking of narcotics. It also organises the prevention campaign and runs a roadshow staffed by officers with specialist schools experience. In 1999, 32,000 pupils were visited in schools throughout the country. MILAD's main task is to create initial awareness of prevention which can then be followed up by local police officers. It is also a forum for debate in relation to the Three-Year Plan.

- The relevant directorates of the Police Nationale (the central directorates responsible for public security, the *police judiciaire*, the border police, general information and Police Nationale training; and the central department responsible for security companies).

Of these, the central public security directorate has the largest number of officers specialising in anti-drugs training (270 PFAD). They are responsible for providing ongoing training for their colleagues, but since 1998 MILAD has encouraged them to meet the growing demand from schools, particularly as part of the CESC. They tell pupils about legal and illicit products, how to behave in relation to them, the various forms of help available, and also the law on drug trafficking and use. Most importantly, they engage in dialogue with adolescents to help them learn about health and citizenship.

In 1999, they carried out 4,525 prevention campaigns and spoke to 101,000 pupils.

- The narcotics brigade of the Préfecture de Police in Paris.

  In 1999, PFADs from the communication, training and prevention unit of this specialist department gave 332 presentations in 81 secondary schools in Paris and the three departments that form the inner suburbs and met 11,000 pupils.
- The prevention, research and anti-delinquency education department of the urban community police directorate of the Paris préfecture de police

The 22 PFADs in this department gave presentations to 13,000 secondary school pupils in Paris.

A total of 160,000 pupils were able to discuss drugs in their own schools with specialist police officers.

Schools campaigns by the Gendarmerie (Défense)

The Gendarmerie Nationale still supports presentations by anti-drug trainers in secondary schools aimed at demythologising drugs and highlighting the social effects of trafficking and the role of traffickers and dealers. They provide information and engage in dialogue with adolescents to encourage them to take greater responsibility for the problem. They also draw on the gendarmerie's educational resources department, which has produced a video entitled *Animal dealer* to support their presentations.

9.1.3 Youth programmes outside schools

The work of the youth and sports ministry

The youth and public education directorate is responsible for coordinating the preventive work done by various bodies covered by the youth and sports ministry.

These bodies are as follows:

- The regional and departmental youth and sports directorates
- National establishments (Centre Régional d'Education Populaire et de Sports, institutes, schools)
- The *réseau information jeunesse* (1,500 offices providing public information on all aspects of daily life)
- Sports and youth associations

Each year, the ministry is allocated a budget by the Mission Interministérielle de Lutte contre la Drogue and la Toxicomanie (MILDT), based on the proposals it submits. **Eighty percent of this budget is delegated to departmental directorates,** which have a specially trained resources officer to deal with issues relating to the fight against drugs and drug dependency.

The departmental directorates work within departmental prevention programmes defined in consultation with other government bodies, local authorities and associations and coordinated by project managers appointed by prefects. Local campaigns, of which there were around 600 in 1997, are supported by decentralised youth and sports departments and implemented by charities. They include the following:

- awareness;
- information;
- prevention-related cultural and/or sports events;
- production and distribution of information documents and educational resources;
- training for the people involved.

During the last few years, these departments have been asked to support prevention campaigns in holiday and non-residential leisure centres.

They have also been asked to ensure that Conseils Départementaux de la Jeunesse are involved in defining and implementing campaigns; 19 of these councils were involved in 1999, and 27 in 2000.

The councils were set up by Marie-George Buffet, the youth and sports minister, to allow young people to talk to the government about their needs and suggestions in areas affecting them such as training, employment and health.

20% of the funds allocated to the ministry by the MILDT are used to carry out national campaigns. In particular, the ministry has supported research into risk behaviour by young people in the area of sport.

As part of this work, a European seminar organised in partnership with the MILDT is to be held at the Comité National Olympique et Sportif Français on 5 and 6 December. This is one of the events being held as part of France's presidency of the European Union.

Campaigns by the Police Nationale in non-school environments

Outside the school environment some 120,000 people, mostly young, have benefited from various prevention campaigns by the Police Nationale.

The work done by the ministry of the interior for young people outside the school context has included the following:

- A travelling drug addiction information and prevention campaign, organised by MILAD each summer since 1995. The MILAD roadshow is run by officers from the department and police who specialise in anti-drugs training and are selected for the purpose. It visits tourist sites and talks both to young people and their parents, who have expressed a strong need for information. Around 17,000 people visited the roadshow and talked to officers during July and August 2000. The campaign was carried out in partnership with the Association Nationale de Prevention de l'Alcoolisme (ANPA). In 1999, the youth and sports ministry also became involved in the project.
- 48 Centres de Loisirs Jeunes (CLJ), set up in deprived urban areas in 31 French departments. 24 of these are open during the whole of the school holidays and on Wednesdays and Saturdays throughout the year. They offer activities designed to make young people feel positive about themselves and to prevent delinquency and narcotics use.
- Prevention ETE projects, of which there were over 100 in 1999, took place in 36 departements including two overseas. These offer similar activities, with the emphasis on sport.

In 1999, some 100,000 young people benefited from the activities run by 400 police officers on a voluntary basis. Most of these came from the central public security directorate with the assistance of the CRS.

9.1.4 Community programmes

Programmes run by the ministry of youth and sports

Training of key workers. In order to ensure that knowledge is up to date and the main principles of the three-year plan are followed, eight training sessions were devised in collaboration with CRIPS[27] Ile de France for over 100 staff of decentralised departments, institutions and offices of the *réseau information jeunesse*. These interdisciplinary sessions were open to youth professionals, sports doctors, doctors responsible for drug detection, institutional nurses, youth information document specialists and others.
After an on-site preparatory project, two additional training sessions specially tailored to local needs were held in Martinique and Guadeloupe. These were mainly aimed at people working on the ground in particular local areas.

The ministry also supported the **"à la carte prevention"** project devised and managed by the charity **AREMEDIA** (project no. 165 on the EDDRA database). This takes the form of an interactive screen

[27] Centre Régional d'Information et de Prévention du Sida.

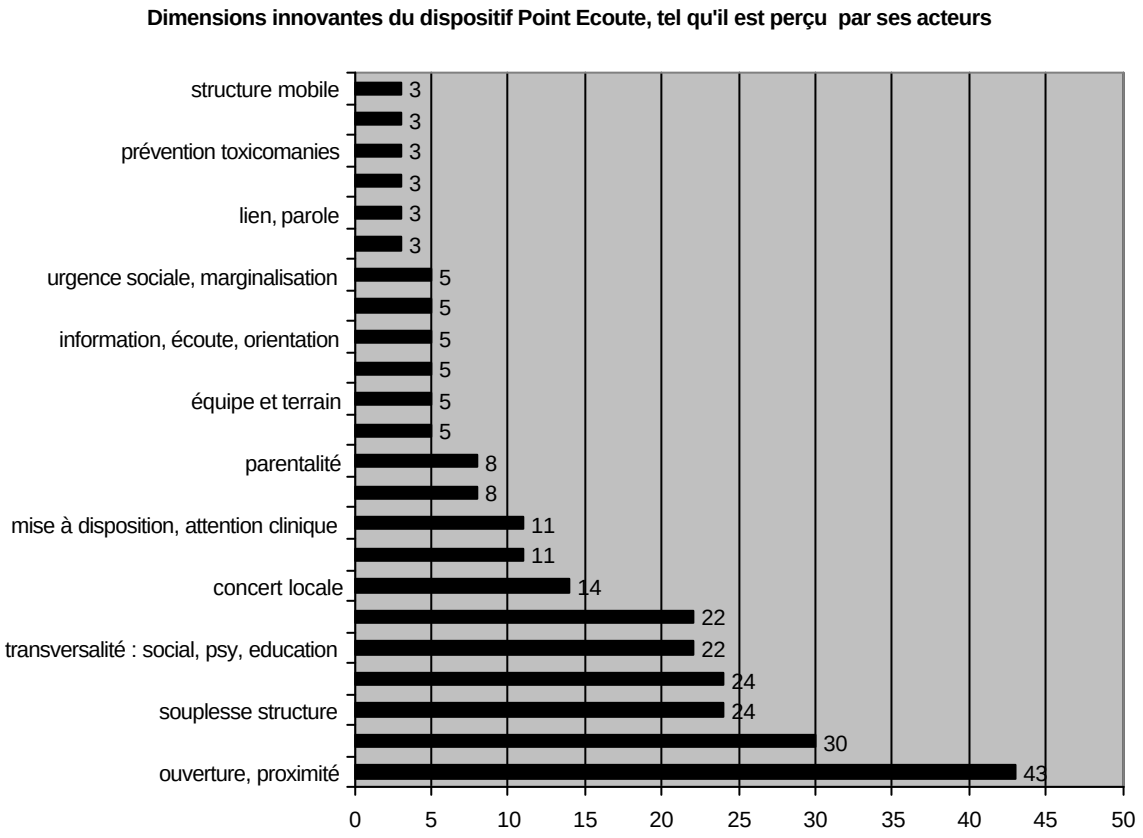
which people can use to answer questions about the degree of risk they face and which provides diagnostic and practical information. It also collects anonymous quantitative and qualitative data which can be used in epidemiological research and debate concerning the implementation of suitable prevention strategies.

As part of a pilot project, this programme should be operational **in some 15 offices of the** *réseau information jeunesse* during the first few months of 2001.

Ministerial programmes initiated by the Ministry of Planning, Cities and Integration and the Directorate-General of Health.

Circular no. 97/280 issued by the Ministry of Planning, Cities and Integration on 10 April 1997 set up the Points Ecoute with a view to preventing drug addiction and marginalisation. The document uses the principle of global intervention, in which drug problems are seen from the perspective of urban social development. It aims to be sufficiently flexible to provide suitable responses to identified local needs, based on existing partnerships and networks in cities. It is essential to work with the city if implementation is to be on a negotiated basis and key partners are to be mobilised within individual areas. The Points Ecoute specifically aim to appeal to young people who are alienated from institutions and therefore sometimes have to develop new forms of intervention (cf. **Error! Reference source not found.**). They are financed by decentralised grants from the Secretariat-Général à la Santé (Ministry of Employment).

Innovative dimensions of the Point Ecoute project, as perceived by the parties involved



Mobile structure
Prevention of drug addiction
Link, dialogue

Social need, marginalisation
Information, listening, guidance
Team and site
Parental role
Availability, clinical attention
Local consultation
Interdiscliplinary: social, psy, education
Flexible structure
Openness, closeness

Source: Jacob (E.), Joubert (M.), Touze (S.), *Evaluation des Points Ecoute Jeunes et/ou Parents*, OFDT, October 1999.

The flexibility of the document setting up the project led to different approaches and methodologies being used, often tailored to the professional skills available within these structures; many of the Points Ecoute teams existed before 1997.

Points Ecoute Accueil Jeunes are places where young people aged 18 to 25 at risk of marginalisation and delinquency can go to talk about their social and family problems. They aim to help young people to fit in better and to regain their psychological and social equlibreium. They also provide emergency help for those with emotional, family and social problems and facilitate access to social services. There were 26 Points Ecoute Jeunes in 1995, 62 in 1997 and 75 at the end of 1999.

Points Ecoute Parents, of which there were 16 at the end of 1997, aim to prevent any deterioration in relations between parents and their children by offering them a place to talk about their problems with each other and, if necessary, establish contact with social services.

Points Ecoute in 1999.

Type of structure	Number of structures
Points Ecoutes Jeunes	54 (72%)
Points Ecoutes Parents	13 (17%)
Points Ecoutes Jeunes et Parents	8 (11%)

An evaluation[28] completed in October 1999 highlighted four main types of strategy within the 40 Points Ecoute taking part in the study.

Community-based

It is very important that the public should be involved in the work being done, particularly in terms of identifying needs. Also, Points Ecoute seek to help people obtain support from the community, for example by working with local associations and mobilising local resources.

Clinical psychology

The emphasis is on providing individual help for users by helping them to clarify and resolve their problems, but there is no substitute for traditional psychotherapy, and where this is thought necessary users are referred to specialist organisations. Most of the staff are qualified psychologists, and the approach is centred on helping people to resolve psychological problems. This helps to ensure that all Points Ecoute follow a reasonably consistent strategy.

Social and educational

Although Points Ecoute help to identify and treat psychological problems, they also provide practical assistance and guidance: social services such as accommodation, resources and emergency assistance, helping people to assert their legal rights, and helping to organise activities, leisure projects, and workshops and other events. Since they are involved in so many different areas, the staff come from a wide variety of backgrounds: they include social workers, event organisers, educationalists and psychologists. Points Ecoute also have an educational role, helping families and teenagers to gain the skills and resources they need and achieve greater independence.

Mediation

This category includes all Points Ecoute which do not fall within the other three, and their role is therefore fairly disparate: they provide information, advice, and most importantly mediation, which in this case means helping people to develop closer links with the rest of society, access the rights and services to which they are entitled, and become a part of their local community. These Points Ecoute are therefore generalist bodies offering a wide variety of skills, and often help to create and develop local networks.

Finally, the 1999-2001 Three-Year Plan provides for an expansion of Points Ecoute to make them more accessible by ensuring greater geographical dispersion and changing the way in which they work, for example by introducing longer opening hours.

[28] To be published: Jacob (E.), Joubert (M.), Touze (S.), *Evaluation des Points Ecoute Jeunes et/ou Parents*, OFDT, October 1999.

9.1.5 Telephone helplines

Drogues Info Service: national telephone helpline

France has had a national drugs and drug addiction helpline since 1991.

This anonymous 24-hour service is available on a free telephone number, 0 800 23 13 13. The telephone centres are located in six cities: Lille, Lyon, Marseille, Paris, Strasbourg and Toulouse.

Drogues Info Service is an inter-ministerial service with the status of a public-interest grouping. It has three main roles: 1) to provide listening, support and advice for people who need help with problems relating to actual or potential drug use, 2) to provide information on products themselves, their effects, and the risks involved in using them, and on the law and the availability of treatment, and 3) to make referrals to organisations specialising in prevention, treatment, rehabilitation and risk reduction.

The calls received are used to produce statistics about how many people phone up, who does so, and what their needs are. Although these statistics do not give a precise profile of all people affected by drug use, they do make it possible to identify certain trends, particularly in relation to products, which can then be compared with other sources of information that are available.

Number of calls

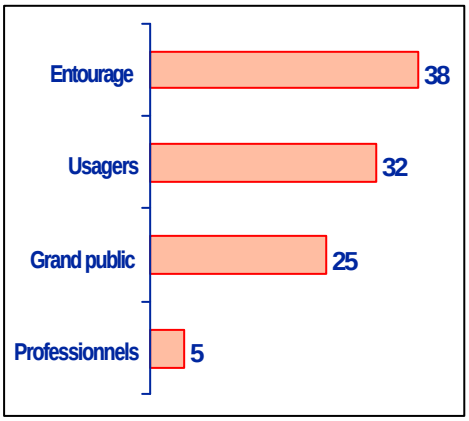
In 1999, the service received 477,000 calls, representing some 60,000 requests for help and information.

A large proportion of calls (40%) were requests for information, particularly concerning products. Another 20% were requests for support, and 18% for advice; 14% wanted specific guidance on obtaining treatment and care.

Categories of callers

38% of callers were friends and relatives of people who were using drugs, or believed to be using them. 32% stated that they themselves were users. 25% were members of the public seeking general information, and 5% were professionals requiring advice in connection with their work.

Categories of callers to Drogues Info Service



Friends/relatives

Users

General public

Professionals

37% of callers were aged between 15 and 20, and 64% were under 25. This emphasises the role of the service in providing information about drugs and the risks involved to teenagers and young adults, whether or not they themselves are using drugs.

56.5% of callers were women, and 43.5% were men.

Products mentioned

The five products most often mentioned by callers were:

cannabis (56.6%)

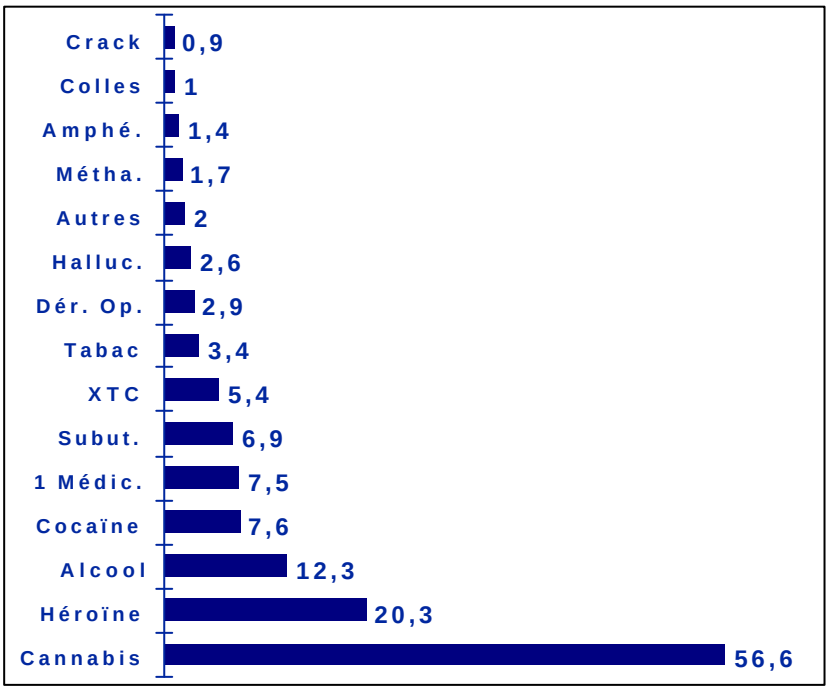
heroin (20%)

alcohol (12.3%)

cocaine (7.6%)

medicines (7.5%).

Products mentioned by callers to Drogues Info Service



Crack

Glue

Amph.

Methadone

Other

Halluc.

Op. deriv.

Tobacco

Ecstasy

Subut.

1 Medic.

Cocaine

Alcohol

Heroin

Cannabis

As in previous years, the products mentioned were both legal and illicit ones. It is significant that **cocaine has reappeared on the list of the five products mentioned most often;** in previous years it was below medicines on the list.

Alcohol and tobacco are the products most often mentioned as being combined with other ones. More specifically, where one product is combined with alcohol, it is most often cannabis (56%), followed by heroin and tranquilisers.

Where alcohol (61%) and tobacco (75%) were mentioned, the great majority of calls came from users.

Préfecture de Paris telephone helpline

The narcotics brigade of the Préfecture de Police in Paris has been operating a toll-free, anonymous helpline for the people of the city since 1991. In 1999 it received more than 2,000 calls, consisting mainly of requests either for health or welfare advice or general information.

9.1.6 Mass media campaigns

The MILDT communication programme for 1999/2000/2001.

In April and May 2000, a TV advertising campaign consisting of four commercials was run on all terrestrial and cable networks. This invited the public to find out more about drugs by obtaining a book entitled “Drogues: savoir plus, risquer moins”.

With a print run of 1.5 million, it was sold for 10 F at newsagents and within the NMPP netweork (400,000 copies). It was then given away free by government departments and by networks of pharmacies, doctors and charities.

The message of the campaign was that there is no such thing as a drug-free society. It distinguished between three forms of behaviour, use, abuse and dependence, and covered all psychoactive substances including legal ones such as alcohol, tobacco and psychotropic medicines.

The campaign was run again in the fourth quarter of 2000 by public demand.

The book will form the basis for other media targeted at young people, such as partnerships with TV and the local press, which will be used to ensure that the message is put across to as many young people and adults as possible.

The budget for the campaign is 20 million francs, most of it consisting of a subsidy from the MILDT to the Comité Français d'Education pour la Santé (CFES), which operates the programme.

Smoking prevention campaign

A press campaign aimed at women was run during the period July to October, with supporting brochure campaigns until the end of the year and TV advertising during the final quarter of the year.

In October, a large-scale general-audience TV and radio campaign was launched; this will also run in cinemas during December. TV and radio partnerships are taking place throughout the final quarter on the theme of "tobacco makes you ill".

Campaign to prevent excessive drinking.

This is based on campaigns for the general public and for young audiences. The rebroadcast of the campaign produced in 1999 ("Do you drink more than three glasses a day?") will be accompanied by large-scale practical guides to alcohol explaining the ideas of excess and moderation.

A press relations campaign will seek to highlight the importance of problem drinking in terms of public health. This will involve round-table debates by experts on specific themes.

Campaigns initiated by the Ministry of Youth and Sports

As part of its information and communication role, the ministry provided financial support for the production of the "**ACCRO"** television series broadcast by La Cinquième. This consisted of fifteen 13-minute programmes on products and how they are used. It also took an active part in a drugs filmscript competition organised by CRIPS (Centre Régional d'Information and de Prévention du Sida) in the Ile de France. This resulted in the production of 24 short films broadcast on all TV channels.

9.1.7 Internet

The public-service drugs information website www.drogues.gouv.fr was launched on 9 December 1999.

It was set up by the MILDT together with four partner organisations: the Comité Français d'Education à la Santé (CFES), the Observatoire Français des Drogues and des Toxicomanies (OFDT), Drogues Info Service (DIS) and Toxibase. Each of these produces specific sections of the website for which they have editorial responsibility.

The website aims to be accessible to as many people as possible, and to provide accurate and reliable information. It provides validated and regularly updated scientific knowledge on all legal and illicit psychoactive substances. The site includes epidemiological, neurobiological and sociological data on alcohol, tobacco and psychoactive medicines, and illicit substances such as cannabis, synthetic drugs, heroin and cocaine.

As well as the general public, the site is also aimed at researchers, policy-makers, and specialist and non-specialist professionals in the fight against drugs and drug dependency.

For professionals, it includes databases of legislation, documentation by MILDT and the charity Toxibase, and a large number of OFDT research reports.

There are also general sections providing large amounts of practical information: a list of useful addresses, a glossary drawn up in partnership with Larousse, and a selection of websites. A section run by DIS entitled “Your questions, our answers” provides confidential and anonymous replies to questions. Other sections include a daily press review, a diary of events, new publications, and press releases and files published by MILDT. Free subscriptions are available.

The site is run by a steering committee which is responsible for approving technical and editorial decisions and overseen by the MILDT. It also includes representatives of external site partners.

The number of hits has grown steadily, from 19,700 (by **9,188 users**) in January 2000, to around 28,500 in April (**11,481 users),** 38,000 (**14,731 users**) in May and 20,429 (**8,475 users)** in September.

The number of hits fell during the summer: in July and August 2000 there were 30,000 by 12,845 users.

9.2 Reduction of drug-related harm

Risk reduction project: see chapter 14, part IV

9.2.1 Outreach work

Drug addiction project in the 18th arrondissement of Paris

An experimental drug addiction prevention project was established in the 18th arrondissement of Paris in October 1999. It has two objectives: to develop better relationships between local people, users and institutions, and to improve the treatment given to users.

Seven specialist frontline educators operate in the street in three different areas of the arrondissement. They respond to the justified concerns of local people, and provide information to drug users and help them to contact health and social services. There are also three staff who coordinate the work done by these staff and deal with problems as they are identified.

The effectiveness of the project is currently being evaluated, with a view to using it in other areas where there is a need to reduce the nuisance created by drug users and help local organisations to look after them and reduce the level of risk they face.

9.2.2 Low-threshold services

As part of the policy of reducing the main health and social risks linked to drug use, alternative forms of access to care have been developed to complement the existing structures, particularly since the spread of the Aids epidemic. The aim is to help bring alienated and marginalised drug addicts back into the health and social services system so that they can receive somatic treatment.

As part of this process, “low-threshhold” or “low demand level” programmes seek to limit intravenous drug use and provide access to treatment. Their basic principle is that many users who inject drugs are unwilling or unable to stop doing so at a given time, and ways therefore need to be found of reducing the risk of infection to themselves and other people. This involves establishing contact with them, being with them when they inject drugs, and offering them the possibility of beginning treatment for their addiction.

These alternative forms of care contrast with high-threshhold programmes which have greater constraints in terms of dosages and observation, the priority being to stop people using illicit drugs and abusing legal products and in the long term to end their addicition.

A limited number of alternative forms of low-threshhold care are available to drug users in France. These include a **syringe exchange programme, boutiques**, **sleep-ins** and mobile facilities such as **methadone buses,** introduced in Paris in 1998 and more recently in Marseilles.

Target groups

These services are aimed at two main groups:

- People who are difficult to reach because they have little or no contact with the care services or with substitution schemes.

- People who are unable to accept restrictions being imposed on them.

Results of evaluation and available data

A number of studies have been carried out into these new forms of low-threshhold alternatives to care, and particularly of the syringe exchange programme and the methadone bus.

The **Paris methadone bus** scheme was set up on a trial basis in January 1998 by Médecins du Monde, and was subject to an external evaluation. It was found to be a success in terms of reaching the target group and providing them with access to health and social services care, but did not result in any demonstrable improvement in terms of helping them to achieve greater social integration.

9.2.3 Prevention of infectious diseases

The main form of infectious disease prevention for drug addicts involves distributing and selling syringes.

Trends in the number of syringes distributed cannot be seen as reflecting trends in the number of intravenous drug users. Prevention messages encourage them to use each syringe only once which, assuming the number of drug users remains constant, leads to an increase in the number of syringes used. A decreasing number of intravenous users can quite easily be accompanied by an increase in the number of syringes distributed; this depends on changing user behaviour.

Sales of syringes to drug users by pharmacies were estimated at 13.8 million in 1997.

Of this total, 4.6 million were sold in Stéribox form. Each of these contains two 1-ml syringes, two alcohol swabs, distilled water, a condom and prevention information.

Based on a survey of a sample of pharmacies, the company Becton-Dickinson estimates that 6.4 million 1-ml syringes are sold to drug users in batches of 30, and 921,000 2-ml ones in batches of 20. These two types are mainly sold to non-drug users, so the proportion sold to users can only be estimated.

In addition, 122,800 1-ml syringes specifically designed for users were sold individually in 1997.

Finally, syringes sold by other companies account for around 20% of the market.

Syringes are also distributed free under syringe exchange schemes. Some of these are agreed and financed by the directorate-general of health, and others are paid for in various ways. A survey of syringe exchange schemes estimated that they distributed 1.5 million in 1996; we do not have any figures for 1997, but they are probably fairly similar. The schemes accounted for only about 10% to 11% of total syringes distributed to drug users during the year.

The number of Stériboxes sold is continuing to increase in the medium term; 2.3 million were sold in 1997. However, sales of non-Stéribox syringes are remaining largely unchanged. If we assume that the proportion of sales to drug users compared to non-users (mostly diabetes sufferers) remained unchanged, this suggests there was a moderate increase in the number of syringes used by drug users between 1996 and 1997.

This increase undoubtedly results from a decrease in the sharing and re-use of syringes, and in this respect it represents a positive trend. However, substitution may have led to less of a reduction in injection than might have been hoped for. It is difficult to know how these factors affect the increase in the number of syringes used, and further surveys of user behaviour are needed if these trends are to be interpreted properly.

Likewise, the impact of syringe access policy on the Aids epidemic is difficult to quantify, though it has undoubtedly made a difference.

The number of new drug-related Aids cases fell sharply in 1996 and 1997. However, the same was true of all cases irrespective of the cause of infection, and the trend is linked to the effectiveness of tritherapy treatments introduced in 1996. When it comes to assessing the impact of syringe accessibility, it is more relevant to observe trends in the rates of HIV positivity among intravenous drug users. This is not monitored statistically in France, unlike new cases of Aids. However, a number of surveys have shown a decline in seroconversion and the prevalence of HIV in those who inject drugs.

Easier access to syringes has not so far led to any significant fall in seropositivity to the hepatitis C virus among users. An explanation of this phenomenon, and more detail on HIV, CHV and BHV infections, is given in the section on morbidity among drug users and the relevant contributions in the Trends section.

9.3 Treatments

9.3.1 Treatments and health care at national level

The institutions covered in this section provide health and social care for drug users. Although we know how many such institutions there are, we do not know how many people they employ.

Specialist healthcare

The different types of institutions providing specialist care to drug users

This category includes bodies financed by the Direction Générale de la Santé as part of its drug use prevention policy.

Under a decree dated 29 June 1992, all specialist bodies financed by the state are known generically as **centres spécialisés de soins pour toxicomanes** (CSST); some provide outpatient care, and some do not. Under the decree, they provide a combination of medical, social and educational services.

In 1998, there were 256 such centres, two thirds of them run by charities. They can be divided into three main types: outpatient centres, of which there were 190; those providing residential care, of which there were 50, and those located in prisons, numbering 16 and all run by the public sector. The first two categories may be operated either by charities or by the public hospital sector.

Outpatient centres provide help and advice for people with dependence problems, medical consultations, psychological counselling, and social and educational services, depending on each person's particular situation. They may provide withdrawal treatment, either on an outpatient basis or by supervising it within a hospital environment, and substitution treatment. They can also provide support for the families and friends of drug users. The centres run 56 outpatient drop-in centres. At the end of 1999 there were 137 outpatient centres providing methadone. Two thirds of these are run by charities.

Residential centres provide treatment and accommodation in two forms: residential therapeutic centres, and community therapeutic centres. Drug users are provided with medical, psychological and educational services, with the aim of getting them back on an even keel and reintegrating them within society. Nearly all residential centres are managed by charities.

Prison drug addiction centres, which are purely for prisoners.

Specialist inpatent or residential drug addiction centres may also operate sheltered apartments and other forms of short-term or emergency accommodation, and provide accommodation with host families. These are discussed below. They may also accommodate clients in hotels, though it is difficult to say how many of these there are.

In total, according to figures provided by the Direction Générale de la Santé, there were about 1,400 specialist residential places available in 1998.

Finally, there are four "unités d'hospitalisation spécifique", treatment centres within hospitals which provide a full range of care for drug users and have beds for withdrawal treatment.

The different types of institutions providing specialist care for drug users

Type of institution	Number in 1999
Specialist outpatient centres	190
Drop-in centres attached to these centres	56
Specialist residential centres	50 (679 places)
Specialist centres in prisons	16
Specialist centres with:	
Sheltered apartments	65 (437 places)
Short-term or emergency accommodation	17 (127 places)

Source: DGS/SD6B

The changing roles of specialist drug addiction treatment centres

In 1998, the Direction Générale de la Santé asked specialist centres to make changes in their treatment policies as part of the five-yearly policy review required by the 1992 decree. Many centres have already made these changes, but the Directorate wishes to ensure that they become universal.

Changes of policy concerning specialist outpatient centres

These centres have been asked to place particular emphasis on the following:

- promoting risk reduction and access to care;
- providing better welfare services;
- providing better care for prisoners who are drug users.

They are also required to network more closely with institutions providing health and welfare services to drug addicts, with the following aims:

- to develop partnerships with health and social services professionals within the framework of common law, and in particular with general practitioners;
- to break down the barriers between themselves and the psychiatric sector so that they are better able to provide help for people with psychiatric problems;
- to take account of multiple drug addiction and new ways of using drugs, for example in combination with alcohol and the consumption of ecstasy.

New policy on residential centres

- Residential therapeutic centres

Originally, patients went into these centres prior to withdrawal treatment, and agreed to stop taking drugs or medicines. This approach was changed with the introduction of substitution treatments, and in late 1998 they were asked to provide help to people undergoing substitution, to work with the local medical team in providing help to patients, and to take more account of patients' social and professional needs.

- Community therapeutic centres

These new institutions are intended to meet the needs of specific patients, often older ones, by providing care based on group dynamics to help people become integrated within society and employment. They involve a longer stay than in a residential therapeutic centre, and there are three of them.

- Sheltered apartments

This form of accomodation aims to enable drug users to regain their autonomy. They are currently restricted to people with major health or social problems, and are also intended to increase the capacity of short-term and emergency accommodation. They allow people to rest and recover after withdrawal or substitution treatment and provide them with secure accommodation. This type of accommodation is also used for drug users coming out of prison or other alternatives to imprisonment.

- Host families

Staying with a host family can be beneficial in a variety of situations and stages of drug use.

9.3.2 Substitution and maintenance programmes

The introduction of susbtitution profoundly changed the treatment given to drug users in France. In 1993, substitution policy was based on approved centres prescribing methadone. Users had to meet a number of conditions: they had to have been dependent on opiates for at least five years and have made a number of previous attempts at withdrawal, and were required to attend the centre daily. In 1995, the number of situations in which methadone could be prescribed and supplied was expanded: all specialist drug addiction centres may now do so, provided they have enough doctors and nurses available. The conditions are also less restrictive in terms of the number of years' dependence on heroin, previous attempts at withdrawal, and daily attendance. However, urine samples are still taken and the maximum period for which methadone may be prescribed and supplied is limited to 7 days.

This period was recently extended to 14 days, but the maximum supply is still restricted to 7 days at a time.

General practitioners can take over the responsibility for prescribing methadone following the initial prescription by a specialist drug addiction centre. They can also prescribe high-dosage buprenorphine (Subutex) without any limitations except that they are required to use secure prescription forms. This drug could originally be prescribed and dispensed for 28-day periods, but in September 1999 the maximum was broken down into 7-day periods, though doctors could ask for treatment to be dispensed once for a maximum of 28 days. Subutex can also be dispensed in specialist drug addiction centres.

Les médecins de ville ont la possibilité de prescrire de la méthadone en relais de la prescription initiale par un centre spécialisé de soins aux toxicomanes.

A circular dated 3 April 1996 stated the objectives of substitution to buprenorphine. This is designed to encourage people to become part of a therapeutic process and obtain medical care for any pathologies combined with psychiatric and/or somatic drug addiction. The treatment is also intended to enable an interruption in the consumption of opiates, notably heroin, and increase the likelihood of social rehabilitation. The circular states that the ultimate objective is to enable each patient to develop an independent life and manage without buprenorphine.

A project to monitor substitution treatments was set up in 1994. The Commission Consultative des Traitements de Substitution, chaired by the Directeur Général de la Santé, is responsible for monitoring at national level. It may give advice to the health minister on developments in this area. The commission is complemented by departmental monitoring committees chaired by the Médecin Inspecteur de la Santé Publique and staffed by representatives of government, members of the professions involved, and persons qualified to carry out local monitoring of substitution treatment.

Following the measures adopted in 1995, the number of people receiving substitution treatment grew rapidly from 1996 onwards, mainly as a result of increased prescriptions of Subutex, which has been available in pharmacies since February 1996.

It is possible to estimate the number of patients receiving substitution treatment using the quantities of Subutex and methadone sold. Assuming an average prescribed dose of Subutex of 8 mg per day, monthly sales at the end of the first half of 2000 corresponded to around 69,000 patient-months. For methadone, assuming an average prescribed dose of 65 mg a day, this gives an estimated 4,300 patient-months receiving treatment from a GP, again at the end of the first half of 2000. There were also around 4,500 patients receiving treatment in specialist drug assistance centres, giving a total of some 78,000 patient-months receiving substitution treatment.

Il est possible d'estimer le nombre de patients sous traitement de substitution à partir des quantités vendues de Subutex et de méthadone. Sur la base d'une hypothèse de dose moyenne prescrite de Subutex de 8 mg par jour, les ventes mensuelles correspondent à la fin du premier semestre 2000 à environ 69 000 patients-mois. Pour la méthadone, sur la base d'une hypothèse de dose moyenne prescrite de 65 mg par jour, cette estimation est d'environ 4 300 patients-mois suivis en ville à la fin du premier semestre 2000. A ce nombre il faut ajouter celui des patients suivis dans les Centres spécialisés de soins aux toxicomanes, soit environ 4500. On obtient un total de près de 78000 patients-mois sous traitement de substitution.

The 1999-2001 three-year plan aims to allow doctors in health institutions to issue initial prescriptions of methadone and to make it easier for patients receiving methadone from specialist care centres to receive it from their general practitioner instead. Prescriptions of Subutex need to be better controlled,

and patients receiving substitution treatment must receive better welfare support. Studies need to be carried out to lay down specific requirements for methadone and Subutex and the conditions required for these treatments to succeed. There are also plans to seek ways of diversifying substitution treatments.

9.4 After-care and re-integration

Housing

In France after-care and re-integration programmes usually form part of the general arrangements for specialised care (see Chapter 9.3.1 Part III)

Two «sleep-in hostels» offer emergency overnight accommodation for dependent drug users deemed at risk: when they enter these structures the users can have access to health and social consultations.

Measure linked to département agreements on targets:

The accommodation of people under court supervision or just released from prison, combined with health and social supervision arrangements is a priority in the département agreements on targets (see Chapter 12.3 Part IV)

9.5 Interventions in the Criminal Justice System

When a drug user is held by the police, the prosecutor has three options, as we saw in the first part: leaving the case on file, prosecuting or issuing a treatment order.

The latter measure, which more or less fell into disuse at the end of the seventies, was revived in 1987. The significance and value of this measure were reaffirmed in 1993 and 1995 in the interministerial '67 circulars' sent to the prosecutors' offices. We recall that the last circular recommended the prosecutors to use treatment orders for heroin and cocaine users, dependent cannabis users or those using cannabis and other products. Under-age and repeat offenders might also be included in this measure.

The treatment order remains a controversial measure which has been much written about, in particular in the last few years. The figures available on treatment orders are limited and provide only some of the elements for assessing current developments. They are far from providing an answer to all the questions which one might ask about the true efficacy of this measure and the possibilities of adapting it to current changes in the field of drug use.

Treatment orders issued by magistrates

Having risen sharply between 1992 and 1995, the number of treatment orders issued stagnated in 1996 and dropped back slightly in 1997.

This drop in the number of orders in 1997 may be related to the drop in the number of heroin users held for questioning in 1996 and 1997. However as we shall see, this measure also involves numerous cannabis users, arrested in increasing numbers year on year. The evolution recorded cannot be explained solely by the reduction in arrests of heroin users.

The development of compulsory care orders (convictions with a suspended sentence and testing, together with compulsory care) which to some extent have replaced the treatment order, may constitute another element of explanation.

Finally it is possible that in the context of current practices in prosecutors' offices in dealing with court orders, which in themselves vary widely anyway, this measure has reached its limit.

The issue of treatment orders remains fairly concentrated in geographical terms, in spite of a considerable expansion over the last fifteen years. In 1981 the courts of appeal in Paris and Versailles issued 92% of the treatment orders. The share of these courts of appeal in the total of treatment orders dropped to 40% in 1996. However this expansion marked time in 1996 and 1997.

In 1997 only 18 départements issued more than 100 treatment orders, thus making up 76% of the total number of orders that year. These départements are located in geographical zones where most of the indicators for drug addiction reach high levels (north and northeast border areas, Parisian region, southeast). It is not possible to compare questioning and treatment orders since the geographical territories are not identical for the two statistics. On the other hand one can compare the number of orders and the number of convictions for offences against the law on narcotics for the same court of appeal. These two indicators develop together from one département to another. However the relation between the two numbers is not constant. Recourse to the treatment order increases disproportionately when the number of convictions rises. At one extreme there is the case of Paris, with more than 2,000 orders for around 4,500 convictions and at the other Bastia, Corsica, with 4 orders for just under 200 convictions. The treatment order seems to be relatively well established in zones with a high incidence of drug-taking, whilst it remains little used in areas where drug use is lower or less high profile.

Orders followed

Around 70 % of the people issued with an order in 1997 actually made contact with the care system. That proportion has remained stable since 1995. There is in fact another loss, which cannot at present be measured, between the decision to issue an order, often taken in a telephone conversation between the prosecuting officer and the police officer, and the notice of the order given by the magistrate to the user in a direct contact. A certain number of users do not attend for this hearing. The statistical recording of the order often coincides with the notice of the order being given, so it is not possible to measure this loss.

The drug user who has received a treatment order must in principle be seen by the DDASS services which direct him or her towards a care structure. Again there is a certain loss, both when contact should be made with the DDASS and when contacting the health system, which however can be measured (30%). On the other hand we do not have any figures on the number of orders followed to completion.

Treatment orders issued and followed :

	1993	1994	1995	1996	1997
No. of orders issued (1)	6149	7678	8630	8812	8052
No. of people sent to the DDASS	4591	6500	7220	7294	6628
No. of orders followed (2)	4064	5760	6072	6331	5723

Sources :(1) : 'Cadres du parquet' (2): DGS

Orders issued for heroin users only represent slightly less than 36% of the orders followed in 1997. The treatment order option is used preferentially for "hard" drug users in only 22 départements of the 83 where orders are issued. On the basis of the proportion of 36% which we have just mentioned, we can compare the number of orders for heroin use (around 3000) with the number of arrests for heroin use (around 9000), which gives a proportion of one third. Certain départements have in the past justified their low take-up of the order option for heroin users with the frequency of the offences associated with use of this drug. We do not have the necessary information to check this explanation thoroughly.

The application of the treatment order to non-dependent cannabis users seems to be spreading and it is increasingly being used for preventive purposes. In 1997 around 60% of the orders followed (in other words those which led to contact with the care system) involved cannabis users.

A summary of the application of the 1995 circular on treatment orders reveals two concepts which lead to the application of this measure to cannabis users. Certain prosecutors' offices try to differentiate cannabis users according to their level of dependency, saving the treatment order for the most dependent. Other prosecutors' offices use the treatment order for cannabis users for the purpose of information, prevention and social and health supervision.

In relation to the number of cannabis users questioned, the orders issued for cannabis users represent a very low proportion of the users of this product who are arrested. However, before comparing these figures, one has to ask whether all cannabis users questioned should be considered potential candidates for a treatment order.

According to the summary of the application of the circular of 28th April 1995 on treatment orders, the use of this measure for under-age users was low in 1995 and did not progress in 1996.

The summary of treatment orders issued drawn up in 1997 by the Ministry of Employment and Solidarity shows a continuous improvement in relations between the public prosecutors and the DDASS, with the development of cooperation arrangements established formally (agreement on objectives and treatment order protocols) or informally (regular coordination meetings).

Follow-up is ensured in 37 départements by general practitioners with whom the DDASS has signed an attendance agreement, in 26 départements by a treatment order unit set up under the auspices of the DDASS or in premises close to the court and in 16 départements by a centre specialising in the care of drug addicts, in the context of a service agreement with the DDASS. The average duration of a treatment order was around 5 months in 1997 but may vary between a single meeting and a whole years supervision.

Funds allocated to treatment orders reached 12 million francs in 1997, an increase of 4% over 1996.

9.6 Specific targets and settings

« NO INFORMATION AVAILABLE »

10. QUALITY ASSURANCE

Quality procedures are one of the "new elements" in the three-year plan in the war on drugs and the prevention of dependency established by the MILDT for the period 1999-2001. In fact the new emphasis of the plan gives preference to a quality approach whose chief characteristic is that it works across the board. In other words, in terms of sectorial intervention to reduce demand (that is in the field of prevention/training, in care or in campaigns intended to reduce demand) the plan defines across the board action which specifically takes the following forms::

- Promoting a process of evaluation of public policy in order to contribute to its lasting development at institutional level ;

- Structuring and developing research in order to better ensure constructive interaction between the scientific and decision-making circles (public authorities.)

- Promoting training enabling the professionals to improve their knowledge and better adjust their response.

10.1 Quality assurance procedures

In order to incorporate French policy on the war against drugs into a quality assurance procedure, it is essential to allocate resources to enable us to render public account of the results of the action taken which has been financed with public funds and also the relevance of the objectives defined in order to better resolve a problem diagnosed or respond to those needs of an impoverished public which have not been met.

A pluralist approach in designing, implementing and evaluating the results of the policy

In fact the plan and the institutional arrangements on which the latter is based translate this political will of the decision-makers to incorporate the programming, implementation and evaluation process of the national strategy into the framework of a pluralist approach. It is obvious that taking the different points of view of the players concerned into account, and the debates which might result from this, will help the making of decisions and the execution of action in transparency and credibility, in short in a quality assurance procedure.

Communication which legitimises public campaign

It is also necessary to ensure a policy of communication and information which provides a basis and legitimation for the public campaign. In this respect the plan defines guidelines in order to make available to the whole of the population validated information, to improve its capacity to formulate suitable responses. This information should relate to behaviour, products and policies conducted. It will also help to remind people of the legal framework. These objectives are presented below:

- Conduct a purposeful communication and information policy, ensure that it is a lasting one
- Undertake more targeted action vis-à-vis young people, professionals, elected representatives, opinion-makers, but also more appropriate action for the specific needs of the overseas départements.
- Open up an Internet site where data and know-how about drugs and dependency will be available. It should be accessible both to the public at large and to professionals and scientists.
- Create a national network of information centres and resources on drugs and dependency.
- Reorganise the drug information service (its name should be changed) to answer calls dealing with all psycho-active products. It will be accessible from the DOMs. It will also run an e-mail service.

The MILDT pays particular attention to the quality assurance procedure within which its policy is to function. But this procedure can only be implemented when adequate instruments have been developed or the relevant arrangements have been made available for decision-makers and professionals. In fact one of the aims of the MILDT has been to obtain suitable systems enabling it to respond better to its needs for scientific expertise and to provide assistance to political decision-making *in fine*.
In this context the political unit – the MILDT – has established a permanent scientific committee directly attached to its structure. This committee of experts and institutional representatives is closely involved in the selection of candidate projects in the context of invitations to tender organised by the interministerial Mission. It also calls upon working parties or consultative committees to which it may

turn in order to launch a particular study, assess am important topic in more depth or validate a campaign. By way of example one could cite the committee for validating tools of prevention, composed of institutional representatives from the different ministries involved and also acknowledged experts in the field of prevention.
Finally the MILDT bases its action on expert advice thanks to the scientific college of the OFDT. This college comprises representatives of the main data-producing bodies plus people appointed on a personal basis. These people have acknowledged skills in the fields covered by the group. The scientific college is consulted on projects which constitute the OFDT's working programme, it formulates opinions on these projects, their progress and their results.

As regards the principles to be respected in the context of a quality assurance procedure, 5 main criteria have been retained for carrying out studies and drawing up reports to illuminate the decisions made by the authorities (according to the criteria of the Scientific Assessment Council):

- The use and relevance of the information produced ;
- The reliability of the information collected should be ensured in order to avoid bias in the conclusions and lessons to be drawn ;
- Objectivity in terms of personal preferences or the institutional position of the principals ;
- The possibility of generalising on the basis of the conclusions;
- Transparency of the process will make it possible to pinpoint conditions for implementation, positions in relation to similar work and current limits.

10.2 Evaluation (Treatment and prevention evaluation)

The evaluation of public policies is one of the priorities defined in the guidelines of the interministerial plan. In this respect two interventions have been chosen:

- On the one hand the installation of a global evaluation framework for all the actions in the plan;
- On the other development of a skills centre.

In order to do this the MILDT commissioned the French Observatoire for Drugs and Drug Addicts to make an active contribution to the execution of these two tasks.

Setting up a global evaluation framework

For the sake of methodological discipline, major efforts have been devoted to preparing the evaluation of the plan. Initially the MILDT prepared an evaluation instruction which was entrusted to the OFDT and validated in an interministerial committee (by the 17 ministerial departments concerned).

That mandate helped to specify:

- The conclusions and contributions expected from the evaluation (in other words the expected use of the results of the evaluation of the plan by the authorities)
- The field of evaluation which covers the design, implementation and preliminary results of the plan.
- The criteria for evaluation retained by the partners, namely relevance (correlation between needs not met and aims set up), coherence (complementary nature) and effectiveness (efficacy of the implementation). Where possible performance (achievement of objectives in relation to the results obtained) would also be valued.

In a second phase, an evaluation reference has been prepared by the OFDT and validated in an interministerial Committee. It was prepared within the context of a participatory procedure with those responsible for drafting the plan. This structuring tool made it possible to define the specific objectives which could be evaluated, in other words those which are realistic, measurable and limited in time. In relation to these specific objectives, the list of actions, arrangements or programmes covered by the field of the evaluation were set out, identifying those which were new (new arrangements) as distinct from the continuation or adaptation of old arrangements.

In particular the reference has served to define the main evaluation principles, including two priorities of a sectorial nature (training and alternative care arrangements) and two operational priorities (the département agreements on objectives and the département prevention programmes). Within the framework of this working plan, evaluations of individual arrangements may also be incorporated.

The evaluation will be entrusted to an evaluation team selected on the basis of an invitation to a project. The evaluation order, running of the evaluation team and the dissemination/exploitation of the evaluation results are the responsibility of those in charge of evaluation in the evaluation unit (OFDT). A final report after three years and annual stage reports are planned.

Development of a skills centre

This will be developed around the following three axes:

- Monitoring (in the epidemiological sense) evaluations made, ongoing or projected, so that they can be integrated into the European information system EDDRA (Exchange on Drug Demand Reduction) piloted by the OEDT.
- Developing method protocols (evaluation guide) which all parties involved can use.
- Formulating opinions on draft evaluations.

Financial resources and complementary human ones have been deployed to ensure that the evaluation missions cited above are brought to a successful conclusion. The provisional budget from 1999 to 2000 has been raised from one million to 2 million French francs. As far as permanent posts are concerned, the personnel allocated to evaluation full-time has been increased from one to three people.

Evaluation also involves a scientific commission comprising four experts (researchers, university lecturers and practicians).

Its role is to :

- Guide the work done in the global system for evaluating public policies and validating its various stages (evaluation mandate, stage reports, final report).
- Validating the final report on evaluation studies (response to an evaluation question, evaluation of an individual arrangement …)
- Provide expert guidance for evaluation projects submitted for the opinion of the OFDT.

The evaluation should make it possible to improve the progression of the present three-year plan but it will also provide information relating to the preparation of the next plan. In particular the evaluation procedure will be guided by the following aims:

- Learning the effects of the implementation of the three-year plan in order to correct and re-align the programmes;
- Contributing to the ultimate objective of reducing the problems linked to drugs and patterns of addiction to psycho-active products ;
- Illuminating the public decision on the subject of the battle against drugs and the prevention of dependency;
- Fuelling the public debate in the war on drugs and the prevention of dependency;
- Preparing the next three-year plan.

10.3 Research

Objectives

The three-year plan for the war on drugs and the prevention of dependency (1999 to 2001) has as one of its priority aims the advancement and dissemination of available knowledge in these fields. One of the main objectives, beyond the support given to research on the subject, is to contribute to the

structuring and networking of the different teams interested in working in the field of psycho-active substances.

Structure and organisation

At present the programming, structuring and financing of research is the responsibility of the MILDT.. Nevertheless the guidelines of the plan define new provisions in this respect. In fact in order to be able to anticipate developments and raise research issues with sufficient independence, it is necessary to consider the creation of a structure which is clearly distinct from the political steering instrument, thus from the MILDT. To do so it is intended in the long term that the Board of the public interest group OFDT and its scientific college should amend their constitutions and remits in a very precise twofold objective.

- Gathering together in one place activities which today are dispersed ;
- Evolving into a single observation, research and evaluation structure dealing with drugs and dependency, in other words an observation site of sufficient durability to conduct long term research programmes.

At present the process has just been launched. A working party run by the MILDT. combining members of the OFDT and various experts acknowledged in this field, has been set up to consider the matter. The first recommendations, concerning the new tasks to be allocated to this single research structure, are expected in September 2001.

A large number of independent researchers and bodies are participating in research into the phenomenon of psycho-active substances and dependency in France. The main public bodies are:

- the national AIDS research agency (ANRS),
- the Board of hospitalisation and care organisation, supporting the hospital clinical research programme (PHRC),
- the national health and medical research institute (INSERM),
- the institute of health monitoring (InVS),
- the French Observatoire for Drugs and Drug Addictions (OFDT)

The mission of the **ANRS** is to stimulate, coordinate, evaluate and finance research into HIV infection and also, since 1st January 1999, clinical and therapeutic research in the field of hepatitis C. Its particular strength is that it takes account of all the scientific disciplines. The different research sectors coordinated by the ANRS cover all the current concerns – biological research (virology, molecular biology, immunology and cell biology), vaccine research, clinical research through and beyond treatment trials, epidemiological research and research into human and social sciences.

The **PHRC** was created in **1**993 to promote medical research in order to contribute to progress in public health. It endeavours to incite hospital and university teams to manage their care activities from a research perspective. By giving these teams their own funding, the objective was to allow them to set up essential relations with the partners in research upstream, whether it be industrial or academic teams under the financial aegis of the Ministry of national education and research (in particular certain university laboratories and those of public establishments with scientific and technological remits (EPST): the CNRS and above all the INSERM which with over 300 units is widely established in University hospital centres (CHUs). When it finances or participates in setting up structures such as the clinical investigation centres (CICs), the PHRC may support these projects for four years. The establishments then have to undertake to extend these structures over a longer term, from their own budgetary resources. The PHRC thus enables them to launch a structuring dynamic which in the long term is carried on by local players. The PHRC **2000** has for the first time scheduled at national level a financing package which will enable the DRCs to be better structured, facilitating the recruitment of clinical research specialists and encouraging – in partnership with the INSERM – the installation of new clinical investigation centres.

The task of the INSERM is to enlighten the authorities and partners who so desire about existing scientific knowledge, in particular in the fields of research which are constantly moving forward. In

addition its role is to provide assistance for decision-making in the field of public health policy and in the field of intervention of medical industrialists.

The INSERM has taken the initiative in conducting a collective study of ecstasy. A multi-disciplinary ad hoc group comprising researchers and clinical practicians in the fields of toxicology, pharmacology, neurology, psychiatry, epidemiology and sociology was set up in 1997.

The conclusions of that study were published in June 1998 in the form of a report, the first part of which is an analysis of international scientific, biological and clinical data on ecstasy (MDMA) and the second part of which is chiefly devoted to the analysis of the French context of consumption of this substance.

The **Institut de Veille Sanitaire** (InVS) is a State-run public establishment which was set up in order to reinforce safety and health monitoring systems in France.. This Institute – which is the successor to the National Public Health Network – falls under the aegis of the Minister responsible for health. The general purpose of the Institute is to monitor, on an ongoing basis, the state of health of the population and the evolution thereof. This task is specifically based on epidemiological monitoring, risk assessment and health observation activities.

In this context the MILDT, whose task is to ensure the programming, structuring and financing of research, coordinates as best it can the activities of these different bodies and independent researchers and/or their partners. In particular on the basis of invitations to tender in support of projects submitted to it by the laboratories of research entities and independent researchers.

Research set up in the context of invitations to tender

In 2000 the **MILDT** launched an invitation to tender designed to promote scientific work on the use of and/or dependency on legal and illegal psycho-active substances, including alcohol, tobacco and psychotropic drugs, together with psycho-active products used to enhance individual performance (psychotropics, synthetic products, doping products).
The invitation to tender is sent to all the scientific disciplines likely to be able to offer illumination of these particularly complex issues. The projects which propose an interdisciplinary or multidisciplinary approach to the topics covered have been particularly encouraged, especially when they have associated several teams together and thus formed a dynamic working network.

The research contracts are financed for a maximum term of 2 years. The financial package for this invitation to tender has been set at 5 million francs. The number of projects to be financed has been estimated at between 15 and 20 projects. The "major projects" may be supported a priori (longitudinal epidemiological surveys, clinical trials...) on the express condition that they are assured of joint financing.

Apart from that it is intended that some projects should be allocated doctoral funding for students completing their doctorate whose thesis topic ties in with the execution of the project. The **Groupe Pompidou** (Council of Europe) provides European grants for the study of and research into drug abuse. Grants relating to drug addiction are chiefly intended to enable specialists in this field to:

- Keep in touch with the various techniques practised in other countries as regards the objectives, organisation, structures and particular aspects of the war on narcotic abuse ;
- Participate in studies and research of common interest whose subject is decided each year by the Permanent Correspondents of the Group.

Other bodies also participate in promoting research by providing financial support for projects and research grants in the context of invitations to tender, in particular the ANRS. Since the year 2000 the ANRS has issued annual invitations to tender and their field of intervention covers all research into HIV/AIDS, research into other retroviruses relevant to the understanding of the physiopathology of HIV infection and in the field of hepatitis C, clinical research, public health research and treatment trials.

Finance is currently dispersed among the different ministerial departments involved in the issue of drugs and dependency; hence these are as yet difficult to identify.

Nevertheless the research budget available to the MILDT is : 5 MF for the year 2000.

Continuous training activities are organised within the aforementioned research organisations (INSERM, InVS etc.) in various forms. For example collective training organised by the Administration in the context of the training plan, training courses organised by public or private training bodies, research promotion seminars and training refresher workshops. The aim is to maintain or enhance the professional qualifications of researchers working in these public bodies. In particular the aim is to contribute to the training of health professionals in thematic and interdisciplinary research techniques.

10.4 Training for professionals

On the subject of drugs and the prevention of dependency, those involved may be institutional decision-makers: State leaders of external departmental projects, territorial collectivities … they may also derive from the association, educational and social sectors or those specialising in dealing with "problem" users of drugs, alcohol or tobacco.

In order to contribute to creating, on the basis of validated know-how, a common culture among all these players, prevention, education, care and law enforcement professionals, the interministerial Mission for the battle against drugs and drug addiction, within the framework set by the three-year plan, intends to promote training activities in order to:

- Provide essential information about user behaviour, about products and about public policies, in particular the policy of risk reduction.

Training the police, law enforcement officers, prison and customs personnel likely to come into contact with drug users

- Over a period of three years 6000 monitors will be given initial and continuous training in the context of the national prison officers college.
- During the same period, 16,500 trainee law enforcement officers and 14,000 security officers will be given initial training. 15,000 law enforcement officers and as a priority those responsible for hostels, will enjoy continuous training.
- The police force will adopt a similar strategy.
- The national customs officer training college will incorporate this training module.

Ensuring common training for all those involved in prevention.

- Providing elements of knowledge on use behaviour, harmful use and dependency, on protection and vulnerability factors, on methods and contexts of consumption, on the products and their effects, on prohibition and the law, on relations between a reduction in supply and demand and on risk reduction.
- Making this training module available to all the colleges and ministries concerned from the year 2000 onwards.
- Conducting an experiment in four regions for 200 trainees of different professional backgrounds.
- Developing regional or département interministerial training.
- Gradually extending these arrangements after evaluation.

Enabling specialist personnel to acquire the skills they lack.

- Training professionals to ask the right questions at the right time, in such a way that the young people do not feel isolated or faced with insurmountable problems. (A specific module will be designed for professionals in education, community leadership and integration who deal with the problems of young consumers).

- Training 600 educators and members of educational staff in three years of initial training and 750 people in continuous training. Training sports coaches to be aware of the risks associated with the use of doping products and other psycho-active substances.

Ensuring more targeted training for the enforcement services.

The police, security and customs services, magistrates responsible for combating drug trafficking should all acquire new investigation techniques in order to adapt to the new forms of delinquency.

Improving initial and continuous training for doctors and pharmacists.

Initial and continuous training for doctors is not very advanced in the field of illegal drugs nor in tobacco or alcohol addiction.

- Organising better training for doctors and pharmacists, in particular with the help of tools such as CD-ROM and the Internet.
- Creating a "specialist complementary diploma in addictology (DESC) in order to enable skills acquired in drug addiction and alcohology to receive university recognition (diploma, planned for the university year beginning 2000, available to house physicians studying for the D.E.S.).

11. CONCLUSIONS: FUTURE TRENDS

Conclusions : future trends

PART 4 KEY ISSUES

12. DRUG STRATEGIES IN EUROPEAN UNION MEMBER STATES

12.1 Application of national strategy and policies

The national public policy set out in the three year plan defines the instruments which will enable us to implement guidelines in the war on drugs and the prevention of dependency.

The implementation translates into combined programming (prevention, risk reduction, training for the professionals and taking in hand individuals brought before the courts). Experimental actions receive specific financing from the MILDT insofar as they form part of new measures. When they are no longer part of the experimental stage they are included in the budgets of ministries and fall under "common law".

The instruments and actions of public policy on the war against drugs and drug addiction deemed particularly decisive form part of the priority operational programmes identified as such in the evaluation reference of the three year plan.

This reference sets out the priorities of public policy on the subject of the war on drugs and the prevention of dependency. It comprises 8 global and strategic objectives which are:

Developing and organising knowledge to enlighten public policies on the war against drugs and the prevention of dependency.

The achievement of this objective is to involve the creation of a single structure for the observation, evaluation and promotion of research. In particular it involves observing the recent evolution of consumption (TREND), developing a global evaluation process and structuring research into all these component parts.

Creating and promoting a common reference base on psycho-active products

The main instruments for achieving this objective are:

- a national communication campaign about the public handbook,

- The communication campaigns

The communication strategy, intended to accompany the three year plan, runs for a term of three years. It is based on the following objectives:

disseminating information to the general public or target groups which is full, scientifically validated and accompanied by coherent messages which make sense as a whole;

working on social images to combat the idea of powerlessness and inevitability ;

working on the reasons for consumption whilst developing people's ability to resist.

This expansion of knowledge should help the public at large and more particularly young people, parents and adults concerned to adopt responsible attitudes when faced with the different types of use and harmful use behaviour.

The information disseminated should particularly deal with the products and their effects, methods and contexts of consumption, risks, epidemiological data, the legislative and statutory framework, useful addresses …It should also cover measures at governmental level and more particularly the policy for preventing initiation, harmful use and dependency, together with strategies for reducing the risks.

Source : MILDT, three year plan 1999-2001

- expansion of the capacities of the Drug Info Service,

- creation of a national board to validate the tools of prevention,

- dissemination of drug information handbooks,

- the establishment of information and resource centres dealing with drugs and dependency ,

- the preparation of new training programmes to standardise the qualifications of the professionals

Information and resource centres dealing with drugs and dependency

Set up at département, interdépartement or regional level, these structures will be available to local players and to public institutions involved in the battle against drugs and in the field of prevention of dependency on psycho-active substances.

They fill the role of documenting and observing and constitute technical back-up for the heads of département projects in their tasks and may provide help and advice to the various collectivities or associations which wish to prepare projects, in particular in the field of prevention.

These structures are usually created from existing resources, by federation. They are chiefly financed by the MILDT and may benefit from local finance (local authorities, social protection entities etc.).

(Source : MILDT)

Extending the prevention activity to all behaviour in the consumption of psycho-active products

In order to encourage prevention practices in relation to patterns of behaviour and not in relation to products, the following actions take priority in the implementation:

- the preparation of département prevention programmes,

The département prevention programmes

The project leader is the guardian of the programming of the département plan. He should be able to call on the steering committee for the war on drugs and the prevention of dependency and also on resource personnel (experts, associations, structure representatives) and on the public, represented by associations and the media. It is particularly important to ensure that prevention, in particular in the school environment, is not confined to the work of the police and law enforcement officers, but is well thought out and executed by all the parties involved. The respective roles of the project leader and the members of the steering committee are defined in the appendices to the circular on the battle against drugs and the prevention of dependency of 13th September 1999.

The preparation of the département plan requires concerted, programmed action tailored to the national objectives and to local needs and evaluated.

The département plan is based on a set of actions which should respond to the chosen objectives.

Existing relevant action will be renewed to allow its strong points to be exploited (multiple partnerships, choice of target, territorial criteria).

Action deemed irrelevant will not be renewed or will be redirected in the light of the criteria of relevance defined above.

The new action should meet the needs which have not been covered but are revealed by the expert assessment, in particular with regard to national and département objectives and new forms of consumption …

The steering committee should ensure that the actions chosen are coherent and complementary..

(Source : MILDT, Circular of 13 September 1999)

- dissemination of the general public handbook

- extension of the CESC,

- dissemination of the Official Gazette "Features of at risk behaviour" in colleges and schools,

- preparation of a guide to good practice in prevention.

Developing risk and damage reduction action for all patterns of behaviour in consumption of psycho-active products

The risk reduction policy is developed gradually and requires the success of experimental programmes such as those which simultaneously implement social mediation between residents and drug users and risk reduction action with low threshold structures, or projects conducted in the context of département prevention programmes.

Adapting care activities to problem consumers for all psycho-active substances

The improvement of the care on offer and of the handling of addiction problems involves putting in place the following:

- creation of a single legal and financial framework for handling addictive behaviour,

- development of hospital liaison teams in addictology,

- increasing alcohology consultations,
- transfer to urban practices of patients on methadone,

- setting up protocols for following up persons undergoing care

The other priority involves diversification of the offer of care, where the execution depends on :

- organising the construction of local responses on the basis of regional health programmes
- medical prescription of heroin.

Integrating public health logic into public safety through appropriate penal policy

The implementation of fresh guidelines in penal policy vis-à-vis consumers of psycho-active products and the enhancement of care arrangements for users in custodial environments involves the generalisation of département agreements on objectives.

Département agreements on justice and health objectives

The initial purposes of département agreements on objectives remain the same (circulars of January 1993). In fact it is a matter of allowing rapid and appropriate care to be offered to drug users coming from the courts, at all stages of the penal process, developing both alternatives to prosecution and alternatives to custody, plus accessory arrangements to the penalty of imprisonment.

In order to achieve this ultimate objective, efforts by the authorities responsible for justice and health issues to work more closely together and communicate better should be pursued and intensified by better defining needs and clarifying their respective arrangements and fields of intervention.

The lines of work proposed by the circular on which the agreements on objectives are based remain relevant and have been confirmed: accommodation combined with appropriate health and social supervision arrangements, complementary responses to users within the département, not excluding under-age subjects from the application of the agreements.

Lines of work to be developed: it will be appropriate to develop partnerships (or to redirect existing partnerships) in order to meet the following objectives:

Arrange a permanent unit to ensure diagnosis of the situation of users and a rapid referral, indeed an immediate referral to educational, social or health structures as appropriate, in order among other things to save the treatment order for drug dependent users. If the local situation allows, specific funds for treatment orders may usefully be redeployed to support this new arrangement.

Standardising intervention in custody and preparatory to leaving prison and in particular facilitating the development of arrangements associated with the punishment so that follow-up after release is ensured.

Providing specific responses for young consumers, in particular with a view to preventing at risk behaviour.

Taking into account action relating to people dependent on alcohol who come before the courts.

These lines of work demand the use of resources which form a bridge between the various kinds of network (specialist care centres, associations devoted to people who have held in the judicial system but also local missions, structures facilitating professional integration, schools, general practitioners, child psychology sector etc.).

(Source : MILDT, guidance orientation of 12 February 1999)

Strengthen the battle against drug dealing by diversifying the modes of action

In order to enhance coordination between the different investigation services, permanent liaison offices have been set up in the North at Pas de Calais and for the West Indies and Guiana.

As far as the assets of the dealers are concerned, the definition of the practical methods of cooperating with the tax services will encourage the use of all the procedural tools available to identify and confiscate dealers' assets.

Finally the national system for controlling precursor products is to be strengthened by strengthening the means available to the National Control Mission for Chemical Precursors and by action to endorse operators.

12.2 Evaluation of national policies

(source : MILDT, internet site, summary of implementation of three year plan submitted to the interministerial committee on 24th March 2000)

Developing and organising knowledge to guide public policy in the battle against drugs and the prevention of dependency.

A watchdog network to observe recent trends in consumption was set up in July 1999 and the first results were disseminated in March 2000. This network is based on the TREND arrangement piloted by the OFDT and the SINTES databank (National identification system for drugs and other substances).

The evaluation of the interministerial action led to the adoption of' an evaluation mandate entrusted to the OFDT and the implementation of various evaluations of specific and experimental arrangements to check whether the main guidelines of the three year plan had been translated into effective implementation and effective and lasting action.

Finally the structure of the research is one of the pillars of the three year plan in the war on drugs and the prevention of dependency. The intention is to regroup current activities of the OFDT (statistical observation, studies, trends and evolution of methods of consumption, evaluation) with the programming, structuring and financing of research.

Creating and promoting a common reference culture on psycho-active products

The television publicity campaign about the appearance of the information handbook for the public "Know more risk less" was conducted throughout the whole of the year 2000.

The handbook was also widely distributed among the professionals. In addition 4 "Know more" information booklets were distributed to the professionals. These deal with: the action of drugs, key figures on drugs and their use, public resources and a summary of the government plan.

A training programme intended for ministries and colleges has been drawn up and is now the subject of an experimental session with instructors from these colleges and ministries.

The common base for the knowledge which has been defined can be used by the instructors to back up the training and help spread a common culture on drugs and dependency, in other words an extension of the field of psycho-active products to legal drugs, an approach founded more on user behaviour than on products and a streamlining of public action based on coordinated public policies.

In the longer term several specific training modules designed by the Judicial Youth Protection Service, the Ministry for Youth and Sport and the law enforcement services will facilitate the dissemination of training content related to the problems associated with drugs.

In addition, at local level, département and/or regional training programmes are being prepared and will also help to spread a common culture in local areas.

Thus initial and continuous training should gradually benefit from content which is more appropriate and uses validated practices and know-how.

Extending preventive action to all aspects of consumption of psycho-active products

Various initiatives in the field of prevention in school environments have already been undertaken with the distribution of 800,000 copies of the Official Leaflet "Characteristics of at risk behaviour" in colleges and high schools and the increase in the number of CESCs. In fact in 1999 there were committees for civic and health education in 47% of schools.

The national commission for validating the tools of prevention has been set up, together with a validation grid to classify projects submitted to it.

Département prevention tools are being prepared or are already completed in several cases. A summary report is currently in preparation.

Summary of the implementation of the Information and Resource Centres for drugs and dependency: in 1999 7 projects were retained bringing the number of CIRRD to 15 for the year 2000.

Adapting care arrangements to problem consumers for all psycho-active substances

The creation of a legal and financial framework enabling users to be cared for is gradually being put in place with the allocation of budgets for increasing tobacco addiction consultations (28 million francs in 2000) and for the creation and enhancement of non-residential alcohol addiction centres (27.5 million francs). In addition finance for the centres specialising in caring for drug addicts from the national health budget is under review and may be provided from 2002 onwards. It will allow the CSST s to be integrated in the arrangements under common law.

As regards the improvement of care, the term of prescriptions for methadone was raised from 7 to 14 days by a decree of 8th February 2000 and the period for which methadone and Subutex can be issued has been raised to 7 days.

Developing steps to reduce risks and damage for all patterns of consumption of psycho-active products

The reduction of risks and damage associated with the consumption of psycho-active products presupposes the simultaneous development of suitable structures for users and systems for social mediation within risk reduction programmes.

With this in mind innovative programmes have been implemented since 1999 to organise the monitoring of social and health care and to make the presence of drug addicts in their neighbourhood acceptable to residents.

In addition the preparation of département prevention programmes should make it possible to support more local initiatives intended to prevent and inform users attending party venues and discothèques. To this end documents and ways of intervening have been prepared with the associations concerned.

Integrating public health concepts into public safety through suitable penal policy

Summary of the Département Agreements on Objectives

15 new départements have been financed, which brings the number of départements committed to preparing a new agreement on objectives in the battle against drug addiction, for taking care of individuals who come before the courts, to 45.

12 départements have extended their objectives to include taking care of offenders in difficulties with alcohol. 7 départements have set up a health and social guidance unit (alternative to prosecution, compulsory care); among these arrangements some also deal with delinquency associated with alcohol abuse.

Finally 13 départements have installed an alternative procedure to prosecution (warning and reminder of the law, registration with a "contact" or "attendance" obligation, treatment order) specially suited to under age subjects and young adults.

Actions financed in 1999 have confirmed the value of a "justice-health" programme allowing health and social guidance adapted to drug users questioned and alcohol-dependent offenders, in accordance with the directives of the circular on confidentiality in relation to judicial responses to drug addiction of 17th June 1999.

Strengthening the battle against dealing by diversifying the means of action

This reinforcement has already been formalised in the adoption of two new circulars in 1999 (Battle against narcotics; strengthening the battle against use and local drug trafficking).

Preliminary work in the fight against local trafficking and the application of the provisions of the 1996 law on drug procurement has been instigated in five towns (Lille, Rouen, Avignon, Lyon and Versailles).

As regards the control of chemical precursors, the national mission for the control of chemical precursors (MNCPC), which is run by the Ministry for economic, financial and industrial affairs, has proposed that an accompanying document be created for the most sensitive precursors when they are being transported within the European community. Finally the MNCPC is conducting campaigns to raise awareness individually among businesses to remind them of their statutory obligations and their obligation of vigilance. Collective campaigns have also been organised in the form of a colloquium in April 2000.

13. COCAINE AND BASE/CRACK COCAINE

New trends in cocaine use, approaches and strategies

The consumption of cocaine in France dates from the 19th century. With the exception of a short period, around the time of the First World War, it has remained modest and never been considered a major problem. The recent increase in the use of cocaine, from about 1996, represents a break with the history of almost sixty years of consumption which remained stable at a relatively low level. During this long period cocaine was always widely overshadowed by opiates, opium and morphine, morphine and heroin and then heroin alone with cannabis.

In the course of the last thirty years, cocaine was considered a luxury item, an accessory of the trendy set. In the street the consumption of cocaine alone was rare, but it was often found in association with heroin. That is why this substance has a "positive" image associated with a certain level of social success and the belief that this product is a relatively easy drug to manage provided it is taken in moderation.

13.1 Different patterns and user groups

Administration and effects sought

The effects sought with the taking of cocaine vary depending on the consumer groups. Two different ones can be distinguished :

- the stereotypical effects such as increased sociability and physical performance ;

- the so-called regulatory effects, meaning any use pattern combining two or more psycho-active substances with a view to modifying the effects of one or more substances already consumed or to be consumed. As a regulatory substance cocaine is used with numerous products: with ecstasy to attenuate too high a trip or to extend the effects of it, with ketamine to neutralise the effects or with alcohol to counterbalance the effects.

Method of administration

There are three methods of administration reported in France:

Nasal[29] used by traditional well established users, taking it in a private context (entertainment industry, night-club patrons, executives etc.) and at techno raves.

Intravenous[30] used both for the hydrochlorate form and base form (crack). Geographically the practice of injecting crack is chiefly a Parisian phenomenon. Elsewhere it has been reported as embryonic or rare. For an injection crack is mixed with lemon or citric acid and then heated, filtered and injected with a 1 cc syringe. The injection of cocaine or crack remains the province of former heroin injectors, people on substitute therapy or extremely marginalised people.

Pulmonary (smoking) : a tiny minority of users smoke cocaine hydrochlorate mixed with tobacco[31] (high loss levels). In France, the cocaine smoked is usually base cocaine (crack). This is prepared from cocaine hydrochlorate to which ammoniac or bicarbonate is added.

To smoke crack, users use either a glass alcohol pipe fitted with a grid consisting of fine metal threads or a piece of aluminium foil with holes in or a bottle with a pipette or a bottle with the end covered with aluminium paper with holes in. The product is heated and inhaled at the same time.

Crack smokers use this method of administration either because they find it difficult to sniff cocaine or because they want intense effects without resorting to intravenous use. This type of consumer generally belongs to certain ethnic minorities, in particular West Indians.

Prevalence, patterns and frequency of consumption

Prevalence

Surveys among the general population

Experimentation among young students : the ESPAD survey carried out in France on a sample of 12,113 pupils (college, vocational training or general and technical college) in the public or private sector, aged from 14 to 18, showed that 1.7 to 3.1% of boys and 0.6 to 1.7% of girls had experimented at least once in their lives with cocaine (table 1) . For crack these percentages are respectively 1,5 to 2,8 for boys and 0,4 to 2,1 for girls.

Experimentation with cocaine and crack : prevalence over age range by sex and by age (in %)

	14 years	15 years	16 years	17 years	18 years

[29] The cocaine is snorted with the help of a straw. This could be an underground ticket or a rolled up piece of card.

[30] It is dissolved in water, warm or cold, and then injected.

[31] One of the methods used consists of putting the cocaine on the tobacco, which is on a piece of cigarette paper. A second method consists of sniffing cocaine in a cigarette which has been emptied of some of its tobacco.

Cocaine					
Boys	2,8	1,5	2,0	1,7	3,1
Girls	0,6	0,7	1,7	1,2	1,5
Crack					
Boys	2.8	2,4	2,0	1,5	1,9
Girls	0,7	1,7	2,1	1,3	0,4

Source : ESPAD 1999, INSERM, OFDT, MENRT N = 12 113

Consumption by adults and young adults : The survey carried out among young people from 18 to 23 called to the national service selection centre in 1996 shows that 2.5% of these young people declared having tried cocaine during their life and 0.4% declared they had taken it in the course of the past month[32]. In another survey of a sample of young adults and adults aged from 18 to 44, 1.7% [1.0-2.4] declared they had taken it at least once in their lives[33].

Police questioning for simple use: In the space of five years questionings for use and use and resale of cocaine and crack have multiplied by almost 2.5, rising from 1374 people in 1995 to 3,397 people in 1999.

In 1999, 2,584 people were questioned by police for using cocaine, which represents 2.79% of all those questioned on the use of drugs. Compared with the previous year the number of those questioned has increased by 8.81%.

In the course of the same year (1999) 636 people were questioned by police on the use of crack, which represents slightly less than 1% of the total number of those questioned for drug use. Compared with the previous year the increase in questionings for crack (8.16%) is very close to that of cocaine (8,81 %.).

Evolution of questioning for simple use of cocaine or crack between 1998 et 1999.

	(1) Questioning for simple use	(2) % of total questionings for simple use	(3) Evolution compared with 1998 (1)/(3)
Cocaine	2 584	2, 79	+ 8, 81
Crack	636	0, 79	+ 8, 16

Source: OCRTIS

Patterns and frequency of consumption

Cocaine is consumed alone for its intrinsic effects (increased resistance to tiredness, awareness and sociability) or in association, as a regulatory substance, with other psycho-active substances. The main products with which it is associated are :

alcohol : cocaine enables one to drink more without becoming drunk. The alcohol helps to attenuate the overexciting effects of the cocaine. The two substances balance each other out and their undesirable effects are mutually neutralised.

[32] OFDT: indicators and trends 1999
[33] Idem

heroin (*Speed-ball)* : a mixture of cocaine and heroin enables one to accentuate the effects of the two products and combine them. On the high it is first the speed effect of the cocaine which takes effect and then the flash of heroin. Heroin then acts to smooth the comedown.

Either cocaine is injected first, to experience the flash and then the heroin to facilitate comedown ("opiate mattress"), or heroin is injected first to anticipate the excessively strong effects of the cocaine.

cannabis : the two products are associated in two different ways:

Simultaneously: using a joint or in a bang (bamboo, bottle), using the so-called holder technique (taking cocaine at home).

Subsequently : consumption of joints whilst coming down.

ecstasy, LSD and Ketamine : cocaine is used in association with these substances in two situations :

- to accompany coming down from ecstasy (less frequently from LSD). This enables one to restimulate the empathogenic effects of ecstasy. For some people this saves them having to take more ecstasy and allows them to have sexual relations (no loss of erection).

- to attenuate too strong a high with ecstasy, LSD or ketamine which the consumer has difficulty in controlling.

As for managing the comedown after taking cocaine itself, it is opiates, tranquillisers and cannabis which are most used.

Social groups, geographical factors

Even just a few years ago cocaine was chiefly consumed by two categories of people:

a *hidden population*, comprised of socially well-adjusted individuals belonging to the worlds of entertainment, night-life and business;

a marginalised *visible population* comprised chiefly of heroin addicts using cocaine in association with heroin.

Over the last three years and more particularly in the course of 1999, we have seen the emergence of two other groups of consumers :

- young people, in particular users of cannabis or ecstasy who discover the product in their residential neighbourhood, at parties or in discothèques. It seems as if in this group, owing to the price and the reference environment (show business), cocaine remains an object of fascination;

- people on the substitutes methadone and Subutex ® who for various reasons have moved on to taking cocaine and for whom the opiate of former times has been relegated to the status of a regulation substance. In this category of consumer we also find some for whom cocaine is the subject of regular use without thereby becoming their main product.

As regards crack, its circle of consumers is also expanding. Apart from the visible consumers who are disaffected wanderers, sex workers, in particular in Paris, or those who alternate the use of crack and opiates, we have also noted the spread of consumption to less common categories such as certain socially well-adjusted people who take it on an occasional basis; and finally old and new consumers of cocaine who experiment at one time or another with the smokable form of their preferred product.

At the heart of the rave sector, namely at free parties, the year 1999 was marked by rapid progression in consumption, which had already been present to a significant extent at discotheques for a long time. In the second half of 1999 a clear increase was seen in consumption at free parties. A survey[34] was conducted by questionnaire of 949 people attending raves (48% at free parties, 24% at paying raves, 17% at private evening parties and 9% in other contexts). The survey was completed at the end of 1998 and the beginning of 1999 by the Medecins du Monde association.

The socio-demographic characteristics of the people who took part in the survey are as follows:

Sex and age : 70 % of the sample were men and 30% women. The subjects were relatively young, the average age being 21.

[34] Médecins du Monde, Mission Rave, Research-action report : users of synthetic drugs (ecstasy, LSD, dance-pills, amphetamines,…), Risk reduction in the techno-rave environment, 1999, 475 pages.

Occupation: the majority of the subjects were wage-earners (30% CDI/CDD) or students (37%).

The percentage of unemployed was 15%. Those receiving income support represent 4% of the sample.

Level of education: 28% had achieved higher education. 33% of subjects had completed secondary education.

Residence: the overwhelming majority of the subjects had a stable home (48% were living with their parents, 45% in their own homes). 2% of the sample alone were of no fixed abode or living in squats.

The results of the survey show that of 896 people who made statements on the consumption of cocaine, 56% replied that they had taken it and 21.5% in the course of the last rave they had been to. Injecting cocaine was less common, it was usually sniffed and often taken in association with other products.

Prevalence of consumption of cocaine among those attending techno-raves

Cocaine	Number of respondents	% of consumers among respondents
	896	56
In their life		
At previous techno-rave	561	21,5

Source : Médecins du Monde N = 896

As far as crack is concerned, the abovementioned survey revealed that of 870 people who made statements on the consumption of *crack/free base,* 10 % (66 people) replied that they had taken it and then chiefly by smoking it (56 people). The other methods of taking it are marginal.

13.2 Problems and needs for services

The difficulties the care services have encountered in relation to the consumption of cocaine and crack are of different kinds:

- the clients often require multiple types of care: medical, psycho-social and long term. Caring for a cocaine addict in a hospital milieu often requires greater personnel input insofar as there are often psycho-pathological disorders present: anxio-depressive states, hallucinatory syndromes, persecution complexes, paranoia, confused states, behavioural, sleeping and eating disorders.

- New users with problems are not sufficiently aware of the specialist services or are ill-informed. Some are suspicious or fearful because the ideas of anonymity and the voluntary nature of their attendance are not sufficiently understood as rights protected by law.

- Socially well-adjusted users tend to consider themselves as cocaine lovers and not cocaine addicts, in the sense that managing or controlling their consumption is their own personal affair. They contact the care services either late or not at all and when they do it is often a last resort. So it is these urgent medical or psychiatric cases which are at the forefront of requests for help.

- The rapid evolution of this consumption requires particular attention from the services which have to deal with consumers with multiple profiles and different methods of consumption and unaccustomed ways of dealing with consumption. Responding to these fresh demands presupposes prior yet profound modifications to the way these services work.

- The specialist care services are not often contacted by cocaine users. These patients are more inclined to contact hospital emergency services for worrying conditions: acute crises of anxiety, severe physical discomfort (palpitations, feelings of suffocation, premonition of imminent death etc.)

- The emergency services for their part are often confronted with the difficulty of addressing the care issue correctly, diagnosis etc…. because the patient does not spontaneously relate the origin of his problems. Sometimes he doesn't see the connection with the consumption of cocaine, which for various reasons he has hidden (psychological, family, moral etc.).

- As distinct from people dependent on opiates, in whom mental disorders are not the first sign on the clinical picture, cocaine addicts often display psychiatric changes of varying degrees of severity caused by the psycho-stimulant. These disorders (real and imaginary) represent one of the major obstacles to providing them with care. The rapid evolution of these users facing problems in finding immediate effective responses creates a defensive climate of avoidance and even rejection of which they may actually become the victims.

- Chemotherapy treatment for cocaine addicts in France is still symptomatic (traditional and moderate prescription of : hypnotics, anxiolytics or neuroleptics). Pride of place is given to individual support therapies, more or less eclectic, or to psychoanalytical guidance.

There are no anonymous groups for cocaine addicts but "Narcotiques Anonymes » is working actively with a large number of users with cocaine problems. Acupuncture is used chiefly in the West Indies and in metropolitan France.

Health consequences and negative effects

Morbidity : The consumption of cocaine and crack has consequences for physical and mental health. The rapidity and intensity of the effects of injection of crack-cocaine increase the risks of acute intoxication, overdosing. Somatic complications (cardiac respiratory) and risks of infection (transmission of AIDS or hepatic viruses) are greater. The smokable form which is very common in the consumption of crack in France causes disorders of an intensity and significance similar to those caused by injection.
The consumption of cocaine among young people poses the problem of certain health consequences specific to these developing subjects. Consumption affects their more vulnerable neuro-biological system and their interaction with their associates and their environment becomes more delicate.

At present consumption of cocaine is often associated with synthetic drugs, in particular synthetic drugs, cannabis and alcohol are pretty widespread. The difficulty with these young consumers is great owing to their lack of easy access to care. There are few structures adapted to the particular somatic problems of these young people.

Health statistics do not currently allow us to give an account of the phenomenon. Cocaine figures as a product leading to care in 13% of calls to the specialist care structures and health establishments in 1997, most often as an associated product. As the primary product leading to care it has a very low profile: 1.87% for cocaine and 0.96% for crack. The average age of cocaine users registered with health and social establishments was 29 in 1997.

Applications for help for using cocaine or crack as the primary product leading to care in 1997

	Cocaine		Crack	
	number	%	number	%
Specialist centres and health establishments	438	1, 87	225	0, 96

Source : DRESS N = 23403

For other pathologies there are no national registers of admission to hospital for somatic or psychiatric pathologies in emergency services or hospital care linked to the consumption of cocaine or crack.

By way of indication one could say that certain somatic and psychiatric pathologies have been reported such as pain, nose bleeds, abscesses; cardiac and pulmonary pathologies inherent in the smoking or injecting methods of administration, foot problems among users of crack in Paris associated with the considerable distances they need to cover to get the product and finally disorders of a psychiatric nature: crises of anxiety, paranoia, aggressivity, anorexia, insomnia etc. … More generally we note the increase in the risks of disease transmitted by the blood such as HIV/AIDS infections and hepatitis.

Mortality : Cases of death associated with cocaine or crack are very few. In 1999 for the whole of France the OCRTIS recorded 13 cases. Among those cases only 4 deaths cited cocaine alone and in the other nine several other products had been consumed by the person.

Death with the presence of cocaine or crack: (13),in the year 1999

Substances identified	Number of cases
cocaine alone	4
cocaine and heroin	2
cocaine and heroin and alcohol	1
cocaine and heroin and cannabis and morphine and tranquillisers	1
cocaine and cannabis and methadone	1
cocaine and medicines (anxiolytics, antidepressants and Viagra ®)	1
crack and Skénan ®	1
death with presence of cocaine + ecstasy	
cocaine and heroin and cannabis and ecstasy	1
cocaine and ecstasy and alcohol	1
TOTAL	13

Source : OCRTIS

Social consequences

Bearing in mind its recent emergence, the consumption of cocaine does not seem to have tangible negative social consequences. The development of open crack scenes in the Parisian region and in the three overseas French départements (Martinique, Guadeloupe and Guiana), has contributed to the deterioration of relations with the residents of the neighbourhoods concerned, who hold the crack users responsible for the lack of safety, aggression and acts of violence which they suffer. In addition crack is often associated with increased social instability for the consumers.

13.3 Market

Physical description

Cocaine is sold in the form of a white powder and crack as a cake, wafers (equivalent to 5 or 6 cakes) or bricks (equivalent to 2 wafers). To get crack from cocaine hydrochlorate powder, this is heated with water and a base product (ammoniac or sodium bicarbonate) for a few minutes, producing a residue in the bottom of the recipient.

Price/purity at user's level

Price : The price of cocaine is dropping but this drop is still hard to evaluate. The average price at ten locations in the second half of 1999 ranged from 425 to 600 francs, that is on average 534 francs. The same weight was traded a few years ago at between 800 and 1200 francs. Data does not allow us at present to distinguish prices according to place of purchase (apartments, street etc.) for the quantities bought, the quality of the products bought and their content of the active substance. This estimate is undoubtedly imprecise, even if it reflects the reality of the prices applied. It should therefore be seen simply as an order of magnitude.

At techno-rave locations in the Parisian region the price has dropped significantly: from 800 francs in previous years to 600 francs in the first half of 1999. It dropped even further in the summer, to 500 francs/g and at the end of November was between 350 and 500 francs a gramme.

As far as crack is concerned the price of a dose has stabilised at between 40 and 50 francs.

Purity at user's level : we do not have any recent data from laboratory analysis on the level of purity of the cocaine sold in the street. However contrary to heroin, the cocaine sold in France is seen by users to be of good quality insofar as the level of purity is generally high and constant from one year to the next.

Availability

All the data agrees in indicating a clear increase in availability. In some locations this availability has held true for some years; this is the case for the northern region bordering on Belgium and the Netherlands, whilst for others the penetration of cocaine has come later, spread over the period from 1996 to 1999.

The availability is manifested in the greater diversity of consumer profiles and penetration into districts which have hitherto been spared. Previously accessible in private locations known only to the initiated, cocaine is increasingly invading public spaces. In some locations such as Paris it is less and less necessary to resort to intermediaries to get some. To some observers the increase in consumption is directly related among other things to the widespread prescription of substitute products.

On the other hand in terms of visibility consumption in public remains rare, in spite of its appearance on certain sites (Marseilles, Metz and Lyons). The consumption of cocaine is still generally confined to private areas (apartments, squats etc.)

Bearing in mind how easy it is to make it from cocaine hydrochlorate, the availability of crack matches that of cocaine. Thus considerable or sporadic consumption of crack is reported from almost all the TREND locations with the exception of one (Bordeaux). However the almost total absence of dealing and consumption of crack in the street, outside Paris and its periphery, translates as a reduction in visibility of the phenomenon.

Open scenes, local markets, trafficking/dealing/distribution patterns, supply routes/counties

Open scenes

There are not specifically open scenes for cocaine in France. On the other hand for about the last ten years there has been an open crack scene in Paris. This scene is both stable and mobile. Stable insofar as it is rooted in the north of the capital, basically in the eighteenth and part of the nineteenth arrondissements. Mobile insofar as dealers and consumers move their activities within that space depending on the circumstances of police repression and hostile and sometimes violent reactions from the residents. Open crack scenes also exist in Martinique, Guadeloupe and Guiana.

local markets, trafficking/dealing/distribution patterns

local markets, dealing

For several years the cocaine market seems to have been getting better structured and organised. New vendor profiles are emerging and the visibility of small scale dealing is increasing, particularly in public places.

Two elements allow us to measure the level of structure attained by cocaine dealing :

- the visibility of small scale dealing in public places: formerly confined chiefly to apartments for discreet and socially well-adjusted users, the street sale of cocaine in the form of hydrochlorate (powder) has emerged, chiefly in Paris, Bordeaux and Metz and to a lesser extent in Lyons. In Paris, small scale cocaine dealing has spread to districts previously spared. Things are happening as if

heroin and cocaine were swapping status and roles: cocaine sales have moved from private places to public whilst heroin has gone the other way.

- Changes in the networks of small dealers in cannabis and heroin: in certain locations small dealers in cannabis and heroin are beginning to sell cocaine also, whilst other small dealers in heroin are gradually turning to the exclusive sale of cocaine.

Where crack is concerned, it seems that it is only in Paris that small dealers have achieved some level of organisation and structure. Evidence of this is the regularity of supplies and the relative stability of the price. Elsewhere crack dealing either does not exist or is only seen on odd occasions.

Trafficking

Questioning : police questioning for cocaine or crack trafficking has been increasing constantly since 1996. In the space of four years it has increased by 64 %. In comparison with the previous year 1999 recorded an increase of the order of 22 %.

Evolution of police questioning for cocaine and crack dealing between 1996 and 1999.

	1996	1997	1998	1999	Evolution 98/99
Cocaine et Crack	721	811	972	1188	+ 22, 22

Source : OCRTIS

Seizures: the high increase in the volume of seizures between 1998 and 1999 should be interpreted with caution insofar as it reflects chiefly the execution of a few exceptional seizures. Apart from those the increase was around 21% compared with 1998. The number of seizures itself has seen an increase of around 10%.

Evolution of quantity and number of seizures of cocaine and crack between 1996 and 1999.

Types of product	1996		1997		1998		1999	
	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized	Number of seizures	Quantity seized	Number of seizures
Cocaine*	1742	1213	844	1471	1050	1688	3687	1865
Crack*	11	244	16	228	25	334	10	405

** Quantity expressed in kg* Sources : OCRTIS

supply routes/countries

In 1999 the main country exporting cocaine directly to France was Colombia, with about two thirds of the cocaine seized. In total the countries of South America account for 81% of seizures. As regards the main transit countries for cocaine destined for France, in order of importance these are the countries of South America, Central America and the Caribbean area. As regards transit through countries of the European Union, Spain holds first place with about slightly less than two thirds (62%) followed by the Netherlands (28 %).

13.4 Intervention through projects

The continuous growth in the use of cocaine and crack over the last few years is far from slowing down; according to most observers it is instead tending to increase.

The consumption of this type of psycho-stimulant continues to represent a major problem for the specialist care services who face a growing demand for help and care.

With a view to obtaining a better response to the problems posed by this use and these users, it has become necessary to diversify the care system.

The opening of drop-in centres and sleep-in refuges and low threshold structures has enabled us to make the problem of very disaffected crack users, for whom access to care and social services was almost non-existent before, more visible. It is only in the context of techno-raves that there are real and specific prevention campaigns based on the use of stimulants and hallucinogenics including cocaine and crack. A health and paramedic presence is organised to enable first aid to be offered in the case of any distress. The same teams ensure that those who take part in these events have access to water, high energy foods, sterile injection kits, contraceptives and information leaflets about the products consumed, their effects, the risks associated with them etc. ..

Research and evaluation

Few specific studies of cocaine and crack consumers have been carried out. Recently the authorities have set up an *ad hoc* project called RESTIM. This is an inter-institutional information, training and development network for clinical and therapeutic knowledge about the use of psycho-stimulants. The aims of this project are:
- collecting and disseminating reliable and practical knowledge;

- developing training on the issues and supporting teams in their efforts to adapt and experiment;

- encouraging existing arrangements to be opened up to new types of reception and care allowing for the specific problems of this type of user ;

- reflecting on the ways of dealing with different stages of consumption and on changes caused by the abuse of psycho-stimulants.

14. INFECTIOUS DISEASES

14.1 Prevalence and incidence of HCV, HBV and HIV among drug users

and

14.2 Determinants and consequences

In France data on the prevalence of HIV and HCV usually derives from surveys based on statements by the people questioned. Occasional surveys covering limited samples provide results based on biological tests. Comparison of these with declared prevalence shows that the results tally for HIV but that declared prevalence of HCV is clearly underestimated. Depending on their objectives and the way they are carried out, each of the surveys will tend to target a certain user population (injectors or non-injectors, located in such and such a geographical zone), which largely explains the differences in prevalence recorded in the different surveys.

Cases of AIDS have to be declared and the increase in the number of these is carefully monitored. Until recently knowledge of new cases of AIDS provided an indirect and delayed indication of the evolution of the epidemic. Until the triple therapies appeared in 1996, various epidemiological studies led us to believe that the impact of the risk reduction policy had helped to reduce and then stabilise fresh HIV contaminations among users of intravenous drugs from the beginning of the nineties. After 1996 the very significant drop in the number of new cases of AIDS among users of intravenous drugs (evidence of contamination which had occurred several years previously) has chiefly been due to the effects of the triple therapies which delay the emergence of full-blown AIDS in patients who have tested positive.

HIV and AIDS

Prevalence of HIV infection

Current level

- All users

The prevalence of declared HIV among all drug users who have attended specialist centres in the month of November was around 13% in 1999. The serological status seems to be better and better known but the proportion of unknown status remains high (24 %). The fairly exhaustive nature of the survey in the specialist centres, its repetition over several years, its national coverage and the high number of users covered gives particular significance to the figures which have emerged from it. However they only relate to the people who attend specialist centres, which is not fully representative of all drug users. Data on prevalence for those cared for in hospitals has not been taken into account, the presence of care services for patients with AIDS among the services which responded has tended to produce overestimates of figures for AIDS prevalence.

The declared prevalence of HIV among people who have attended specialist centres in the month of November seems to indicate a drop. The evolution recorded for consultations as a whole however may have been affected by the modification of the structure of the products consumed. Between 1997 and 1999 the share of heroin and opiates in the products leading to consultations diminished, which is naturally reflected as a drop in the prevalence of HIV, since positive testing is rare among users of cannabis. It is therefore more meaningful to look at prevalence among users of intravenous drugs.

- Users of intravenous drugs

Among intravenous drug users seen in the month of November, the prevalence of HIV was between 14 and 16% in 1999. Since the levelling off seen in 1997, the prevalence of HIV has continued to drop, thus continuing the decrease which began in the mid nineties.

The survey of one weeks data carried out by the health monitoring unit and INSERM among drug users, all injectors, attending syringe exchange programmes in 1998 shows that among those who know their serum status (89% of the total sample), 19.3% declared that they were positive. This figure should be compared with the prevalence of 15.9% recorded in the survey conducted by the DREES in November. People attending PESs are often thought to be in a situation of greater risk than people who attend care centres, which might explain a slightly higher prevalence among the former. However the PES survey shows that quite a high proportion of users seen in these structures had already attended care centres.

The prevalence of HIV among residents in care centres with accommodation in 1998 (see CESES survey in method references) on the other hand was far lower than in the two previous surveys (11.2% in the first half of 1998 compared with the high value of the November survey). Remember that this population was 90% injectors in 1993 and 80% in 1998.

Declared HIV prevalence in specialist centres	1993	1994	1995	1996	1997	1999
Users as a whole						
% HIV positive*	20,3	19,8	17,2	15,3	15,8	13,1
% HIV status unknown	33,6	31,2	26,4	24,9	27,2	24,2
Injecting users						
% HIV positive*	nd	23	20	18	18,3	15,9
% HIV status unknown	nd	nd	nd	nd	17,3	14,3

Source : DREES

* among people who knew their status

- Evolution

Until the mid nineties the drop in prevalence could be explained by the combination of the risk reduction measures and the increase in the number of deaths among users owing to AIDS or overdoses. From 96-97 onwards this second component loses its significance in explaining the drop in prevalence owing to the strong decrease in the number of deaths among drug users. Finally it is not impossible that because of the declared nature of the prevalence cited here, factors associated with perceptions of HIV and its seriousness may have affected the drop in the figures.

Discriminating factors

The studies we have reveal the great heterogeneity of the data on prevalence at local level. There is not one epidemic but several, differing in extent depending on the region. In the month of November 1999 the prevalence of HIV among those attending specialist centres for those using injections was particularly high in Corsica (34%), Provence-Alpes-Côte-d'Azur (23 %), Ile-de-France (22 %) and Aquitaine (22%). On the other hand it was far lower than the national average in Lorraine (4 %), Nord-Pas-de-Calais (4,6%), Basse-Normandie (4,5 %) and Limousin (6 %). In the IREP survey prevalence was low in locations in the north and northeast, owing to the late development of the epidemic in these regions but was high in the Parisian suburbs and in Marseilles. In the study coordinated by GT69 and

covering 1996, prevalence among users seen by general practitioners was 7 to 8% overall, with 2 to 3% in the départements in the north and the Rhone and 25% in Seine-Saint-Denis.

The average age of HIV positive drug users seen in November 1999 in specialist centres was 35.4 years as against 31 for the HIV negative. The average age of people whose serum status is unknown is around 29 years.

Among residents in care centres with accommodation, prevalence rises from 11% among 25-34 year olds to 22% among those over 35. Prevalence tends naturally to increase with age since there is a longer period of exposure to the risk of infection. The lower prevalence among the youngest is undoubtedly also the result of less exposure to the risk of infection among people who started taking drugs after the beginning of the nineties, thanks to the measures to reduce the risks. The great majority of intravenous users do not regularly share syringes and even when they do, the reduction in the epidemic reduces the risks of transmission. The epidemic has not been fully controlled in zones where it developed earliest and most widely and contamination via sexual routes continues. In the GT69 survey around a quarter of HIV-positive users declared that they did not use contraceptives. The regional dimension of the epidemic is itself strongly linked to the period when consumption started. The results of the multicentre study by the IREP show that in Marseilles, where the level of prevalence of HIV is highest, only 6% of drug users questioned started taking heroin after 1989. At the other extreme we see in Lille and in Metz, where prevalence is the lowest, a proportion of more than 50% of users who started taking drugs after 1989.

In 1999 in the DREES survey, as in the PES survey, the prevalence of HIV among injectors was higher among women than men (18% for women against 15% for men in the DREES survey, 24% versus 18% in the PES survey). The survey among residents in residential care centres consistently shows a higher prevalence among women than men.

New cases of AIDS

The number of new cases of AIDS is dropping among drug users. The drop was particularly pronounced in 1996 and 1997. Between 1997 and 1999, the downward movement continued although at a slower pace. A similar evolution in new cases of AIDS was seen among homosexuals. The new cases diagnosed among heterosexuals are also dropping but at a slower pace than among drug users and homosexuals, among whom the spread of infection peaked in the mid eighties.

The efficacy of treatments associating several antiviral drugs largely explains the reduction in new cases of AIDS in all these transmission groups and particularly among drug users.

Compared with declared cases among heterosexuals the proportion of cases where AIDS is declared in people unaware of their serum status is far lower among drug users, which seems to suggest good access to screening. A fairly high awareness of their serum status has enabled drug users to benefit, like homosexuals, from the new antiviral treatment associations which appeared in France in 1996.

New cases of AIDS declared (AIDS among drug users)

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999*
Total	342	640	905	1079	1218	1341	1491	1373	1312	957	419	332	250

Source : IVS

* adjusted data

Hepatitis C

For hepatitis C a high proportion of unknown serum levels was found in the surveys, which leads one to advise that not too much importance should be attached to minor variations in prevalence figures. Only the main trends should be taken into account.

Prevalence

Level

- Users as a whole

The declared prevalence of HCV among users being cared for in specialist centres in November was around 51%. The serum status was known for slightly less than one user in four, a far higher figure than in 1997 (one in three).

In the survey conducted in Toulouse in 1996 the prevalence of HCV measured by a biological test (saliva test) was 67% and confirmed an underestimate of their HIV-positive status among users who declared they knew their serum status. 35 % of people who declared that they were HIV-negative proved positive in the saliva test. Prevalence among non-injectors was 13%, a result compatible with that of the survey in November 1997.

- Intravenous drug users

In November 1999 the prevalence of HCV infection among intravenous drug users being cared for in specialist centres was around 63%. In the first half of 1998, in the CESES survey, the prevalence of HCV was also 63%.

As regards the survey among users attending PESs, conducted over one week in 1998, the prevalence of HCV was 59.4% among users who knew their status (81% of the sample).

Evolution

Since users have been questioned in the surveys about their HCV status, the prevalence of this infection has been increasing constantly. The rise in prevalence among injectors however was quite slow between 1997 and 1999. Awareness of their serum status improved but the studies nevertheless showed that the extent of prevalence of HCV among drug users tended to be underestimated.

Declared prevalence of HCV in specialist centres (%)

	1993	1994	1995	1996	1997	1999
All users						
% HCV positive*	41	43,5	45,7	48	52,3	51
% HCV status unknown	59	49,5	40,7	35,5	34,7	27,7
Injectors						
% HCV positive*	nd	51	53	57	62	63,1
% HCV status unknown					24,8	18,5

Source : DREES

* among people aware of their serum status

Discriminating factors

There are also differences between the regions in the prevalence of HCV measured in the November 1999 survey, even though the situation appears more homogeneous than for HIV. The regions of high prevalence among injecting users being cared for by specialist centres were Corsica (83%), l'Ile-de-France (71%), Rhône-Alpes, Midi-Pyrénées and Languedoc-Roussillon with a level of prevalence between 67 and 69% in these three regions. At the other extreme there is Champagne-Ardennes (34%), Réunion (39%). Auvergne, Picardie, Lorraine and Basse-Normandie with a prevalence of between 50 and 55%. In other regions prevalence is close to the national average.

As with HIV, **HCV-positive users cared for in specialist centres in November 1999 were older than the HCV-negative users, slightly over 33 years old in the first case against 30 years in the second.** This link between prevalence and age is largely explained, as with HIV, by a lower awareness of their status among the youngest and a longer period of exposure to the risk of infection among the eldest. The drop in prevalence according to when they started taking drugs is far less clear then for HIV, a difference which might be attributable to the massive nature of the epidemic, the higher viral load of HCV and its greater resistance in external environments. These characteristics of the virus enable it to be transmitted even in the absence of shared syringes, when a user reuses his own syringe.

Prevalence of contamination with HIV HCV and HBV in recent studies

	November specialist establishments	**Multicentre IREP study**	**Town-hospital network of départements of Nord, Rhône and Seine-Saint-Denis**	**Survey of drug users in Toulouse**	**PES survey**	**Town-hospital network of département of Vaucluse**	**Ares 92**	**SUBTARES**
% HIV-positive	16%	17-20%	6,7-8%	15%	19%	14%	22-29%	20-22%
% status unknown	14%	12%		nd	11%	nd	25%	10%
% HCV-positive	63%	48-76%	61-68%	67%	59%	49%	81-87%	56-62%
% statut inconnu	18%	28%	18%	nd	19%	nd	37%	13%
% HBV-positive	NA	23-44%	35,2%	NA	17%	22%	68-81%	34-76%
% statut inconnu	nd	28%	30%	nd	23%	nd	37%	32%
Population	Injectable drug users attending specialist establishments	Injectable drug users	Consulting network doctors and hospital structures caring for infectious diseases	Users seen by various health and enforcement agencies	Users attending syringe exchange programmes (all injectors)	Patients cared for by general practitioners using substitution	Attending general practitioners	Attending general practitioners for substitution
Types of data	Declared by care centres	Declared by users	Declared by general practitioners on the basis of biological tests	Saliva tests on users	Declared by users	Declared by doctors	Declared by doctors	Declared by doctors
Number of patients	15279	1703	689	249	1004	197	95	300
Year	1999	1995	1996	1996	1998	1997	1996	1996
Geographical zone	France as a whole	Paris and Parisian region, Lille, Metz, Marseilles	Départements of Nord, Rhône and Seine Saint-Denis	Toulouse	France as a whole	Vaucluse	Hauts de seine	Paris, Strasbourg, Nice, Bordeaux

Source : OFDT

Prevalence of HIV and HCV among users in custody

According to a survey conducted in four French prisons among 1,212 detainees in 1997 et 1998 it was found that more drug users were likely to have tried HIV or HCV screening tests. On the other hand the vaccination cover against hepatitis B was fairly close among users and non-users, and was totally inadequate. Also prevalence of HIV and HCV obtained from voluntary saliva tests was higher than in the general population and particularly alarming among the drug users.

Practices at risk and prevention among detainees according to drug use

	Non user(57 %)	Non injectable drug users (43 %)	UDVI (12 %)	Active UDVIs (9%)
HIV screening	59 %	78 %	76 %	76 %
HCV screening	20 %	37 %	58 %	59 %
HBV vaccination	24 %	34 %	27 %	24 %
Prevalence of HIV	1,5 %	3,1 %	11,4 %	13,3 %
Prevalence of HCV	3,5 %	14,3 %	52,5 %	55,3 %

Source : European prevention network for HIV and hepatitis in prison, 1998 report

14.3 New developments and uptake of prevention/harm reduction, care

The policy of the battle against infectious diseases among drug users in France

Risk reduction measures

In France, the policy for reducing risks of infection was instigated by the authorities in the nineties to cope with the spread of the HIV and then hepatitis C epidemic among intravenous drug users.

The objective pursued is to facilitate access to syringes and all sterile injection equipment for intravenous drug users. It is also to combat complications arising from the use of drugs :

- complications associated with the use of venous routes and the injection of products in poor hygiene conditions ,
- social problems associated with isolation and wandering

Further to the 1987 decree on the deregulation of sales and the plan of campaign against drug addiction adopted in 1993 several initiatives by the minister responsible for health have encouraged the development of action to reduce the risk of infection :

- State support for setting up syringe exchange schemes, installing dispensers and the opening of neighbourhood hostels (drop-in and sleep-in centres)
- marketing of prevention packs for intravenous drug users (Stéribox®, Kits®, and Kap®)

This scheme is intended to provide access to injection equipment whatever the social situation of the drug users. It is based on the actions of the players involved in the risk reduction policy being complementary :

- pharmacists who issue syringes singly and prevention packs
- associations managing syringe exchange programmes
- associations managing the hostels
- local authorities who are responsible for installing automated machines, dispensers, syringe recovery and exchange schemes (prevention packs)

Syringe exchange programmes

The exchange of syringes began at the end of the eighties on the initiative of humanitarian associations such as Médecins du monde. However there were still less than about ten syringe exchange programmes in 1993. The plan adopted that year incorporated the development of syringe exchange programmes in its objectives. On first March 1994 16 programmes were being financed and there were 61 in 1996 and about a hundred at the end of 1999. The PES distribute syringes singly or prevention packs. The syringe exchange programme teams are supposed to implement neighbourhood schemes among users in their habitual environment. That is why they are usually based in a mobile unit or "bus" fitted out for the purpose. Unfortunately we have no recent information about the evolution of the number of syringes distributed by the PES.

The Stéribox and other prevention packs

Further to the pilot scheme conducted by the Apothicom association in the regions of Ile-de-France and Provence-Alpes-Côte d'Azur, the sale in pharmacies of the Stéribox® prevention pack, containing roughly the same as the Kit® or the Kap®, has spread throughout France. State subsidies enable this prevention pack to be sold at a modest price. More than 2.9 million Stéribox® were distributed or sold in 1999, that is about 240,000 per month. Since 1996 the number of Stéribox sold had been increasing. Sales in the first half of 2000 are less than the first half of last year. However the Stéribox® only represents part of the total of syringes sold to users (estimated at 30% in 1997). Consequently it is difficult to determine the overall development of the number of syringes sold or distributed to drug users.

The Stéribox® is a prevention pack intended for intravenous drug users. It contains two syringes, two alcohol plugs and sterile water for the injection. State subsidies enable it to be sold at a modest price. Kits and Kaps are distributed free by associations working in the field of risk reduction. The content of the packs was modified in 1999 (Stéribox 2®, Kit+®) to better respond to the risks of HCV infection associated with sharing injection equipment Since then they contain two heating and dilution vessels, two filters and two dry plugs in addition to the previous content.

Dispensers

The installation of syringe recovery units and automatic dispenser units for prevention packs on public streets, encouraged by the authorities, is a decision governed by the town halls. The investment expenditure necessary to these installations can be borne 100% by the State, the running expenses are borne by the local district authorities. At the end of 1999 there were about 250 automated units, dispensers, recovery and exchange units for prevention packs. These include electronic or mechanical exchange units (one syringe for one token), simple recovery units (syringe bins), mechanical dispensers (one kit for one token) and finally prevention posts or poles (modular urban

fixtures which may contain a mechanical recovery unit, a mechanical dispenser of Kit+, a contraceptive dispenser and an information panel). Two categories of dispenser are currently available on the market: dispensers installed on the street, usually set up at the initiative of the municipality, and the Stéribox 2 dispenser, fixed to the wall of a pharmacy and activated when the latter is closed.

Drop-in centres

The drop-in centres are reception centres for active drug users at serious risk, who do not wish to interrupt their consumption of products, or at least not yet. Two drop-in "shops" -from the name of the first reception centre - were created in 1993. Their number increased rapidly and reached 34 at the end of 1999.

Risk reduction arrangements as at 31st December 1999

Type of arrangement	**Number**
Syringe exchange programmes	Around 100
Drop-in centres	34
Number of Stéroboxes sold	2,9 million
Number of automatic dispensers	250

Source : Board of Health / SD6B/ AIDS Division

The risk reduction policy in 1998, as expressed in a circular from the AIDS Division of the Health Board, follows the line of previous years. Aware of the risk of divisions between the first stop structures (drop-in centres, buses) and common law and specialised structures, the circular calls for the risk reduction culture among all the players in the health and social sectors to be developed further. The circular also proposes that associations should prepare "general" risk reduction projects directed at marginalised populations apart from just drug users.

The three year plan adopted by the MILDT in 1999 provides for the development of the risk reduction policy by creating jobs in front line structures, programmes for exchanging syringes and mobile neighbourhood teams in the most difficult district, together with automated syringe dispensers.

The national plan to combat hepatitis C[35]

To deal with the major public health threat which hepatitis C represents, and bearing in mind the new prospects for treatment, a national plan to combat hepatitis C was adopted by the government in 1999. It gathers together in a single coherent measure prevention, screening, care and research. This plan of campaign relates to all the populations affected or likely to be affected by the hepatitis C virus. Drug users who constitute one of the most exposed populations are in the front line of the plan's provisions.

Since 1990 various measures to combat hepatitis C have been adopted. They have covered the raising of awareness and information among the professionals, making safe blood products, ease of

[35] The text which follows basically reproduces extracts from the file on hepatitis C held on the website of the Ministry of Employment and Solidarity www.sante.gouv.fr

access to screening and care with a 100% referral of files since 1993 and target screening, recommended targeted care and reorganisation of care around 30 points of reference on hepatitis C enabling work to be done on a network basis. However in spite of these measures screening remains inadequate and the proportion of sick people benefiting from antiviral therapies remains limited. In view of this situation the programme defines, over a 4-year period, national priorities to be implemented at regional and local level. Its aim is to facilitate and enhance access to screening and the offer of care through networking around the sick person. This programme also places the emphasis on the prevention of infection with the hepatitis C virus and on training and research. It is accompanied by fresh measures. State loans for the fight against transmissible diseases were increased in 1999 to allow for specific campaigns against hepatitis (16 million francs) and responsibility for new treatments has been incorporated into the national objective of health insurance expenditure in the Social Security financing law.

Increased access to screening

Objective

To ensure, by the year 2002 that at least 75% of patients carrying HCV know their serum status (30 % knew it in 1994, currently over 40%).
To do so, among other things there has to be more information given to people who are particularly exposed and doctors need to be made aware of the value of screening anyone who may have been contaminated through the blood or who presents clinical signs suggesting hepatitis C.
Since 1997 the remits of the anonymous and free screening centres have been expanded to include screening for hepatitis C.

New measures contained in the plan

- Encouraging screening by a targeted and appropriate campaign of information (2 million francs in 1999) among people who are particularly exposed (intravenous drug users or sniffers, former or current; people who received blood transfusions prior to March 1991).

- Additional funding (1.5 million francs in 1999) enabled the offer of screening in the CDAGs, the General Council dispensaries and the care units in penitential institutions to be expanded.

The resources
3.5 million francs for new measures in 1999. These funds are additional to the 10 million francs already allocated to screening for hepatitis C and HIV among intravenous drug users.

Improving care uptake

Objective

By the year 2002 at least 80% of patients requiring antiviral therapy should be in treatment. .

Measures already adopted

In 1998, a 12 million franc loan enabled 30 hepatitis C bases to be enhanced, dealing with diagnostic and therapeutic protocols. They are responsible for informing health professionals, coordinating scientific research work and supporting epidemiological monitoring. They also develop HCV networks. In 1995 and 1996 loans amounting to 10.7 million francs enabled them to be set up.

New measures contained in the plan

- "HCV networks" to be developed. Organised around the individual, these networks make it possible to improve the quality of care thanks to cooperation between the free and hospital sectors and user associations. More than four thousand patients consult one of these structures every day.

- Ribavirin received a marketing licence in 1999. The European conference on hepatitis C in February 1999 recommended treatment by dual therapy in all new or relapsing patients; depending on the case the treatment takes 6 months or one year (the cost of treatment in dual therapy is around 40,000 francs for 6 months and 80,000 francs for one year).

- The setting up of a combined medical file for people infected by HCV will make it possible to involve the different health players in order to improve the organisation and quality of care and follow-up. It will be sent to every person involved.

- Making available to people living with HCV an information booklet on the physiopathology of HCV, the aggravating factors in the infection – in particular the consumption of alcohol – and treatments will facilitate treatment compliance.

The resources

12 million francs in 1998 and 13 million in 1999 to enhance centres and hospital clinical service, 7.4 million for new measures for neighbourhood network action and information to the professionals.

Reducing the risks of new contamination by HCV

Objective

Reducing the incidence of HCV infection among intravenous drug users and sniffers, and also reducing the risks of nosocomial infection.

Existing measures

- Informing intravenous drug users and sniffers and making them aware of at risk behaviour which could transmit HCV.

- Recommendations on decontamination, disinfection and sterilisation practises in hospital environments.

New measures

None of these new measures specifically affects drug users. Nevertheless one can cite:

- Ongoing experiments and evaluation of the PCR dose in blood donation in order to reduce the residual risks in transfusion,

- Reinforcement of hygiene measures in prison: making available equipment for individual and/or disposable use (razors, toothbrushes...),

- Stepping up the battle against infections of viral origin through committees for combating nosocomial infection (CLIN). Preparation and distribution of good practice protocols in particular for disinfection of medical material.

- Installation of new screening and follow-up systems for people accidentally exposed to blood (care protocols are in preparation).

- Establishment of training for professionals, in particular on the history of the disease, treatment indications and good practice for admission to care,

- Establishment of regional guides intended for socio-health workers working in the various structures and their functions in relation to screening and taking care of HCV patients.

The resources

In 1999 35 million francs allocated to risk reduction measures for drug users and 2.6 million francs for new measures to progress communication campaigns among other target populations.
The battle against transmission of the hepatitis C virus is a priority among measures to improve hygiene in health establishments.

Improving knowledge

Objective

Developing knowledge of :

- the clinical evolution of treated and non-treated hepatitis C,
- the incidence of serious events,
- morbidity indicators (cirrhosis, hepatocellular carcinoma),
- new contaminations.

Several clinical, therapeutic and epidemiological studies financed within INSERM or by the ANRS and the Hospital Clinical research programme are to be pursued or developed, thanks to the establishment of a reference group of people living with HCV. These will deal chiefly with:

- as yet little understood methods of contamination (studies of primary infections),
- at risk behaviour and the role of combined morbidity factors,
- doctors' attitudes to screening and patient follow-up
- the clinical evolution of patients with a single HCV infection and patients with combined HCV and HIV infections
- the efficacy of different therapeutic strategies.

Resources
In 1998 more than 20 million francs was allocated to research into hepatitis C,
In 1999 an additional 9 million francs is to be reserved to research into HCV, in particular through the expansion of the remits of the ANRS.
Hepatitis C has been retained as a priority topic for the Hospital Clinical Research Programme.

Monitoring and evaluating the evolution of the epidemic

Objectives

- Monitoring the epidemic by tracking the prevalence of the infection and the incidence of new cases diagnosed
- Evaluating the evolution of recent infections and consultations for screening and care.

Action

- Monitoring of cases of newly registered hepatitis C patients: this continuing monitoring project is designed to follow the progression in care of hepatitis C through the three stages: screening, care consultation and care uptake. It will be based on information collected regularly from the hepatitis C reference centres. The monitoring will complement the collection of information on hospital activities established by the Hospitals Board and the Board of Research into studies and evaluation of statistics of the Ministry of Employment and Solidarity.
- New HCV infections: here it is a case of identifying, through a national survey, the residual methods of transmission of HCV (in particular nosocomial). This study of recent serum conversions was recently set up among regular blood donors (French Blood Agency); it is to be extended to other sources of data. On the basis of this survey a reference group of people with a known infection dates will be set up.
- Other studies of new infections **:**

o Incidence of HCV infection in a reference group of intravenous drug users in the regions of Lille and Metz : this project was started in 1999 thanks to joint funding from the National public health network (RNSP) and the national AIDS research agency (ANRS).

o Survey of HCV infections after accidental exposure to blood and monitoring of viral hepatitis among blood donors. The monitoring of regular blood donors shows an incidence of 2.69 per 100,000 people per annum.

At national level the work of the different hepatitis registers is to be coordinated.

Resources

In **1**998 the funds allocated by the national health monitoring institute (InVS) to the epidemiology of hepatitis C were stepped up (+ 1,2 million francs).
In 1999 2 million francs were specifically allocated to this epidemiological evaluation.

Evaluating the programme

Objective

Adapting the programme to the evolution of therapeutic knowledge and to the needs of the people concerned.

- **At national level** : a follow-up committee will be responsible for implementing the programme and its evaluation and any re-alignment. This committee will link all the structures involved with the epidemic of hepatitis C infection. The evaluation will cover:

  o the resources used ;

  o the number of people taking up care ;

  o comparisons with other countries.

- **At local and regional levels** :the programme will be adapted and piloted by the decentralised services of the state, taking into account the epidemiological and local demographic characteristics in conjunction with the reference centres.

The resources 500,000 francs per annum have been allocated from 1999 onwards for the evaluation of the national programme to combat hepatitis C.

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