Observatoire Français des Drogues et des Toxicomanies
French Monitoring Centre for Drugs and Drug Addictions

DRUGS AND DRUG ADDICTIONS

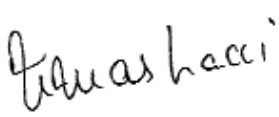
Indicators and Trends

1999 Édition

The publication of this new edition of "Indicators and Trends", two and one-half years after its last publication, provides an updated and in-depth look at the current state of the use of psychoactive substances and the resulting consequences of this use. It is important to emphasize that this work was designed to facilitate the implementation and evaluation of public policy.

This undertaking, which was carried out in a very precise and pedagogical manner, proved to be particularly useful within the framework of preparing the 1999-2001 triennial plan for the fight against drugs and the prevention of drug addiction. It will constitute a reference for all those involved in providing new impetus to public action in this field.. Centred on behaviours, and not only substances, this report fits within the scope of the new approach developed by the public authorities.

As was the case with the first two publications, this report is the fruit of a collective effort based upon the confrontation of varying points of view and approaches from different disciplines. We would like to welcome this report and thank each individual and organization that at one time or another participated in its preparation.



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As the Observatory publishes the third edition of this report, government authorities have just finished outlining new orientations and provided new momentum to actions to be taken for the prevention and reduction of harm caused by the consumption of psychoactive substances. The evaluation presented in this report, in conjunction with the launching of a new governmental triennial plan in this area, makes it possible to better understand the scope and complexity of the phenomenon with which we are faced.
All of this work was conducted under the aegis of the Scientific College, which was associated in each phase of the report and validated the final draft.

Public policy is moving toward a new approach, one that endeavours to prevent and deal with all uses of psychoactive substances in spite of their individual judicial status. While this approach recognizes the medical and social characteristics of each substance, it gives priority to the notion of behavioural use rather than the notion of substance. In order to better fulfil its mission, who is angled toward providing help in decision-making, the Observatory must broaden its range of observation accordingly. This present report is an initial illustration of this broadening, as it takes into account alcohol, tobacco and psychoactive medications in the same capacity as illicit drugs. However, considering the fact that this extension is fairly recent, it was not always possible to put all information into a global perspective. It has remained limited to certain areas, mainly such as the description of uses.

Definition of Drugs

In French, the term "drug" may have several different meanings. In the XIXth century, it was initially applied to substances prepared by apothecaries. The word progressively took on a pejorative connotation, opposing medication to substances whose therapeutic effectiveness was questionable, or could be used purely to seek pleasure. In current language, the word drug is often associated only with illicit substances that are classified as narcotics. Lawyers, policemen and judges have also accepted this definition of the term. Clinical doctors classify substances in function with their capacity to lead to addiction and harm the physical and mental health of their patients. Specialists in toxic substances differentiate in function with the intrinsic toxicity of each substance, regardless of the risk of addiction and health and social consequences involved in taking it. This subject is difficult to discuss because of the ambiguity of the word. It is thus necessary to begin by defining this term as clearly as possible.

Definitions found in current dictionaries refer to the toxic character of "drugs" ("toxic substances, narcotics" - according to the dictionary *Grand Robert*), and the addiction they create ("Natural or synthetic psychotropic substance, that causes a desire to continue consumption in order to re-experience the good feeling it provokes" - according to the *Grand Larousse Universel*). Definitions in more specialised works contain the same elements. The *Dictionnaire des drogues, des toxicomanies et de la dépendances** defines the term drug as a "psychoactive substance that could cause abusive use and is capable of leading to manifestations of addiction." According to Inaba and Cohen's reference guide on uppers, downers and hallucinogens*, "any substance that causes distortion in the functioning of the central nervous system" may be considered a drug.

Thus, to clarify the concept of "drug," there are two accepted definitions of the word. The first is very broad, toxicological in type, and corresponds to the last definition mentioned. Many medicines would thus be included as drugs. The second definition, more restrictive, is based upon the notion of addiction. The latter has been defined by the international scientific community (refer to annexe 1 of this report).
Within the framework of this report, the **temporary definition** that follows was used to define the term "drug": Natural or synthetic substance used with the intent to alter one's state of consciousness, for which use may be potentially harmful, abusive or addictive, and which may be legally or illegally used. This definition includes: narcotics (UN conventions), alcohol, tobacco, glues and solvents, hallucinogenic mushrooms, and synthetic substances that have yet to be classified. This definition excludes vital substances (water, air), coffee, chocolate, and psychoactive medicines not being used to alter one's state of consciousness.

Based upon this definition, and by convention, the term **"drugs"** (or sometimes "psychoactive substances") covers all of the substances taken into account in the report. This includes the following subsets: **alcohol, tobacco**, "psychoactive medicines", and **"illicit drugs"**. **Psychoactive medicines** include the following four classes: hypnotics, neuroleptics, sedatives, and anti-depressants. Illicit Drugs include narcotics (not medically prescribed) and some misused substances not classified as narcotics (i.e. glue, solvents, hallucinogenic mushrooms, synthetic substances, misused medicine). In an attempt to simplify the language used, the singular term "drug" will be used in the sections dealing with illicit drugs.

Definition of Drug-Use Behaviours

In regards to behaviours, there are three distinguishable categories: use, harmful use, and addiction. These are common distinctions within the international scientific community. They are based upon definitions used by the World Health Association (CIM 10) and the American Psychiatric Association (DSM IV).

Use is the definition of non-harmful consumption, which may vary in intensity and be qualified as: experimental, occasional, or regular.

Harmful use or abuse defines any consumption, which involves, or could involve, harm. The nature of this harm may have health (somatic or mental), social (incapacity to fulfil obligations: work, school, or family etc…) or legal implications. This harm may be dependent upon specific contexts in which substances are used (driving an automobile or pregnancy). Lastly, this harm may be caused by the user him/herself or by another party.

Addiction is the definition of psychopathological behaviour, which has biological, psychological, and social characteristics. The main criteria contributing to its definition are: experiencing a compulsive desire for a substance, having difficulty controlling use, taking a particular substance in order to avoid withdrawal symptoms, experiencing the need to increase doses to feel the same effects, and having a substance occupy a central position in the user's life.

These international definitions, written from a clinical perspective, lead to certain problems. An example is that some dangerous, but occasional, forms of use are not included under the term of harmful or abusive use. It is also true that much discussion could be given as to the definition of addiction. Moreover, it is difficult to take these concepts into account in a statistical manner. In some cases it is possible to distinguish between harmful use and addiction, and effort should be made to go in this direction. Nevertheless, in the report, the two concepts will be understood in a global manner under the empirical term **"problem drug use"** in addition to the term **"use"** which is understood to be non-harmful or repetitive use.

Thus, the terms **"use/user"** and **"consumption/consumer"** will not only be used to encompass behaviours from the three categories described above, but also consumption behaviours for all psychoactive substances and corresponding populations. The terms "addiction/drug addict" will be used as ordinarily understood, linked to the phenomenon of addiction to illicit drugs.

Sources of Information

Surveys are based upon statements made by respondents. This type of investigation is designed to measure the global population's behaviours or attitudes toward drug use. Methodology, which has been implemented to this effect, is supported by constituting a representative sample, which may sometimes be limited to a fraction of the total population (i.e. age groups). The main advantage of using this method is that it enables one to make direct measurement of the phenomenon throughout the entire population, and more particularly, its size. Therefore, surveys provide a picture of consumptions that have been declared. These data may be matched up with data on the sale of various substances when they are available. If this is the case, we can evaluate how well they can represent true consumption.

It is also possible to estimate some harmful uses by using national statistics derived from mandatory notifications, which provide data on harm that has been induced (death, AIDS ...).

Administrative statistics and some studies, which target a specific clientele as defined by the particular institution working in the field (i.e. health/individuals undergoing treatment, justice/incarcerated individuals), provide partial estimates: consumers seen in a particular institution. It is, by definition, not possible to calculate the size of the hidden population not seen by the institution.

A final approach uses specific studies that deal with population sub-groups directly affected by drug use, but have not been selected by institutions. An example of this would be ethnographic works. In addition to quality descriptions of uses and behaviours, this type of approach makes it possible to reach the "hidden" part of the phenomenon: individuals not seen in any institution.

It is currently important to highlight the limits of existing information sources in France.

This is particularly the case for general population surveys. There are many different surveys of varying lengths (quarterly to decennial), and partial coverage in terms of the age of the surveyed population and substances taken. Moreover, the way in which consumptions are described and questions are formulated varies from survey to survey, making it difficult to monitor the phenomenon's evolution. Survey methods differ, not always making it possible to obtain a reliable calculation of the estimated quality of the results. The various questioning procedures used (telephone, one-on-one...) introduce non-measurable bias when comparing results.

A large portion of available data comes from administrative statistics, and is thus based upon populations "captured" within institutions. This is particularly the case with illicit drugs. They reflect part of the phenomenon and the action taken by the institution in regards to it. The production of these statistics meets the needs of institutional logic and the institution's need for information to carry out its action. These sources of information are particularly valuable when analysing heavy trends because they are dependable, consistent, and available. Nevertheless, using them may be tricky, and it is important to take their limits into account. The indicators they produce are "indirect indicators" for which the inherent inertia of the way in which they are produced generally does not make it possible to highlight recent trends in a phenomenon. Moreover, these sources of information present specific problems: limited theoretical field, reliability and double counting.

Work Method

In this report, a multi-disciplinary attempt to synthesize available data and analyses on drugs and drug addiction has been made, in order to avoid the usual over-segmented approaches taken in this field. Significant and innovative efforts are needed to present this phenomenon, its evolution and patterns in the most global manner possible. It requires work designed to explore, clarify, and compare series of numbers. This must be done even though data has been derived from completely different sources, have often been produced using different methodological protocols, both qualitative and quantitative: clinical, statistical, epidemiological and ethnographic data. This work is not always obvious, and creates the very basis upon which such a multi-disciplinary process can be developed.

The organisation used in drawing up this second report is identical to that used in the preceding reports. The Observatory oversaw up the supervision and writing of the report with the help of a project group. The diverse skills and approaches of its members richly contributed to defining its orientations and the various steps necessary to carry it out. The scientific college was involved in validating the initial orientations as well as the rest of the report. Competent experts from outside of the Observatory validated each chapter.
The process that was selected is one that strives to achieve both pedagogical and technical objectives. Not only is there a question of presenting indicators and uncovering patterns, but also of clarifying their origins and limits in their interpretation by trying to interpret information through the confrontation of various points of view.

The report is comprised of three sections. The first section is dedicated to presenting the legal and institutional framework under which drug consumption falls. It goes beyond a simple reminder of key legislation related to different drugs by retracing the evolution of actions taken by public authorities over the past 30 years, and describes the current state of systems used in fighting drugs.

The second section deals with measuring the drug phenomenon in France and is supported by a certain number of indicators. Thus, only the quantifiable aspects of this phenomenon are described here: concerning demand (number of users, problem users, related characteristics, and measurement of harm incurred linked to drug consumption); concerning supply (number of individuals affected by drug business, seizures, etc.). For each question addressed, there is at least one statistical indicator of measurement that may be monitored from one period to another. Data are critically presented along with methodological information. When possible, the process of observing this phenomenon by using indicators is supplemented with data from selective surveys or qualitative studies.

In the third section, articles written by various authors are presented. These describe results of surveys, studies, or research. This work, which may fall into different scientific fields, sheds additional light on the subject, and may even contradict measurements from indicators. They may include questions that have not yet been considered, or aspects that they are unable to clarify (qualitative approach, short term patterns that indicators will not be able to interpret before a certain period in time). The OFDT sought out authors with scientifically guaranteed research. However, only the authors are bound by the context of each work.¤

*Richard (D.), Senon (J.-L.), Dictionnaire des drogues, des toxicomanies et des dépendances, Larousse, 1999.
**Inaba (O.S.), Cohen (W.E.), Existant calmants, hallucinogènes : effets physiques et mentaux des drogues et autres produits actifs sur le psychisme, traduit de l'anglais par Lagier G., PICCIN, 1997

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Each OFDT report is an occasion for us to devote ourselves to the difficult task of assessing recent trends in the field of drugs and drug addiction. We would like to repeat that our goal is not simply to synthesize the elements described in this report, but to select prominent characteristics derived from confronting existing quantitative data with more qualitative approaches ("expert") on the current evolution of the phenomenon.
The mission of the OFDT was recently broadened to cover alcohol, tobacco, psychoactive medications, and stimulants. For certain aspects, such as the evolution of consumption, it has already been possible to uncover certain patterns for the different drugs. For other aspects, the OFDT is currently only able to assess patterns for illicit drugs.
In this report, we would like to highlight the most outstanding features of changes that have occurred in the drug situation since the first OFDT report was published before going into detail about measurable changes in the different fields of observation.

■ The first element to note was the strong decrease in overdose-related deaths and AIDS-related deaths amongst drug users. These two changes have independent origins.

■ We have also observed that there has been an important drop in heroin use over the last years. This phenomenon is most likely partially linked to a decrease in the number of deadly overdoses. It is possible that this decreasing trend had been occurring for several years, but had not been perceptible. It appears that in 1997 and 1998, this phenomenon was unquestionably occurring, showing up in statistics on arrests of heroin users and traffickers as well as field observations. This development is linked to the rapid increase in the number of individuals undergoing substitute treatment since 1996, and to a loss of the popularity of this substance.

■ Nevertheless, this decreasing trend has been contradicted by the appearance of occasional heroin use amongst young people in the wake of synthetic drug use. At the present, this use is very limited but has perhaps been hidden until now. It is still too early to know if there is a dynamic involving new use of this substance, or if it is the persistence of residual heroin use.

■ Lastly, the third important change to point out was a normalisation of the use of cannabis.

Drug Use

Illicit Substances :

■ Cannabis consumption is becoming more and more commonplace, particularly amongst young people. There is a growing distance between the law and its implementation on one hand, and use on the other. Cultivating cannabis is a developing phenomenon.

■ It also appears that the use of synthetic substances, belonging to the families of stimulants or hallucinogens, is on the increase. However, it is not possible to confirm this pattern with current available indicators. New use of anaesthetizing substances, such as Ketamine and GHB has been observed, as well as the development of new substances such as DOB (derived from amphetamines).

■ The decreasing trend in the number of "problem" heroin users has continued.

■ Cocaine use is on the increase. This phenomenon has shown up in arrest data, surveys conducted amongst young people, as it has in observations from the field.

■ Intravenous heroin use is certainly on the decrease even if we do not have indicators that can clearly show this. On the other hand, we have noted that injection has appeared as a method for taking stimulants.
- Amongst young people, using drugs and associating multiple substances during festive occasions (including licit substances) is on the increase.

Licit Substances :

■ Average alcohol consumption (the quantity equivalent to pure alcohol) is in a long-term decreasing trend. This decline was weaker in the 1990s. It is not possible with available data to clearly define recent developments in this phenomenon. Nevertheless, it can be shown that there has been an increase in the number of drunken episodes amongst young people, and an increase in the number of regular consumers of alcoholic beverages other than wine.

■ Average tobacco consumption has been declining since the end of the 1980s. This trend was still present in 1997. The number of men stating they use tobacco is declining while the number of women smokers is on the increase.

■ The sale of anti-depressants greatly increased until 1997 (last figure unknown). On the other hand, there has been a decrease in the sale of anxiolytics. There has been a strong increase in the misuse of some types of medicines.

Health Treatment

■ The number of drug users treated by general practitioners increased from 1995 to 1997. The number of doctors seeing drug users seems to have stabilised and increased treatment seems to be mostly linked to a greater number of appointments with doctors already treating this type of patient.

■ There was a large increase in the number of individuals treated in specialised drug addiction treatment centres and hospitals between 1996 and 1997.

■ 1996 and 1997 were marked by a large increase in the number of substitute treatments using Subutex, which most likely explains a large part of the treatments noted amongst regular doctors, hospitals and specialised centres. The number of prescriptions given for Subutex was much lower at the end of 1998.

■ The French are almost unanimous in accepting the principle and usefulness of providing health and social treatment to drug users. However, many difficulties are encountered when this idea must be implemented. There is growing opposition amongst local residents regarding the implementation of health and social treatment centres for drug users near their homes.

Consequences of Illicit Drug Use

■ The number of overdose-related deaths has strongly decreased from year to year since the middle of the 1990s after experiencing an almost steady increase since the 1970s. The percentage of heroin-related deaths has decreased while medicine-related deaths have increased.

■ There has been a spectacular drop in the number of drug users dying from AIDS over the last few years. This development is largely due to recent therapeutic progress that has resulted in a global decrease in the number of AIDS deaths, despite the way in which these individuals were infected. For this same reason, the number of new AIDS cases also strongly decreased.

■ HIV prevalence has decreased since the beginning of the 1990s at different speeds according to different regions. Since the middle of the 1990s, this change seems to have occurred more slowly, at least amongst drug users being treated in specialised centres. This development must be confirmed.
The number of HCV seropositive individuals, amongst the "problem" drug users, is still at a very high level. The number of individuals who stated they did not know their serological status has decreased. HCV prevalence as stated by the users themselves is on average lower than the rate of prevalence determined by surveys based upon biological testing.

Law Enforcement

■The number of arrests for drug-related offences has strongly increased over the last few years. This development is the result of contradicting trends: a strong increase in the number of individuals arrested for cannabis use, and a decrease in the number of heroin use-related arrests. The number of arrests for cocaine use has increased, even though it is still fairly limited. In some departments, the number of arrests for cocaine use was higher than the number of arrests for heroin use, which had never before occurred.

PUBLIC POLICY AND THE FIGHT AGAINST DRUGS

■ Anti-Drug Policy - legal framework and developments

■ Structures and means used in the fight against drugs

ANTI-DRUG POLICY
LEGAL FRAMEWORK AND DEVELOPMENTS

This chapter provides a description of the legal and institutional system used in the fight against drugs and drug addiction in France. In the field of drugs, where involvement on the part of public authorities goes virtually unquestioned, there is constant interaction between activities conducted by the authorities and drug use. Understanding public policy[1] and its history, are necessary elements in successfully observing the drug phenomenon.

The case of both illicit and licit drugs will be successively dealt with in this chapter. Recent publications of conducted research, study projects and reports, and the original specialization of the OFDT on illicit drugs, have been used here to describe developments in public policy in the fight against these substances since the Law Of 1970 was created.

Contributions made by the OFDT in the field of licit drugs are still fairly recent. Thus, information in this area is more limited to covering key legal and regulatory legislation.

Illicit Drugs

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 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 on December 29, 1988 the category of narcotic substances).

Punishment for **trafficking** is particularly harsh[2] , and 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[3] , 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"[4]. 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 «Departemental» 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.

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).

[1] *Our definition of public policy here is restricted to actions conducted by the government in a given field, and not the broader definition of coordinated and voluntary action with the goal of achieving a well-defined objective with specificcally identified means.*

[2] *According to article L-627 of the public health code imprisonment for importing, exporting, producing or making narcotics spans from 10 to 20 years (until 1994-it was then transferred to the new penal code).*

[3] *Article L-628 du Code de la santé publique (Public health code).*

[4] *Article L-355-14 du Code de la santé publique (Public health code).*

Legislative Measures 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 to the one applied to 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 organized 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.

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 prefets 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, organizing 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. It did not reconvene until 1993.

At the same time an administrative coordinating structure was created. It 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 Report[5], 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 organization 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[6] that the there is some "ambiguity" in this situation.

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 organize 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 departements, this new structure was unable to find its place. New measures for local coordination were made in the 1990s.

[5] *TRAUTMANN (C.), La lutte contre la toxicomanie et le trafic de stupéfiants, rapport au Premier ministre, La Documentation française, février 1990.*
[6] *Cour des comptes, Le dispositif de lutte contre la toxicomanie, Rapport public particulier, Cour des comptes, Paris, 1998, 248p.*

The coordination of local actions was redefined in a letter written by the Prime Minister on July 9, 1996[7]. An assessment of departmental committees for the fight against drug addiction showed that only 30% of the departements 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 computerization 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 specialized 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. At time of publication, a new triennial plan was in the works.

Implementation of the Law Of 1970 and Evolution of Public Policy

The implementation of the Law Of 1970 quickly caused problems and led to an abundant production of administrative documents, implementing decrees, circular letters and notes. Questions in the legal domain dealt with distinguishing between use and trafficking, the notion of use, and court-ordered treatment. The second aspect, related to health, concerned practical ways of treating drug users. Three reports, Pelletier (1978), Trautman (1970) and Henrion (1995), assessed the implementation of the law and policies related to fighting drugs and drug use. Existing administrative texts and the three official reports support the description of evolution in public policy presented here.

[7] *Circulaire du 9 juillet relative à la lutte contre la drogue et la toxicomanie au niveau départemental, NOR : PRMX9601580C, JO du 10 juillet 1996.*

Legal Policy

Problems were encountered in applying the law right at the beginning of the 1970s. These problems were linked to the dual nature of users, who were seen to be both delinquent and ill, and to questions about the line between using and trafficking drugs.

Initial Circular Letters Regarding the Application of the Pelletier Circular Letter
iThe first part of a letter sent out by the Ministry of Justice stated that the object of the new law was to "increase punishment for drug trafficking and incite users to seek treatment[8]". While the letter left the prosecution the freedom to evaluate each case, it indicated that individuals should be charged when drugs had been acquired, held, or transported for personal use. On the other hand, individuals could not be charged with only this in any cases when drugs had been provided or supplied to another individual. This letter also stated that individuals accused of using drugs could not be temporarily held.

Apparently, all prosecutors did not follow these recommendations since a 1973[9] circular letter criticizes "straying" from the law by prosecuting users under article L.627. The latter was written to repress trafficking, holding small quantities of a substance, and cases where in individual was caught using drugs.

In a roundabout fashion, this letter brings up the question of user-dealers. The law distinguishes trafficking from use, but leaves it up to the judge to determine where to draw the line between these two categories. It appears that in the 1970s and the beginning of the 1980s, users-dealers were treated more often as users than traffickers. Yet, in 1977 a new circular letter[10] recommended that users-dealers, who were accused of seeking to influence others[11], should be more frequently sentenced to time in prison. There was an increasing amount of recommendations that the courts be harder on user-dealers throughout the 1980s.

The end of the 1970s was marked by the publication of a report produced by the Pelletier Commission. Upon a request by the president of France, it established an initial assessment of anti-drug policies seven years after the law was enacted. The report regretfully stated that the most common method of dealing with users was through legal consequences. It also noted a consistent increase in the number of users who had been temporarily detained. The report highlighted that treatment alternatives, which had been written into the law, did not work well. Quantitatively speaking, fewer individuals were ordered to undergo a treatment programme than were convicted for use. It was difficult for legal and health authorities to work together, and doctors, especially, were sceptical and reserved about the principle of forcing an individual into treatment.
The Pelletier Report made its mark by proposing the idea that drug users should be differentiated according to the substance they have taken. According to a circular letter[12] inspired by the report, cannabis users cannot be considered to be "true" drug addicts, and detoxification treatment and court-ordered treatment are not appropriate for them. Thus, in most cases, cannabis users should only receive a simple warning. Court-ordered treatment should only be used for repeat offenders.

At the time, this letter was perceived to decriminalize cannabis use. As with all circular letters, it expressed the intentions of the Ministry of Justice but could be diversely enforced by the prosecution. However, it was a point of reference until 1987.

From the Pelletier Circular Letter to Reviving Alternative Treatment
On a legal level, the decade of the 1980s appears to have been a period of time marked by security problems, during

[8] *Circulaire n° 71-8 du 25 août 1971.*
[9] *Circulaire n° 73-11 du 30 mars 1973.*
[10] *Circulaire 69F389 du 7 mars 1977.*
[11] *Ibid.*
[12] *Circulaire 69F389 du 7 mai 1978.*

which, there was a growing desire to repress trafficking, users-dealers, and delinquent acts committed by users. Since bills that recommended taking a more restrictive attitude towards users were unsuccessful, this period finally led to the option of alternative treatment. As a result of this, public authorities then began trying to improve the implementation of this measure.

A circular letter from 1984[13] came back to the question of use-resale. Although it deplored the fact that one could still be sentenced to hard time just for using drugs, even though this rarely occurred, it revealed worries that drug-related delinquency was on the increase. It encouraged prosecutors to try to discover if trafficking was more important than using drugs amongst user-dealers. According to the Trautman Report, this circular letter greatly changed the legal approach to the problem "by tending to no longer excuse an offence because of drug use, and integrating imprisonment into the normal path of a drug user who always deals at one time or another"[14].

This same circular letter mentioned that court-ordered treatment had "shown its limits because of the restrictive character of the treatment" and the association between doctor and judge "under conditions which were difficult for the user to understand."[15] This letter subtly expressed how discredited the concept of court-ordered treatment was at this time.

In 1986, a newly elected majority intended to modify the Law of 1970 by making it more repressive and restrictive for big traffickers, dealers, and users. Bills regarding users were based upon the failure that it perceived of the concept of court-ordered treatment. The bill presented by the Ministry of Justice at that time, Albin Chanlandon, made provision for stricter sentencing of users, which could only be avoided if treatment was indeed administered. Amongst the different measures considered was the creation of prison treatment units that would make it possible to detoxicate incarcerated users within the framework of "forced" treatment. The desire to increase the amount of care provided by treatment organizations was shown when the Le Patriarche Association was authorised to make a large number of treatment areas available. This bill was strongly opposed. Many key figures, even in the government, expressed reservations concerning it. The measures concerning drug use were finally taken out of the bill, presented to the deputies by the government, and article L-628 remained unchanged. As in 1978, the government attempted to implement its new philosophy on use in a circular letter, while leaving out the most controversial measures.

The Justice-Health circular letter from May 12, 1987[16] repealed preceding circular letters and introduced a new distinction for drug use which was not based upon the substance, but upon the occasional or repeated use of narcotic substances. For all cases involving drug use, a report had to be sent to the prosecution and dealt with by a specialised judge. "Occasional" users, who were well integrated into society were to be given a simple warning. The letter recommended court-ordered treatment or prosecution for "habitual" users. Illegal foreign users were to be immediately tried and banned from the French territory. Lastly, user-dealers or delinquent users were to be prosecuted as a head dealer or for harming others or goods. This letter also marked a will to revive court-ordered treatment and clarified how it should be enforced. In 1988, additional credits were made available to the DDASS to achieve this goal.

The 1990s

Legal policy on fighting drugs in the 1990s was in a great measure the continuation of policy enforced in the course of the 1980s, for both use and trafficking.

Two circular letters written about repressing drug use in 1993 and 1995 confirmed the key points of the 1987 letter that was based upon distinguishing between occasional users, habitual users, and users-dealers. These two letters re-affirm the government's desire to revive the concept of court-ordered treatment, which became one of the objectives found in the plan of 1993. The 1995 circular letter set time limits for the transmission of statements sent to the prosecution and for notifying a user of court-ordered treatment. It also provided a clear definition of candidates for court-ordered treatment: all heroin and cocaine users, addicted cannabis users or individuals who took cannabis with other substances. Generally speaking, since 1987, instructions on this matter have moved in the direction of finding conditions that make it truly possible to enforce court-ordered measures. Legal, health and social authorities have been encouraged to better cooperate, and have been prompted to support departmental agreements on drug addiction-related objectives and contracts containing objectives on court-ordered treatment.

Health Policy

The Emergence of Specialized Structures

Once the principle that users should have free and anonymous access to "care" had been set, concrete methods of treatment had to be worked out: who should treat drug users, and what type of treatment they should be given. As early as 1971, the Ministries of Justice and Health together established a list of establishments that were authorised to organise detoxification treatment programmes. However, most of the traditional health sector was hesitant to take in drug users, even those who had not been ordered to undergo treatment. Drug users were perceived to cause problems, to be difficult to control, and were certainly not like the other patients. The few who were willing to put some effort into the issue of drug addiction were psychologists and psychiatrists who regarded institutions critically. These individuals were favourable to the idea of creating specialized structures for drug users. When Dr Olievenstein and his team opened the Marmottan Centre in 1971, the system began moving toward specialization. More and more specialized centres have come into existence over the years as traditional health establishments preferred to send drug users to these newly created structures.

In the early 1970s, little was known about treating drug addiction, and thus was a good time for experimentation. Though detoxification and abstinence were the objective of the law and all these newly specialised professionals, there was still the issue of getting in contact with the population of drug users. Also, following detoxification, it was necessary to work out a drug-free transition period (post-treatment, host families).

The Ministry of Health chose to support experimenting with different programmes and thus subsidised many different projects. These projects included reception and "post-treatment" centres, or prevention centres, ideas that came from associated sectors that were more flexible and open to innovation than public structures. These associations have remained one of the most prominent features of the French health and social system for fighting drug addiction.

During the 1970s, these emerging structures moved from the pioneer phase during which there was a utopian attitude centred around meeting with drug users and gaining their confidence, to a phase in which more professional treatment was administered with an increasingly psychotherapeutic approach.

The Pelletier Report made this approach official. It logically led to eliminating other drug addiction treatment options: therapeutic communities and methadone substitution. The majority of the profession opposed these two types of treatment, experimented with during the pioneer phase. In the context of the 1970s, which were marked by the distrust of psychiatric institutions and the neurobiological approach to mental illness, the distribution of methadone in two hospitals at the beginning of the 1970s met with indifference and hostility, finding little support[17]. More and more people began supporting therapeutic communities. Some of them specialized in the field of drug addiction, and more significantly were

[13] *Circulaire CRIM.84-15-E.2/ du 19 septembre 1984.*
[14] *TRAUTMANN (C.), op.cit. p. 19.*
[15] *Circulaire Crim.84-15-E.2/ du 19 septembre 1984.*
[16] *Circulaire CAB 87-01 du 12 mai 1987.*
[17] *Two experimental methadone distribution programmes existed until the 1990s.*

those who were public and legal authorities. Nevertheless, the large majority of professionals in the field of treating drug addiction, rejected the behavioural and often authoritarian conception that seemed to have inspired these institutions (particularly those which had been visited in the North American countries). Monique Pelletier took a stand against this approach to treatment, and Simone Veil, who was the Minister of Health at that time, decided to limit the number of therapeutic communities. In France, much of the debate focused on the very controversial le Patriarche Institution, which probably contributed to further blocking reflection on the possible interest of therapeutic communities.

The 1980s: The Rationalization of Specialized Structures

A Rationalization was a phenomenon that marked public action in the health and social field in the early 1980s. This eventually translated into central management of the health and social system.

Since the fight against drug addiction remained within the scope of State responsibilities, it was removed from regional councils following the law of decentralization enacted in 1982. From then on, all management and financing were taken care of by employees of the Ministry of Health and Social Affairs. For the first time, the administration was able to outline the structure of the system, and it moved in a phase of standardisation and consolidation.

In many of the French departements, specialized treatment centres, in which psychologists and psychiatrists played an increasingly important role, began offering detoxification treatment with psychotherapy. The Trautman Report, previously mentioned, stated that there were insufficiencies in this system due to uneven geographical distribution, a lack in quick response to psycho-social emergencies, and not enough being done to integrate, or re-integrate individuals into society.

The Report explicitly criticized the relationship between the administration and the system, stating that because of state financing, there appeared to be "abuse of power and objectives were not being defined within the framework of a controlled partnership"[18].

Following a decade of working toward administrative standardization, and perhaps because of criticism levelled in the report, specialized structures were re-defined in 1992[19]. From that time on, authorised centres that specialised in the treatment of drug addiction had to sign five-year agreements. These agreements, which defined their objectives, had to be approved by the prefect. They were responsible for ensuring that drug users receive medical, psychological, social and educational treatment. These changes were also indicative of a desire to clarify the mission of specialized treatment centres that had to re-focus on providing care.

AIDS and Drug Use: The Specialised Structure Challenged

The end of the 1980s was punctuated by an increasing gap between the specialized treatment system (which used a psychotherapeutic approach to treatment), and the many drug users confronted with AIDS (whose state of health was deteriorating and many of whom were no longer integrated into society).

In May, 1987, the AIDS problem caused Michèle Barzach, Minister of Health at that time, to approve a one-year suspension of a 1972 decree that individuals purchasing syringes must present identification. Because of the dissuasive nature of this obligation, drug users were sharing needles and thus spreading AIDS. As early as 1985, Dr Olievenstein and others had proposed that syringes be made available over the counter, but many in the field of drug addiction disputed this, and the issue was set aside because it was too sensitive to deal with right before elections. The decree was suspended again after the IREP[20] positively evaluated this measure. A decree made on August 11, 1989 permanently legalized the sale of syringes over the counter. This initial step toward harm reduction remained isolated until the beginning of the 1990s.

At the end of the decade, the Trautman Report made a rather positive assessment of French policy on fighting drug addiction "which has become known for closely associating responses to the supply and demand of drugs through repression, prevention, and treatment"[21]. Although the AIDS issue was not completely missing from the report, it was far from given high priority. The gap between how little the issue was dealt with in the report and the impact of AIDS on public health at that time, was particularly striking. In an annex devoted to drug addiction and AIDS, the report recommended developing syringe exchange programmes and questioned the effectiveness of substitute treatment for harm reduction without providing any clear answers. Nevertheless, heated debates in the report began to sow doubts.

The 1990s: The Turning Point

During the 1990s, there were important changes in the direction taken in fighting drug addiction. This was particularly characterized by the official adoption of harm reduction policy. This change in policy was for the most part made in 1993, even if it was very carefully approached in the beginning. Most of the orientations selected in 1993 were subsequently confirmed and developed. An initial aspect of 1993's plan related to improving treatment in specialised structures and in the general health sector, particularly by increasing the number of in-patient spaces, improving treatment in hospitals, and creating a city-hospital-drug addiction network. The second aspect related to developing a harm reduction system. The third aspect related to substitute treatments.

At the same time the 1993's plan was launched, an announcement was made that a new advisory commission on drugs and drug addiction was being set up. Professor Roger Henrion presided over the commission that made its report available in February, 1995. The Henrion Report confirmed most of the orientations selected in 1993 in the health field (with the exception of modifying the law), but asked the public authorities to accelerate the development of substitute treatment and harm reduction. The most important assessment of the reports was the worsening state of health of drug addicts. Faced with this situation, but also to help users become free of addiction, the members of the commission proposed that this marginalized and excluded population be reintegrated into society particularly by opening the health system to the treatment of drug users.

The orientations taken in 1993, which were subsequently confirmed and developed, largely contributed to the shape of the current health and social system as presented in the following chapter.

Prevention Policy

The Law of 1970 does not approach the problem of prevention, which was perhaps not a major preoccupation at that time. Nevertheless, a circular letter from the Ministry of National Education in 1973 proposed that "health clubs," designed to inform young people of the dangers of drugs and provide other information, be created. This became a directive in 1977[22]. It should be mentioned here that there were prevention clubs and teams that played an important role in the field of prevention all throughout the 1970s. Some of these structures, which were not specialized in drug addiction, efficiently included the drug issue in their work that was based upon contact with young people on the streets and other areas. The Pelletier Report provided a very current viewpoint of the prevention issue, making several proposals. Some of these, presented in a slightly different manner, were eventually carried out in the 1990s.

Nevertheless, prevention was officially included in policy objectives when the Permanent Mission for the Fight against Drug Addiction was created in 1982. However, after laws pertaining to decentralisation and distributing responsibilities

[18] *TRAUTMANN (C.), op.cit., p. 107.*
[19] *Décret N°92-590 du 29 juin 1992 relatif aux centres spécialisés de soins aux toxicomanes, J.O. du 2 juillet 1992*
[20] *INGOLD (F-R.), INGOLD (S.), Les effets de la libéralisation de la vente des seringues sur le comportement des usagers de drogues consommant leur produit par voie intraveineuse, Bulletin des stupéfiants, vol. XLI, n°1 et 2, 1989.*
[21] *TRAUTMANN(C.), op.cit., p. 23.*
[22] *Cité par Robert BALLION dans : Les comités d'environnement social, Rapport d'étude OFDT, mai 1998.*

were enacted, leaving the State responsible for the area of drug addiction, local communities tended to relieve themselves of any responsibility in the area of prevention. Many prevention clubs and teams no longer received financing for drug prevention activities, which in some cases called into question the very existence of these structures.

Thus, during the 1980s, drug prevention was based upon specialized treatment centres and structures that were implemented to prevent delinquency following a report published by G. Bonnemaison (departmental and community councils for the prevention of delinquency). Drug prevention in national education led to the implementation of an "adult relay" network (1983), then "resource teams" (1985) in the educational community. Lastly, the first national drug prevention campaign was launched in 1986 with the theme "let's talk about drugs before drugs talk to them".

The Trautman Report made the following diagnosis of prevention at the end of the 1980s: "on the whole, drug addiction professionals have experienced, and are still experiencing, many difficulties in coordinating actions with their partners within the dynamics of local prevention policy"[23]. Personnel working in specialized centres, engrossed in treating patients who have come to them, may not always have effectively taken over action on the "streets" which were previously conducted by prevention-oriented clubs and teams

In the early 1990s, prevention policy was marked by the creation of a certain number of national structures that are described in the chapter on structures designed to fight drugs and drug use. Furthermore, the decree of 1992, which refocused the action of specialized centres upon treatment, tends to restore an important position to local communities in the prevention mission[24]. Prevention policies, which were originally oriented toward substances, gradually developed into an approach in terms of the behavioural use of psychoactive substances. As early as the beginning of the 1980s, the French national education system had adopted a policy relating to the prevention of all risky conduct and behaviour that caused an individual to feel negative[25]. More recently, the Parquet Report reorganized and lengthened this approach to prevention based upon identifying different behaviours in consumption, use, harmful use, and addiction.

New MILDT Orientations (1998)

The government appointed a new president to head the MILDT in June, 1998. The letter, which accompanied this nomination very clearly and openly, stated the missions being entrusted to her: to increase the effectiveness of the anti-drug structure, and coordination between the different ministries. Then, three specific points are mentioned:

- broadening the field of action of the MILDT in fighting the abuse of licit substances such as alcohol, tobacco, and psychotropic medicines;
- improving the structure for local coordination in fighting drugs;
- evaluating actions conducted or supported by the MILDT over the last three years, and implementing procedures for evaluating future actions on a regular basis.

On October 15, the president of the MILDT, Nicole Maestracci, sent an initial note presenting MILDT orientations for the next three years. The government confirmed this note.

[23] *TRAUTMANN, (C.), op.cit. p.23.*
[24] *See M. JOUBERT's contribution in the part «Trends» .*
[25] *Circulaire du 27 juillet 1983.*
[26] *For more information on this subject see the Summary of the report by Pr Parquet (annex2).*

Proposals

The list of proposals formulated in this report is fairly long. Although we cannot repeat all of them here, most of them are accounted for. The proposals are centred on several main themes:

Knowledge and Understanding
In order to make public policy more effective, being able to measure and understand problems linked to drugs is essential.

Research, which is too weak and too dispersed, must be made the object of perennial planning, and the research milieu needs to be more structured. Results of studies and research must be systematically developed, disseminated, and made more accessible.

General population surveys with identical methodologies should be conducted on a regular basis so that development can be measured and results can be compared with European data.

In an area where changes rapidly develop, an observational network is necessary so that changes in patterns and contexts for drug use may be monitored in real time. This would make it possible to adapt public policy on a regular basis. This type of network, which corresponds to the requirements for common European action taken against synthetic drugs, would make it possible to monitor substances which are being circulated and the dangers involved in taking them.

Communicate and Inform
There is inadequate communication with the public about these phenomenons. As a result, too many messages from different sources, which are incorrect and often contradictory, are being projected. It is essential for MILDT to base public action on a common culture of complete, scientifically validated information that sends out a coherent message. By increasing the French people's knowledge of drugs, the targeted goal is also to increase their capacity to identify suitable answers to problems linked to drug use and abuse without systematically having to resort to specialists in this field. Communication and information about the various licit and illicit substances must be consistent. Information must always be available, which means related materials must be updated and disseminated on a regular basis, and made more available to everyone (Drug Info Service, Internet site).

Broaden and Synthesize the Field of Prevention
In the past, prevention policy lacked coordination. Although many quality actions were carried out, they were often fragmented or contradictory.

In order to make preventive actions more coherent, the MILDT proposed to define an approach to prevention that included all behaviours relating to psychoactive substances in spite of their legal status, and the creation of a reference "guide to good practices" for administrations and those working in the field. Participants in fighting drugs must be educated, and their actions must be perpetually financed. The impact these actions have on the representations and practices of young people and their parents must be systematically evaluated.
The report proposed that "Health and Citizenship Education Committees" become standard by providing them with the means to carry out needed actions. It also made provision for carrying out harm reduction actions and for assisting self-supported associations in producing effective prevention messages.

Coordinate the Knowledge of Key Participants in the Fight against Drugs
Information given in initial and continued training programmes in the field of drugs must be made more coherent. Educational and health care professionals must also be trained to recognize risky behaviour earlier, and to find answers to related problems.

Initial and continued training for doctors in the fields of alcohol, illicit drugs and tobacco should be improved. Courses of

study and diplomas recognised by universities and hospitals in the area of treating addictive behaviours should also be developed.

Help, Direct, Treat and Integrate Drug Users
The MILDT Report made the assessment that there have been many positive results in this field. The capacity of the health and social system to adapt to new developments more quickly is the most current issue. Specialised treatment centres are being encouraged to be more open to new categories of drug users and to diversify their methods. On both a departmental and regional level, needs must be better identified, and means in dealing with them better distributed.

Several proposals have been designed to bring structures which target illicit drug users closer to alcohol-related treatment structures, which are too few in number (for specialized centres, city-hospital networks and liaison teams in hospitals). Policies concerning harm reduction, better integrating users into society, and the treatment of incarcerated users should be carried out and researched more in depth. In the area of substitute treatments, making methadone more accessible, better training for prescribing Subutex® and more systematic social support for patients undergoing treatment was recommended. Lastly, the report underscored a lack in existing responses to adolescent multi-drug users and established the urgent task of better understanding how to deal with them.

Enforcement of the Law
The report recommended that priority should once again be given to fighting trafficking, particularly on a local level. Reviewing provisions made for enforcing the law of May 13, 1996 that was mentioned earlier could do this. This law concerns profiting from drug money. Incarcerating simple drug users should be avoided and direction should be available on all levels of this procedure. Legal policy should make provision for the monitoring of young prisoners who have been convicted of using or trafficking drugs after they leave prison. This type of situation could be avoided by more systematically resorting to other types sentencing which are not currently used enough (release on parole, suspended/deferred sentence with conditions, partial release, placing individuals where they can receive further help).

Lastly, the development and circulation of synthetic substances lead us to question the efficacy of the structure which controls the substances needed to produce them.

Seeing that laws that limit the access of minors to alcohol are rarely enforced, the report suggests that a determined action be carried out to prevent, provide information about and repress of this problem.

In addition, the impact of alcohol use on crime and violence should be evaluated.

Experiment, Evaluate
In order to improve the effectiveness of drug-related public policy, experimenting with new programmes and procedures used in systematically evaluating policy and programmes must be developed.

The Maestracci Report suggests that a statute be given for experimenting with new programmes. This could be done by defining criteria for decision making and financing as well as for developing evaluation procedures that could indicate the timeliness and conditions for generalising them.

Generally speaking, the evaluation process should be a part of any new programme.

The report also recommended that a permanent evaluation structure be set up to measure the real impact of all anti-drug policies.

Coordination on a Local and National Level
On a national level, the report asks that the scope of MILDT activities be broadened to include licit substances and that the interministerial anti-drug committee include the Ministries of Culture, Agriculture and Industry, as well as the Interministerial Delegation on Road Safety.
MILDT missions should be redefined. It should be a reference for all drug-related questions and for developing interministerial work. Principles to which the ministries should be held need to be clarified. The various human and financial means provided by these different ministries dedicated to fighting drugs should be made visible. The functions and conditions for allocating interministerial credits must be redefined.

Concerning local coordination, assessment of an action for which project leaders were appointed in 1996, is fairly negative: their missions and scopes of responsibility were not clearly defined. They were superimposed with other structures, particularly within the framework of city policies, where a lack of sufficient financing makes implementing true local policy difficult. Thus, it was suggested that the scopes and missions of these project leaders and this restricted committee be redefined, and the most of the credits for drug addiction be regrouped and decentralised.

The report also suggested that "resource centres" be created in the largest departments or regions. In these centres, elected officials, educators, state services and local participants in the fight against drug addiction could seek documentation, specialized information, knowledge, and the help and guidance necessary for carrying out their projects.

Alcohol, tobacco

Alcohol

According to article L-355-1 of the law of July 25, 1985, the State organizes and coordinates prevention and treatment for alcoholism. Since January 1, 1999, state health insurance covers costs related to financing outpatient treatment centres for alcohol addiction.

In chronological order, lawmakers first made legislation on repressing public drunkenness in the 19th century. However, it wasn't until the early 1950s that public authorities began to enforce more active policies in fighting alcoholism. This led to the creation of a code for drinking establishments and drinks, the creation of a high committee devoted to studying and receiving information on alcoholism, and the enactment of a law on dangerous alcoholics. Specific treatment and prevention structures for "non-dangerous" alcoholics began to be developed in 1970. At this same time, the first legal measure concerning alcohol and driving was passed.

The Evin Law, passed in 1991, relating to fighting smoking and alcoholism, particularly deals with the question of advertising for alcohol and tobacco and distributing alcoholic beverages at sports events. A clause (art. 13) made provision for evaluation reports to be made concerning it, to be submitted to the parliament.

There are many anti-alcoholism measures, of which we will only discuss generally here.

Repression of Public Drunkenness

Any individual who is clearly drunk in public may be punished with a fine designed for second-class infractions. A second offence is also punishable by fine. If a third offence is committed in a one-year period, the individual may be imprisoned for six months and fined 25,000 francs. After having been convicted for public drunkenness, any individual who commits a new offence within five years may be imprisoned for one year and fined 50,000 francs[27]. Drinking establishments must refuse entry to any individual who is clearly intoxicated. These measures seem rarely enforced.

Law of 1954 regarding Dangerous Alcoholics

A law passed on April 15, 1954 states that dangerous alcoholics must be brought to the attention of health authorities. Dangerous alcoholics, who cannot be left free to circulate in public, are brought before a departmental medical commission. This commission has the power to petition the prosecutor to have the individual summoned to a civil court. The court may order the individual to be placed in a specialised alcohol treatment establishment. Two types of establishments are available to treat these individuals: alcohol rehabilitation departments in psychiatric or general hospitals, and autonomous specialised rehabilitation centres. Only one of the latter establishments has been created.

This law made no provision for the treatment or prevention of "ordinary" alcoholism. It was rarely applied and appears to be obsolete.

Specific Treatment and Prevention Structures for Alcoholism

- Circular letter, November 23, 1970:
Creation of alcohol treatment consultation structures. These structures, which provided free and anonymous treatment, were created for "excessive drinkers." Their objective was to intervene before the individual became addicted, and not disillusion him by comparing him to other psychiatric patients. These structures were financed under prevention and their budget could be reviewed on a yearly basis.

- Circular letter, July 31, 1975: alcohol treatment centres.
This circular letter generalised structures by giving them the responsibility of receiving, testing, diagnosing, treating and helping excessive drinkers and those seriously ill with alcohol addiction.

- Circular letter, March 15, 1983 in which alcohol treatment and alcohol centres were created (CHAA).
These centres were designed for outpatient treatment. Their missions were broadened to include prevention and the provision of information and research. This had spontaneously developed and was no longer only limited to excessive drinkers. The letter also confirmed the fact that these centres were treating an increasing number of cases of serious alcohol addiction.

- An amendment to the law of July 29, 1998, which concerned fighting exclusion, created outpatient alcohol treatment centres (CCAA) to replace the CHAAs.
This amendment gave the CHAAs a stable legal status, clearly defined their missions, and ensured that they would be permanently financed within the health and social framework defined by the law of June 30, 1975. From then on, the CCAA had the status of a social and medical-social institution.

In the law that financed social security, passed on December 3, 1999, article L.355-1 of the public health code specifies that the medical-social costs of these structures are the financial responsibility of the State health insurance.

Alcoholism and Driving

- The law of September 9, 1970 set a two limit blood alcohol level: If there are 1,2 grams per litre of blood, it is a criminal offence; if there are between 0,8 and 1,2 grams per litre, the individual is fined. Provisions were also made to test the blood alcohol level of any individual involved in a car accident involving bodily injury or an offence against the Highway Code.

- The law of July 12, 1978 institutes blood-alcohol testing even in cases where no offences have been committed or there was no accident.

- The law of February 8, 1983 sets the legal blood alcohol limit at 0,8 grams per litre of blood (or a rate of 0.4 mg per litre on one's breath). Any drivers whose level reached this limit may be fined or sentenced to prison (raised to two years in 1987).

- The law of January 17, 1986 enabled judicial police officers and agents to keep one's driver's license when the alcohol test and behaviour of the individual indicated that he/she was driving under the influences of alcohol (rate equal to 0,8 grams per litre of blood). The licence may be suspended for up to six months.

- A decree made on July 11, 1994, lowered the tolerated blood alcohol level 0,7 grams per litre of blood.

- A decree made on August 29, 1995 lowered this level to 0,5 grams per litre of blood. When the rate is between 0,5 and 0,8 grams per litre, the driver may be fined 900 francs and three points are removed from his licence. Over 0,8 grams per litre is a criminal offence, punishable by removing six points, a fine, a prison sentence and revocation of one's drivers licence.

Advertising

Alcohol-related measures in the Evin Law, passed on January 10, 1991, set conditions under which alcohol beverages may be advertised. This reversed a preceding law that permitted the advertisement of alcohol except under specific circumstances.

Only a few types of advertising, which we will not list here, were authorised. The outcome was that no advertising for alcoholic beverages might be done on television, at the movies, or in publications that are designed for young people. Sponsoring that directly or indirectly advertises an alcoholic beverage is prohibited.

In a law passed in 1991, advertising with posters was only authorized in alcohol-producing areas and under conditions defined by decree. A law passed on August 9, 1994 that eliminated production zones modified this measure. Therefore, advertising with posters is not limited, even in stadiums. However, as a rule, these posters may not be used when events are televised.

Advertising messages must be limited to providing indications on the degree of alcohol, where it is made, its name, etc. A warning that alcohol abuse is harmful to one's health must be included in most of these advertisements.

[27] *Cf. Code des débits de boissons et des mesures contre l'alcoolisme, Ivresse publique, Titre IV.*

Distribution

Four types of licences are allotted to drinking establishments, (licence I to a licence IV). Only a licence IV permits the sale of all alcoholic beverages. These establishments are subject to certain conditions.

Selling alcoholic beverages in vending machines is prohibited. (art. L.13 of the code for drinking establishments and drinks).

Selling, distributing, or bringing alcoholic beverages into any establishment designed for physical activity or sports is also prohibited. However, the law made provision for temporary dispensations to be granted by the prefect under certain conditions set by decree. An initial decree authorized one dispensation per club per year. This was increased to ten in 1996. The Council of State cancelled the second decree. An amendment to the corrected law of finance on December 22, 1998, re-established the maximum number of dispensations to ten.

The law prohibits the sale of alcoholic beverages in petrol stations between 22:00 and 6:00, and sales to minors under the age of 16.

There are also protected zones within which establishments that sell alcohol are prohibited. A protected zone is a defined perimeter around certain buildings, as ordered by the prefect: places of worship, cemeteries, schools and youth-oriented establishments, prisons, military barracks, and public transport buildings.

Tobacco

LLaw n°76-616 passed on 09/07/76 (Veil Law), which concerned the fight against addiction to smoking, regulated advertising in favour of tobacco and tobacco products. One year later, it was followed by a decree regarding its enforcement that limited advertising for tobacco products to the written press according to quotas. The amount of tar and nicotine, as well as a warning marked " abuse is dangerous " had to be mentioned on each package. The protection of non-smokers began to take shape when measures were taken to prevent smoking in public areas, "where this could have dangerous health consequences."

Law n°91-32 passed on 10/01/91 (Evin Law) targets prohibiting the free distribution and direct or indirect advertising of tobacco. These rules have been extensively defined in order to better control the many attempts by cigarette makers to do so (athletic treks, clothing…). The law also attacks passive addiction to tobacco by prohibiting smoking in community areas (particularly in schools and public transportation) except in special smoking areas. Access to smoking areas is prohibited to those under the age of 16. In the workplace, smoking is prohibited in closed and covered collective areas. This law focuses upon prevention, and the provision of information to the public.

Law n°92-60 passed on 18/01/92 strengthens the protection of consumers by no longer taking tobacco into account in the cost of living index.

Law n°94-43 passed on 18/01/92 specifies that a health-related message must be included on tobacco packaging products.

The tar content in cigarettes has continued to decrease since 1991 (15 mg per cigarette down to 12 mg on 01/01/98).

Information included in the preceding chapter may be looked up in the public reports cited in the general bibliography, the circular letters cited in the text, and the following works and articles:

- BERGERON (H.), *L'État et la toxicomanie : histoire d'une singularité française, Paris, Presses Universitaires de France, 1999, 370 p.*
- BERNAT de CELIS (J.), *Drogues : consommation interdite. La génèse de la loi de 1970 sur les stupéfiants,* Paris, L'Harmattan, 1996.
- SETBON (M.), *L'injonction thérapeutique, Evaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés,* CNRS, Groupe d'analyse des politiques publiques, 1998, 144 p.
- SIMMAT-DURANT (L.) et autres, *L'usager de stupéfiants entre répression et soins : la mise en œuvre de la loi de 1970,* Guyancourt, Cesdip, Etudes et données pénales n° 77, 1998, 503 p.

STRUCTURES AND MEANS USED IN THE FIGHT AGAINST DRUGS

Illicit Drugs

Public policy in the fight against illicit drugs is supported by the actions of a certain number of structures and institutions. There are two key areas: health and social structures and law enforcement structures. The latest figures will be presented to describe the structures and means being used at this time. It is always difficult to make this type of measurement which tends to be too small, and inaccurate. Other, more qualitative approaches must be used to complete the description of the health and social system given here.

Health and Social Structures

The institutions accounted for in this section participate in the treatment of health and social problems linked to drug use. Information is available on the number of existing structures, but it is currently not possible to measure the human means that contribute to this type of treatment.

Specialized Health Services

The different types of specialized drug addiction treatment centres:

This system includes the structures financed by the General Health Department for fighting drugs. Since a decree was made on June 29, 1992, all specialized state-financed structures have been given the generic name of Specialized Drug Addiction Treatment Centres (CSST) (for both inpatient and outpatient centres). Since the decree was made, these structures have been responsible for jointly providing medical-social and socioeducational treatment.

In 1998, there were 256 specialized drug addiction treatment centres, two-thirds of which were run by associations. It is possible to distinguish between three key types of structures: outpatient treatment centres (190), inpatient treatment centres (50) and prison treatment centres (16 in 1998). The latter fall under the public sector. The first two types of centres may be run by associations or by a public hospital.

- Outpatient Treatment Centres[28] ensure that any individual who is having an addiction-related problem is met, given direction and medical consultations, psychological monitoring and social-educational guidance adapted to each situation. They can provide outpatient detoxification treatment and guidance through detoxification in a hospital, as well as subsitute treatments. They can also provide support for family members or the entourage of individuals concerned by drug use. The outpatient treatment centres run 56 outpatient reception areas. At the end of 1998, 137 outpatient treatment centres provided methadone treatment. Associations run two-thirds of these centres.

- Inpatient Treatment Centres can provide two types of inpatient treatment: residential therapeutic centres or community therapeutic centre[29]. Drug users are treated from a medical-psychological and socio-educational angle. The object of this treatment is to restore personal equilibrium and social integration for residents. Nearly all of the inpatient treatment centres are run by associations.

- Prison Treatment Centres, ex "drug addiction treatment units", function within the prison milieu.

Specialized drug addiction treatment centres, whether they are outpatient or inpatient, may also run therapeutic apartments, transitional or emergency housing, or host family networks. These forms of treatment will be described in the section on new orientations set for specialized treatment centres at the end of 1998. The centres also have overnight stays in hotels that are difficult to number.
All in all, and according to figures given by the General Health Department, the specialized structure had around 1,400 beds in 1998.

Lastly, we will mention that there are five "specific hospitalization units." These are treatment centres inside hospitals, where global treatment is provided to drug users. There are detoxification beds in these units.

Specialized structures that provide treatment to drug users

Types of structure	Number in 1998
Specialised outpatient treatment centres	190
Outpatient reception area (structures managed by the specialised centres but in a different geographical location)	56
Specialised inpatient treatment centres *(résidential or community)*	50 (679 places)
Therapeutic apartments - relay	65 (437 places)
Transitional or emergency housing	17 (127 places)
Host families	(150 places)
Specialised prison teatment centres	16

Source : DGS/SP3

Developments in the Missions of Specialized Drug Addiction Treatment Centres
In November, 1998[30], the General Health Department asked the specialized centres to integrate new orientations into their therapeutic plan that is currently being revised. Many of the centres have already implemented these orientations. The General Health Department would like all of the centres to be generalized.

[28] *The following lines were largely inspired by the presentation of different structures in the specialized system which figures in the «Annuaire spécialisés des centres spécialisés de soins aux toxicomanes conventionnés avec l'Etat», January, 1999, edition produced by the Ministry of Employment and Solidarity.*

[29] *Refer to therapeutic centres mentionned below.*

[30] *Note d'orientation n° 98-659, op.cit. relative à la révision des projets thérapeutiques des centres spécialisés aux toxicomanes, DGS/SP3, 5 Novembre 1998.*

New Orientations for Outpatient Drug Addiction Treatment Centres

Outpatient centres are particularly encouraged to emphasize the following areas:

- Promoting harm reduction and access to care;
- Improving the social function of the centres;
- Strengthening treatment for incarcerated drug users.

Specialized centres must also resolutely fit into the movement supporting developing a network for health and social treatment for drug addiction. The orientation goals are:

- To integrate partnerships with common law health and social professionals, particularly with general practitioners;
- To decompartmentalize the specialised system and the psychiatric sector in order to better account for psychiatric co-morbity;
- To take into account multi-drug addictions and new patterns in drug use (consumption associated with alcohol, ecstasy consumption).

New Orientations for Inpatient Treatment Centres

- Residential Therapeutic Centres

Originally, patients entered centres after detoxification, making a commitment to no longer take any drugs, including medicine. This approach was modified when substitute treatments were introduced. At the end of 1998[31], therapeutic centres were urged to soften their conditions for accommodating patients, to ensure collaboration with local medical teams, and better recognize the social and professional needs of patients.

- Community Therapeutic Centres

These new structures were designed to meet the needs of certain, (often older) patients by offering group-styled treatment to assist their reintegration on a socio-professional level[32].

- Therapeutic Apartments

This type of housing is designed to help drug users regain their autonomy. Today, they are reserved for individuals who are experiencing serious health and social difficulties. These apartments may also be used as emergency or transitional housing, where treatment can be provided by enabling users to have a "break," stabilise detoxifiction or substitute treatment, or wait for a more stable housing environment. This housing is also available for drug users who have just left prison, or for those who have been given alternative measures to incarceration.

- Host Families

Staying with a host family is suitable in many different situations, and may occur at different times in the experiences of a drug user.

Substitute Treatment

As early as the 1970s, hospitals experimented with prescribing methadone to drug users. The programmes lasted until the mid-1980s without drawing any particular interest. The question of substitute treatment was brought up again at the end of the 1980s. In circular letters sent out in 1990 and 1992, the General Health Department proposed that methadone be prescribed in more cases, but under very restricted conditions. However, it is significant to note that no, or very few requests to do so were received by the General Health Department from specialized centres. At that time, and even within the profession, there was heated debate over the question of substitute treatments. Many were still opposed to it. Bernard Kouchner, who was appointed Minister of Health in 1992, was in favour of methadone[33], the first to do so at that level. The election of a new government one year later, and the appointment of Philippe Douste Blazy to Minister of Health, did not lead to any significant changes in this area. The triennial plan for 1993-1996 made provision for the development of substitute treatment programmes. These would be carried out in centres authorised by the Ministry of Health, where patients could be closely monitored and global treatment given in an effort to help individuals lead a life free of addiction.

However, as early as the following year, developing capacities for prescribing treatment with methadone was given high priority[34]. The number of available places (limited to 275 at the end of 1993), increased to over 1,500 in the middle of 1994. The National Commission for Substitution was also set up on a departmental level in 1994.

At the beginning of 1995, all authorised specialized centres were given permission to provide methadone under less restricted conditions. On March 31, 1995, authorization to sell methadone on the market was given. This enabled doctors to prescribe it and pharmacies to carry it, but treatment still had to be initiated in a specialised centre.

The sale of Subutex® on the market was authorized on July 31, 1995. Unlike methadone, any doctor could prescribe it. The only limitation was that it be prescribed with a counterfoil book[35]. It was made available in pharmacies in February 1996, and its use grew quickly over the following months. A circular letter, sent out on April 3, 1996, specified the objectives of substitute treatment using Buprenorphine[36] . Use of the latter was designed to encourage integration into a therapeutic process and the monitoring of possible psychiatric or somatic pathologies associated with drug addiction. Treatment with Buprenorphine should enable a user to stop using opiates, particularly heroin, and make social integration possible. Lastly, the final objective is to enable the patient to develop a life free of drug addiction, including addiction to Buprenorphine.

According to certain estimates[37], 7,200 patients underwent methadone treatment in December 1998. Twenty-eight hundred were treated by a regular doctor, and 4,400 were treated in specialised centres. The same type of calculation estimates that there were 57,100 patients undergoing treatment with Subutex®. This treatment is mainly prescribed by doctors, but may also be in specialized centres. More detailed information on these figures is available in the chapter on users undergoing substitute treatments. The question of evaluating substitute treatment is addressed in France Lert's contribution found in the section on "Trends".

Harm Reduction Structure

Syringe exchange programmes were instituted as early as the end of the 1980s upon the initiative of humanitarian associations like Médecins du monde. However, fewer than ten exchange programmes still existed in 1993. Amongst the objectives of the governmental plan adopted that same year was the development of more syringe exchange programmes. On March 1, 1994, financing was made available for 16 programmes. There were 61 in 1996 and 86 at

[31] *Note d'orientation n° 98-659, op.cit. relative à la révision des projets thérapeutiques des centres spécialisés aux toxicomanes, DGS/SP3, 5 Novembre 1998.*
[32] *Ibid.*
[33] *To be completely exact, Mr Schwartzenberg, short time State Health secretary under Michel Rocard's government was the first member of the French government to have publicly shown support for developing the idea of substitute treatments. He resigned several days after being appointed.*
[34] *Harm reduction policy was officially launched by Simone Veil in her press conference given in July 21, 1994.*
[35] *Counterfoil books make it easier to monitor precriptions, eventually making it possible to dtect doctors who are prescribing abnormally high doses of a particular medication.*
[36] *Circulaire DGS/DH n° 96-239 du 3 avril 1996 relative aux orientations dans le domaine de la prise en charge des toxicomanes en 1996, annexe 1.*
[37] *Refer to section that deals with substitute treatment («Indicators»)*
[38] *There are PES that are financed and listed by the Ministry of Employment and Solidarity.*

the end of 1997[38]. The PES's distributed both individual syringes and prevention packages (Kit® or Kap® which contained two one ml syringes, one or two alcohol pads, one or two doses of sterile water, a condom, and a prevention message).

Stéribox® prevention packages, similar to Kit® or Kap® packages, were made available throughout France after the Apothicom Association carried out a pilot project in the regions of Ile de France and Provence-Alpes-Côte d'Azur. This package could be purchased at a reduced price because of state subsidies. Over 2.3 million Stéribox® packages were distributed or sold in 1997.

Whether or not syringe and prevention package distributors, or used syringe receptacles, are made available in public areas is a decision made by each city. State authorities have highly encouraged this. One hundred percent of the costs related to implementing these distributor/receptacles may be entirely covered by the State, but costs involved in running and maintaining them are the responsibility of each city. In 1997, there were 50 receptacles and 148 automatic syringe distributors.

The governmental plan of 1993 also made provision for the creation of emergency housing/reception centres for the most marginalized drug addiction population. The contents of this measure were specified in a circular letter sent in November, 1993. Two "boutiques," named after the first structure of this type, were created in 1993[39]. The number of these boutiques rapidly increased to 32 at the end of 1997, and financing was made available for two more in 1998.

Thus, a veritable harm reduction structure developed along with the classic structure within a few years. Most harm reduction activities were supported by associations outside of the specialized system and often received support from local communities.

Harm reduction structure on December 31, 1997

Types of structures	Number
Syringes exchange programs	86
Boutiques	32
Number of Stéribox® packages sold	2,3 millions
Number of atomatic distributors	148
Number of receptacles	50

Source : General Health Department / Aids division

Harm reduction policies expressed in a circular letter from the AIDS Division of the General Health Department in 1998 are consistent with policies from preceding years. This letter, which warned against the risk of creating barriers between structures in which initial contact was made (boutiques, bus) and common law and specialized structures, called for all individuals in the health and social sector to develop the culture of harm reduction. This circular letter also proposed that associations develop "non-specialized" harm reduction projects oriented towards helping other marginalized populations.

General Health Care System (Hospitals and Doctors)

The question of detoxification beds in hospitals had already been addressed in a 1985 programme designed to "maintain and develop floating beds", reserved for the hospitalization of drug addicts. In 1989, the Trautman Report recommended better coordination with hospitals in dealing with AIDS. However, it wasn't until the Henrion Report was published that an official report noted addicted drug users were not receiving sufficient medical treatment and that ill drug users encountered difficulties in getting treatment in hospitals, including emergency departments. The Parquet Report, which looked into the role of hospitals in treating drug addicted patients, made the same assessment. It proposed that transdisciplinarian structures which focus upon addiction, training hospital personnel in treating addicted patients, and the setting up of drug addiction units in hospital administrations, be created. As a result, the drug addiction file was entrusted to the AIDS mission at the main hospital administration[40].

The 1993 programme recommended that hospitals be more involved in detoxification. Three to five beds had to be reserved for detoxification treatment in any hospital serving a city of more than 50,000 inhabitants. This issue was the object of a circular letter in 1994[41] .

One of the objectives of the governmental health policy was then to encourage more access to hospital treatment for drug users. In 1996, priority was given to medical appointments areas, implementing liaison and treatment teams, for drug users (known as ECIMUD in public hospitals), reinforcing some of the departments which treat drug users in times of crisis, and training hospital personnel.

Following the publication of this circular letter, financing was made available for 96 hospital projects at a total cost of 47 million francs. The majority went to financing drug addiction liaison and treatment teams, of which there were 46 at the end of 1997. However, this funding was also used to improve treatment for addicted prisoners, supporting certain treatment services and creating city-hospital drug addiction networks[42].

The inventory of the structures presented in the chart below in not exhaustive and refers to the 70 establishments having benefited credits for the setting up of a programme[43] initiated by the 1996 circular letter[44].

Hospital treatment structure (non-specialized centres) in 1998

Types of structure	Number of structures
Liaison teams	46
City-Hospital Network*	47
Medical appointment areas	40
Hospital coordination	13
Other	8

** These are not city-hospital networks listed in the survey. There was a total of 57 city-hospital drug addiction networks financed by the DGS in 1998.*

Source : Department of Hospital Administrations/E02

The credits used created 89 full-time positions. Twenty-five of these positions were medical and 64 were non-medical. The positions created were distributed as follows: 32% in psychiatry, 19% medical, 17% emergency departments, 8% specialized, 8% in specialized treatment centres run by hospitals, and 21% for other non-specified services.

[39] *Circulaire du ministère des Affaires sociales, de la Santé et de la Ville du 9 novembre 1993.*

[40] *BOURDILLON (F.), TORTAY (I.), Evaluation de la prise en charge des personnes toxicomanes à l'hôpital : bilan de la circulaire, Actes de la rencontre nationale sur la prise en charge des personnes toxicomanes à l'hôpital, ministère de l'Emploi et de la Solidarité, juin 1998.*

[41] *Circulaire DGS n° 14 du 7 mars 1994.*

[42] *BOURDILLON (F.), TORTAY (I.), op.cit.*

[43] *BOURDILLON (F.), TORTAY (I.), op.cit.*

[44] *Circulaire DGS/DH n° 96-239 du 3 avril 1996 relative aux orientations dans le domaine de la prise en charge des toxicomanes.*

A circular letter from 1995 was the basis for the creation of 30 reference centres designed to improve access to treatment for hepatitis C. These structures were not specifically oriented toward drug users. In most of these centres, networks were set up to group together public and private treatment establishments, and health professionals (particularly physicians, but also pharmacists, nurses and biologists). It is noteworthy that in 1997, only three of these networks had doctors from specialized drug addiction treatment centres, or city-hospital drug addiction networks amongst their members.

In 1993, there was an increased desire to improve the treatment provided by doctors to addicted users by creating city-hospital drug addiction networks supported by associations subsidized by the General Health Department. These associations grouped together general practitioners[45]. The question of AIDS also played an important role here since these networks were modelled after networks that had been set up to monitor HIV infected patients. In some cases, these AIDS networks became involved in dealing with drug addiction. These networks had to rely upon a hospital site, bringing together hospital physicians, general practitioners and one or more specialized centres. There were 57 city-hospital drug addiction networks at the end of 1998.

Integration and Prevention Structures

Three prevention structures were also created at the beginning of the decade when the1990 action programme was carried out. These were: Social Environment Committees (CES), "Drug Info Service" (DIS), and "Listening Areas for Young People". The governmental plan of 1993, and the additional programme from 1995, made provision for extending these structures and other prevention measures. During this decade, focus was increasingly placed upon evaluating and making the different prevention actions more coherent.

The mission of the CESs, which were almost completely financed by the DGLDT, was to develop the prevention of drug addiction and all harmful behaviour in schools. This was done by using both adults and students from the educational community and individuals who directly participated in the social life of a particular area. Both the plan of 1993 and the additional programme of 1995 made provision for developing these structures. They have substantially increased in number ever since. Nevertheless, these structures were only found to exist in 28% of secondary schools, and some of them only formally existed in 1997. In 1998, these committees were renamed Health and Citizenship Education Committees, which confirmed that a global approach to treating the various difficulties encountered by young people had been adopted[46].

Drogues Info Service is a national telephone helpline available to everyone. It was designed to provide information about drugs and drug addiction, and support prevention. This service is provided 24 hours per day, seven days per week and has been a toll-free call since 1991. Drug Info Service has a national centre in Paris and five regional centres.

Listening areas for young people are designed for communication dialogue that targets individuals 18 to 25 years of age. The latter are generally lacking both socially and in their family life and are at risk of becoming involved in marginal and delinquent behaviour. The objective is to prevent failure to cope with life and to help re-establish psychological and social equilibrium. Their mission also includes providing a response to emergency situations that are due to emotional, family or social problems, and helping young people get access to social services. There were already 26 Listening Areas in 1995, and 62 at the end of 1997.

Listening areas for adults, of which there were 16 at the end of 1997, offer help for families designed to prevent or stop the deterioration of the parent-children relationship, to re-establish communication and possibly lead to contact with the treatment system.

[45] *Circulaire n°72 du 9 novembre 1993 et circulaire n°15 du 7 mars 1994.*
[46] *Refer to R. Ballion's contribution found in the section on «Trends».*

Two "sleep-ins" provide urgent overnight emergency housing for addicted drug users. During their time in these structures, they may have access to appointments with healthcare or social professionals.

Preparing prisoners who used drugs for social reintegration was also one of the points addressed in the governmental plan of 1990. After this was recommended, several pilot programmes were implemented. The first, called "quartier intermédiaire sortant" (QIS), began at the Fresnes prison in March, 1992. This training programme, started during the last four weeks of incarceration, was designed to prepare individuals for prison release. The governmental programme of 1995 made provision for developing this project, and "unités pour sortants - courses for prisoners who had finished serving time" (UPS), were created at 7 other pilot sites in 1996.

Prevention and integration structure in 1997

Types of structure	Number of structures
Listening areas for young people	62
Listening areas for adults	16
Sleep-ins	2
Outbound prisoners courses	8
Integration workshops	25

Source : General Health department/SP3

Law Enforcement

French public policy also relies upon actions conducted by law enforcement organizations. Police, gendarmerie, and customs services are each responsible for detecting narcotics-related offences within their scope of activities, arresting perpetrators, and informing the commission of committed offences. It is the responsibility of legal authorities to judge the guilt of those charged, decide whether legal penalties or other legal measures should be sentenced, and enforce them. We would also like to mention that there are two transversal structures responsible for fighting the laundering of drug-related money and organized crime, and controlling substances that may be made into illicit drugs.

There are relatively few specialized structures. Specific narcotic-related activities are interwoven with the global activities of these different organizations, making it difficult to clearly define them.

National Police

The National Police is the only institution that has a large number of specialized anti-drug entities.

On a central level, the Mission for the Fight against Drug Addiction (MILAD), under the authority of the Head of the National Police, is responsible for coordinating and orientating policies to the various departments of the Ministry of the Interior in the areas of fighting trafficking, drug use, and money laundering. Besides adapting the strategies and means of the Ministry of the Interior, it also develops and defends the position of this administration in national and international proceedings. It also prepares prevention actions for the Ministry of the Interior.

Two entities within the National Police are more particularly concerned with fighting drugs: the Central Police Headquarters (DCPJ), and the Central Public Security Headquarter (DCSP).

Within the DCPJ, the Central Office for the Repression of Drug Trafficking (OCRTIS), which employs approximately 100 civil servants, is responsible for centralizing all information that could facilitate the research and prevention of illicit trafficking of toxic narcotics, and to organise any operations aimed at the repression of this trafficking.

On a local level, regional police services (dependent upon the DCPJ), are responsible for fighting local or regional trafficking occurring within their geographical area. National or international affairs involving drug trafficking are handled by the OCRTIS. There are narcotics divisions within the departmental police services.

Within the DCSP, narcotics squads designed essentially to fight local drug trafficking and use, have often been created on a local level.
Police anti-drug trainers (PFAD), who are specially trained in preventing drug use may be placed within police or public safety services. Their role is to provide further education and training to police officers working in the field. Most of their focus is to work with young students in the area of prevention.

In 1995[47], there were a little over 2,000 police agents entirely dedicated to fighting drug-related offences. It is much more difficult to determine how much anti-drug activity is conducted by non-specialised police agents. Using 1995 estimates on costs involved in fighting drugs, this number increased to a little over 4,000 (full-time) for a total figure of 6,500 civil servants.

National Gendarmerie

Problems related to fighting drugs and drug use, are centrally monitored by a superior officer from the police office at the General Headquarters of the National Gendarmerie.

Directly dependent upon the central administration, an office is specially designed to carry out and coordinate actions in the field.
Thirty research sections, within the competence of the Appeals Courts and 302 research squads situated on a departmental level (or for an arrondissement), contribute to the fight against drug trafficking. This is either done on their own initiative or to strengthen the 3,600 territorial squads of metropolitan France.

In the field of prevention, there are 25 anti-juvenile delinquency squads whose mission includes the prevention of trafficking and drug use. Fourteen of these units are to be created in 1999.
At the end of 1999, there will be approximately 475 non-commissioned officers (anti-drug trainers), some of which will be assigned to anti-juvenile delinquency squads.

Lastly, we will mention the technical department for legal research and documentation located in Rosny-sous-Bois, where an Internet surveillance network has been set up.

As the National Gendarmerie has no specialized services, it is even more difficult to make calculations than for the national police. An approximate number may be calculated by using estimates found in the above-cited study. There were approximately 2,000 full-time anti-drug gendarmes in 1995.

General Customs and Indirect Duties Department
The Customs Department (amongst other responsibilities) carries out surveillance missions for the flow of merchandise, people and capital, at the borders of the European Union and all throughout the French National Territory. It is within this framework that controls are conducted for illicit narcotic substances and merchandise (arms, alcohol, tobacco, counterfeit products).
According to the General Customs Department, 500 civil servants could be considered full-time anti-drug trafficking employees in 1995. Using estimates similar to those used for the two preceding institutions, there were a little over 2,000 non-specialized customs agents (full-time) in 1995.

Justice

In this area, there are prosecutors who are specialized in drug-related offences. Upon recommendations made in a circular letter in 1995 concerning court-ordered rehabilitation treatment, judges are also often appointed to be responsible for these measures.
There were just over 200 full-time judges entirely dedicated to fighting drug-related offences in 1995. Approximately 400 additional civil servants, working within the justice system, should be added to this number. If we assume that the activities of prison and socio-educational personnel are proportionately spread out over the number of incarcerated individuals, there are around 3,400 full-time workers in the prison administration who are completely dedicated to fighting drug-related offences.

System for Fighting the Laundering of Drug-Related Money

The system designed to fight the laundering of drug and other crime-related money is supported by a structure called TRACFIN, created within the Ministry of Economy and Finance. This organization is responsible for collecting notifications of suspicious transactions which financial institutions are obligated to report. It has the power to freeze these operations and to gain access to all necessary private financial information. If need be, after analyzing and investigating these notifications, TRACFIN sends them to the judicial authorities (refer to the section anti-money laundering for an assessment of TRACFIN activities using figures).

Within the Central Police Headquarters, there is the Central Office for the Repression of Grand Financial Delinquency (OCRGDF). The mission of the latter is to fight large-scale economic and financial offences, particularly money laundering. In general, it deals with files that TRACFIN has transmitted to the judicial authorities. The OCRGDF centralizes information and coordinates the activities of the police departments involved in fighting economic and financial delinquency (financial research and investigation squads, and the OCRTIS).

Prosecutors who specialize in financial matters may now also support the fight against the laundering of illicit drug money.

System for Controlling Substances That May Be Made into Illicit Drugs

The control of substances which may be made into illicit drugs, included in a law enacted on May 19, 1996, is supported the National Mission for the Control of Chemical Precursors (MNPC). This organisation is connected with the Ministry of Industry. All operators must go to this organisation concerning all clauses covered by the law (request for preliminary approval, notifications of suspicious behaviour, mandatory answers for requested information). The MNPC relies upon the Precursors, Chemical substances and Psychotropics Committee at the OCRTIS for documentational work and surveys.

[47] *KOPP (P.), PALLE (C.), Vers l'analyse du coût des drogues illégales, rapport OFDT, mai 1998.*

Expenditures Linked to Anti-Drug Policies

Measurements in terms of structures and personnel may be completed with data on the financial means used within the framework of anti-drug policies. These are only expenditures made by the nation, either on the State budget level, or from another nationally financed budget. Some structures and activities may be clearly identified with anti-drug policies (for example: specialized drug addiction centres). Other activities may not easily be differentiated in terms of structures of financing (activities involving gendarmes or customs agents in fighting drug-related offences). Estimating expenses is becoming more difficult.

We do not take in account here some drug use-related costs that cannot be figured into public policy carried out in the area of drugs. An example of this would be costs involved in treating drug users infected with the AIDS or hepatitis C virus. These expenditures fall within anti-AIDS and hepatitis C policies. Another example is delinquent acts committed by drug users.

Specific Collective Expenses

Special Credits in the State Budget

The budget of the Ministry of Employment and Solidarity contains two items that specifically concern the fight against drugs. These are expenditures in item 47-15 of the employment and solidarity budget and interministerial credits in item 47-17.

The number of interministerial credits, which decreased from 1990 to 1995, increased strongly in 1998. Health and city credits more than doubled during the period of 1990-1998, with particularly strong increases in 1991, 1996 and 1997.

Specific credits linked to anti-drug policies
(credits voted in initial finance law)

Credits in millions of francs		1990	1991	1992	1993	1994	1995	1996	1997
Interministerial credits (45-17)	250,0	250,0	246 ,9	246,9	237,0	215,5	230,5	230,5	294,5
Health and city credits (47-15)	352,6	438,9	439,9	461,1	484,5	619,1	690,4	751,4	779,7
Total	602,6	688,9	686,8	708,0	721,5	834,6	920,9	981,9	1074,2

Source : Le dispositif de lutte contre la toxicomanie, National Audit office, 1998

AIDS Division Credits

Credits for promoting AIDS prevention amongst drug users, which are broadly linked to the harm reduction structure, can be added. These expenditures were evaluated at around 40 million francs in 1995, 53.5 million francs in 1996, and 66.3 million francs in 1997.

Breakdown of interministerial credits (ch.45-17) for 1998 expenditures
(in millions of francs)

Ministerial sectors	1992	1994	1996	1998
Health, Social affairs	59,5	45,9	68,1	47,9
National Education and Research	11,9	12,9	12	19,5
Youth and Sports	10,1	9,2	17,2	13,7
Interministerial Délegation to cities	2,8	9,2	10,5	13,2
Justice	22,8	18,4	18,4	18,9
Interior (police)	23,8	27,6	19	18,5
Defence (gendarmerie)	9,8	11,5	8,8	10,7
Economy and finance (customs)	24,1	22,5	16	15,6
Foreign Affairs	10,8	9,2	6	5,8
Cooperation	2,5	2,7	2	1,6
Other	0,8	0,9	-	6
Specific MILDT Activities	55,1	48	52,5	77,7
Total	234	218	230.5	249,1*

Source : rapport sur l'activité interministériel DGLDT, MILDT

**The difference between this total and the total in the preceding chart (294.5 million for interministerial credits in 1998) may be explained by a deferment of 45 million francs of credits voted in the initial budget.*

Other Public Expenditures

Local communities, regions, regional councils and towns provide financing for, or co-finance anti-drug actions particularly in the field of prevention.

For example, the Nord-Pas de Calais region spent 4.7 million francs in 1994-1995 for the section on prevention in the State-Region plan[48]. The Ile de France region and the State, co-financed the implementation of therapeutic apartments for AIDS patients, spending 10.4 million francs in 1994-1995[49].

The Regional Council of the Seine-Saint-Denis department spent 5 million francs in 1996[50] on fighting drugs. It is, however, difficult to estimate total expenditures for local communities. Expenditures are probably concentrated amongst a restricted number of cities, departments, and regions most affected by the drug problem.

Expenditures Financed by the Social Security System

Hospital Expenditures

A circular letter published by the Department of Hospital Administrations in December of 1995 set drug treatment-related hospital expenditures at 0,06% of all hospital spending (150 million francs in 1996). This amount was ultimately limited to 76.3 million francs[51].

Expenditures related to the treatment of drug users in emergency departments are not included in this figure.

[48] *Cour des comptes, Le dispositif de lutte contre la toxicomanie, op.cit.p 23.*
[49] *Idem.*
[50] *KOPP (P.), PALLE (C.), Vers l'analyse du coût des drogues illégales, rapport OFDT, mai 1998.*

- Expenditures linked to Substitute Treatment (prescribed by doctors outside of specialised clinics)
According to the above-mentioned report, published by the National Audit Office, the global cost of Subutex® treatment to the state health system was estimated at around 500 to 600 million francs in 1997.

Costs of prescribing methadone in the same manner, which have not yet been calculated, should be added to this figure.
The total amount of specific collective expenditures that have been compiled reached 1.6 billion francs in 1997.

Non-Specific Collective Expenditures

A study based upon information from 1995[52] also provides approximate non-specific expenditures for other administrations. Many problems were encountered when estimating these expenditures, and there was a large margin for uncertainty. It is particularly difficult, even impossible, to make estimates of prevention activities that are not specifically labelled as such.

Law Enforcement Administration Expenditures
A simplified explanation of the method used to calculate these expenditures is to charge global anti-drug budgets in proportion with the share of drug-related offenders out of the entire clientele in these institutions. It is assumed that the average cost of treating a perpetrator of a narcotic-related offence is not very different from the average cost of treating any other offender. It is likely that there are a few very costly cases for this type of offence (important drug-trafficking affairs), as is the case with all other offences. The majority of these cases cost very little (arresting simple cannabis users). In spite of the large number of arrests for simple cannabis use, these cases probably represent a minor fraction of total "drug" costs for law enforcement agencies.

Expenditures for all of these institutions reached 3.6 billion francs in 1995. This total has not been updated since. However, it is notable that a slight increase in global expenditures for prison administrations, combined with a decrease in the number of defendants and individuals convicted of committing drug-related offences amongst the incarcerated population, led to stability in anti-drug expenditures from 1995 to 1997.

It difficult to break down these expenses into personnel-related costs and functioning-related costs, due to the heterogeneous nature of data used in making these calculations. The majority of the costs for most of the administrations are personnel-related. Budgeting data was used to estimate that the percentage of personnel-related costs was 85% in the case of the National Police, around 80% for Customs Departments, between 65% and 70% within the penitentiary system, and between 50% and 70% for judicial departments.

Expenditures in other Ministries
Other ministries, with expenditures that correspond to actions that are more easily individualized and not part of the two preceding categories, generally obtained direct funding from these administrations.
Upon reading these figures, it was noted that law enforcement expenditures greatly exceeded those linked to treatment and prevention.

Some comments should be made about this observation:
- Part of the expenses for treatment was included in the social security budget. Taking these charges into account would substantially increase expenditures for treatment. In 1997, the ratio between collective treatment on one hand, and expenditures for law enforcement agencies on the other, was in the order of 1 to 2.

Cost of public involvement in drugs in 1995 (in millions of francs)

Nature of expenditures	Spending **Specific budget**	Spending Interministerial credits	Spending Totals
Justice	1.520	16,56	1536.56
including :			
Legal services	200		
Prison administrations	1.320		
Legal protection for youth			
Police	1.235,7	24,84	1260,54
Gendarmerie	459,2	10,35	469,55
Customs	430	20,25	450,25
Health	630,2 (1)	26,1	656,3
Social affairs	14	14,58	28,58
Interministerial city delegation (DIV)	22	9,45	31,45
MILDT	(2)	45,36 (3)	45,36
National education	2	9,9	11,9
Youth and Sports	17,7	8,28	26
Research	42	2,43	44,43
Foreign affairs	14	7,2	21,2
Cooperation	18	1,8	19,8
Work, employment and professional training		0,81	0,81
Contribution to the EU drug budget	30		30
Total	4.434,8	197,9	4.632,7
AIDS prevention for drug users (harm reduction)	40		

(1) This figure is the sum of credits in item 47-15 (articles 10 and 40), expenditures relative to the implementation of court order treatment, and spending for DDASS and DRASS personnel working on drug issues.
(2) It was not possible to calculate spending for the MILDT. Part of its budget comes from the Prime Minister's budget, and to the best of our knowledge MILDT spending is not identifiable.
(3) DGLDT actions (Drug Info Service, Departemental objective conventions, OFDT, etc.)

- It is difficult to estimate prevention expenses. They are only included in this calculation if they have been specifically linked to the fight against illicit drugs. A great number of social workers operate in the field of "general" prevention. By including a share of their cost we would also increase the figures for prevention expenditures.
- Law enforcement expenditures are globalized, but it is likely that the largest share is devoted to the repression of drug trafficking. Spending for incarceration, which is quite high, mainly concerns individuals being held for trafficking.

[51] *Cour des comptes, Le dispositif de lutte contre la toxicomanie, op.cit.. p 23.*
[52] *KOPP (P.), PALLE (C.), Vers l'analyse du coût des drogues illégales, rapport OFDT, mai 1998.*

Alcohol

Treatment and Prevention Structures

Specialized Structures

Structures that specialize in fighting alcoholism are responsible for prevention, treatment, and the provision of social guidance to any individual showing signs of harmful alcohol use. This action has to be carried out with other health and social workers who operate before and after in the treatment process. These structures have also been endowed with a mission of informing, training and making the public aware of problems involved with harmful alcohol use.

In 1997, there were two main types of specialized structures: Alcohol treatment and alcohol centres that focus on treatment and social guidance, and departmental committees that focus on prevention.

Since January 1, 1999, these structures have been financed by health insurance schemes, under the title of prevention, with open credits from item 47-17 article 20 of the Ministry of Employment and Solidarity budget. Previously, they had mainly been financed by the State budget for prevention and treatment.

Other structures also provide treatment for alcoholism: hospitals, for somatic problems, emergencies, detoxification and post-detoxification centres; doctors who have integrated alcoholism treatment into their practice; general health educational structures, and associations of former alcoholics which provide personal, family and social support.

All of these structures may be either private or public. Two-thirds of them were run by associations in 1997. Amongst these, the National Association for the Prevention of Alcoholism was largely in the majority. Hospitals play a dominant role within public structures.

Legal status of administrative structures

Types of structure		1996	1997
Private	National association for the prevention of alcoholism	86	87
	Associations	39	45
	Other	4	2
Sub-total		129	134
Public	Hospitals	43	51
	Communities	9	11
	Departemental department of health and social affairs	3	3
Sub-total		55	65
Total		184	201

Source : Le dispositif spécialisé de lutte contre l'alcoolisme, DGS, 1999.

Whether these structures are public or private, they can specialize in providing care (31 structures), prevention (45 structures), or both types of treatment (125). The public sector mainly focuses upon providing care.

There are different types of structuring. For example, a departmental committee for the prevention of alcoholism may run one or several alcohol treatment and alcohol centres.

Activities in specialized structures are often conducted in a decentralized manner in areas that are more accessible to drug users. Some of these areas are permanently open, and some are only open for limited periods of time. These areas have had several different names: alcohol treatment centre, alcohol centre, remote unit, consultation area, etc. These centres, now a part of the medical-social system, are called Alcohol Outpatient Treatment Centres (CCAA).

Of the 677 areas listed in 1996, 262 were open at least 20 hours per week. The others were open fewer than 20 hours per week. There were around 230 of these Alcohol Outpatient Treatment Centres in 1997. This number had remained stable since 1994.
There are an estimated 1,687 salaried professionals working in specialised structures. Most conduct their activities in this area part-time. The number of full-time employees was 925 in 1997. Forty percent were from the health sector, 16% from the social sector, and 18% were from the prevention sector. The share of personnel from the health sector working in these structures seems to be growing.

The Hospital System

The Reynaud-Parquet Report, published at the end of 1997, underscored weaknesses in treatment for alcoholic patients in hospitals. According to the report, diagnosis of excessive drinking was only made in half of all cases. Secondary alcohol-related complications are often dealt with before treatment is provided for the initial addiction. The proportion of individuals sent to specialized structures (CCAAs) is relatively low. The role of psychiatry in treating individuals with alcohol problems has never been clearly defined. Treatment of alcoholic patients is not coherently organized in most hospitals.

Chart : % of each category out of all personnel working in specialised structures

Types of job	1994	1995	1996	1997
Health (doctors, nurses, nurse's aide, dieticians, psychologists, etc.)	37,1	33,5	34,3	38,8
Social (social workers, specialised educators, social visitors)	16,8	17,5	18	15,8
Prevention (activity leaders, delegates or directors)	19,7	20,4	20,6	18,5
Common (secretaries and other jobs)	26,5	28,6	27	26,9

Source : Le dispositif spécialisé de lutte contre l'alcoolisme en 1996, DGS, 1998.

A circular letter published on March 28, 1978 recommended - without making new beds available - "The creation of a treatment unit for alcoholics, and election of an alcohol referent within the hospital medical corps responsible for ensuring the interdisciplinary coordination of global treatment of individuals showing alcohol-related ailments"[53]. Enforcement of this circular letter was limited: few units, or parts of units, specialize in alcoholism treatment and cases of coordination between services are generally an exception.

The Reynaud-Parquet Report states that there are around 50 alcoholism treatment units with an average of 10 to 40 beds, for a total of 1,063 beds for 20,000 patients per year. The report highlights the lack of planning in their distribution and the weakness of these structures that are not administratively registered.

The concept of alcoholism treatment liaison teams was revived in a circular letter dating September 10, 1996. Provision was made for one team per region. Only 16 of these teams were created due to a lack in credits granted. These credits were taken away in 1997.

The Reynaud-Parquet Report listed 25 centres, mostly run by associations that provided follow-up treatment and rehabilitation. These centres, still called post-detoxification centres, have 373 beds for men, 160 beds for women, and 274 mixed, for a total of 807 beds. These structures are capable of treating 8,000 patients per year.

Law Enforcement

The largest share of responsibility for law enforcementservices in fighting alcoholism is in controlling the blood alcohol level of drivers. Activities related to fighting alcoholism-related delinquency are not included here (as was the case with activities linked to drug use). In 1996, police and gendarmerie agents tested nearly 8 million individuals, of these a little over 132,000 tested positive. Testing by police and gendarmerie agents has more than doubled since 1988. We are currently unable to measure the number of full-time police and gendarmerie agents mobilised to carry out this task.

Driving under the influence of alcohol represented one-fourth of all court activity, thus mobilizing a large part of the legal system.

Expenditures Linked to Anti-Alcoholism Policies

As was the case with illicit drugs, we are limiting our figures to expenditures that are directly linked to anti-alcoholism policies. These expenditures should include specific credits from the State budget and social organizations dedicated to fighting alcoholism in the areas of treatment, health and social prevention, and law enforcement. In the health field, only expenditures related to treatment alcohol patients were taken into account. The High Committee for Alcoholism-related Studies and Information estimated that the global cost of alcoholism, including the cost of morbidity and mortality (indirectly linked to alcoholism), and induced delinquency, was between 100 to 200 billion francs in 1987. A new estimate is being developed as we publish this report.

Number of blood alcohol tests and convictions for driving under the influence

	1988	1990	1992	1994	1996
Number of tests conducted (1)	3 234 997	4 868 579	6 615 717	8 105 975	7 990 692
Number of positive tests (1)	111 510	116 613	119 601	129 910	132 283
Convictions for offenses committed while driving under the influence of alcohol (2)	86 022	94 812	101 469	102 914	97 259

Source (1) : National Interministerial Observatory for road safety, annual report, 1997
Source (2) : SDSED, ministère de la Justice

[53] *ROUSSEAU GIRAL (A-C.), BONO (R.), REMY (P-L.), Rapport d'audit du dispositif français de lutte contre l'alcoolisme, Inspection générale des affaires sociales, IGAS, cité par REYNAUD M., PARQUET PH.J.: Evaluation du dispositif de soins pour les personnes en difficulté avec l'alcool, Rapport de la mission, Direction générale de la santé, Direction des Hôpitaux, novembre 1997.*

- Specific anti-alcoholism credits from the Ministry of Employment and Solidarity
State subsidies distributed under item 47-17 article 20 reached 168 million francs ion 1997 and represented an average 69% of financing for specialized structures. In 1998 specific credits for fighting alcoholism reached around 180 millions francs.

- Expenditures covered by the social security system
In a report[54] produced by the Centre for Research Studies and Documentation of the Health Economy (CREDES), annual hospitalization costs for alcoholism equalled 6,4 billion francs in 1991. Specific expenditures for treating alcoholism in outpatient centres were nearing 180 millions in 1998.

Lastly, we can mention expenditures linked to "post-cures". This equalled 150 million francs for 21 post-cure establishments, and 80 million francs[55] for re-integration establishments. These costs are reimbursed by the state healthcare system.

Direct and indirect costs of alcoholism

The Reynaud-Parquet Report[56] tried to estimate alcoholism-related costs. Its estimate was based upon the number of alcohol-related cases for each pathology for which alcoholism was a direct factor or a factor of risk. Two hypotheses were used in calculating the percentage of risks attributable to alcohol: alcoholism prevalence rates amongst the general population equalling 10% and 15%. The global medical cost attributable to alcoholism may be obtained by applying the percentage of cases for each of the recorded pathologies (outpatient and hospital) to the total cost. After these calculations, the total cost for a 10% rate of prevalence would be 14 billion francs, and 16 billion francs for a rate of prevalence of 15%. The cost of pathologies directly linked to alcoholism (alcoholism and alcoholic psychosis, cirrhosis of the liver, and cancer of the aero digestive tract) was a little under 7 billion francs. The cost of pathologies for which alcoholism was only a factor of risk varied from 7.5 to 9.5 billion francs.

The cost to the social security system was a little less than these 14 to16 billion franc figures, as part of these costs were directly covered by the patients.

It was not possible to determine the cost of traumatic incidents directly involving alcohol-related accidents because of a lack of information in this area.

As is the case with any economic study of this type, this estimate is based upon a certain number of hypotheses and is only an attempt to determine the amount of these costs.

[54] *COM-RUELLE (L.), DUMESNIL (S.), L'alcoolisme et le tabagisme chez les hospitalisés, CREDES, 1997.*
[55] *REYNAUD M., PARQUET PH.J., op.cit. p. 54.*
[56] *REYNAUD M., PARQUET PH.J., op.cit. p. 54.*

Tobacco

Along with adopting and implementing the Evin Law, the public authorities undertook a policy designed to increase the price of tobacco. These prices nearly doubled between 1991 and 1996 (refer to section on tobacco use amongst adults). The action of the public authorities was also based upon prevention through communication campaigns. At the end of May, 1999, the government followed up the prevention programme initiated in 1997 by adopting a plan to fight tobacco addiction. It also made provision for a certain number of measures that would help individuals to quit smoking.

The focus of the CFES communication plan for 1997-1999 was stopping tobacco use. During the 1997 campaign, the question was asked, "A tobacco free life... When do you start it?" The campaign continued in 1998 with the objective of helping users to answer this question. The number for the "Tabac Info Service" (08 03 30 93 10), was mentioned in advertisements. The helpline was created upon an initiative of the CNAMTS and became functional in September, 1998. Three types of services are offered: 1) The immediate answering of questions found on a list of questions and answers (validated by experts); 2) The proposed sending of a guide on quitting smoking to the caller; 3) The transfer of the call to a specialist on quitting smoking. Approximately 1,000 of the 1,500 calls recorded per week were dealt with. Ninety percent of the callers were smokers, of which half were looking for information on products and methods to quit smoking. This number, which was disconnected at the end of December, 1998, was re-established in May, 1999[57].

In 1999, communication campaigns were designed to remove the obstacles facing smokers who desired to quit, and help those who had already begun this process. Provisions were also made for specific actions targeting: children and pre-adolescents (to prevent them from beginning to smoke), for adolescents (by showing the value of a counter model), and women (the number of whom smoke has continually increased).

The 1999 plan against tobacco addiction contained measures to help smokers quit. The entire range of nicotine substitutes will be made available in pharmacies without prescription at the beginning of the year 2000. Furthermore, particular efforts have been made to help individuals in unstable social situations quit smoking. They will have free access to these products within the framework of medical treatment in a Health Examination Centre and Outpatient Alcoholism treatment Centres. Nicotine substitutes will also be provided to hospitalized smokers.

There are currently around 50 tobacco detoxification centres in which the most addicted smokers, and those suffering from a related pathology, are treated. The 1999 plan made provision for 150 new centres in the year 2000.

Training programmes for health professionals and educators must be created, and specific tools need to be made available to them (help in generating dialogue, standardized files for monitoring patients, pedagogical information).
A specific structure has been planned for women and pregnant women. Training midwives on the effects of tobacco on pregnancy and the health of the infant, as well as measures designed to detect addiction to smoking and to help women to quit will be reinforced. A new individual interview to be conducted during early pregnancy will be one way of reminding women of the dangers of tobacco use and encouraging pregnant women to stop smoking. A document on making individuals aware of the dangers of smoking will be sent to all gynaecological obstetricians.

Lastly, in addition to the re-opening of the Tabac Info Service helpline, we would like to mention the creation of an Internet site about tobacco (in liaison with the French Office on Tobacco Addiction), the continuation of 3615 Tabac Info, and the reprint of the guide on how to quit smoking (distributed by the networks of the French Centre for Health Education, the National Social Health Insurance, and salaried employees at Tabac Info Service).

[57] *VELTER (A.), ARWIDSON (P.), Une ligne téléphonique d'aide à l'arrêt du tabac : Tabac Info Service, in Les dossiers de la snté de l'homme n°38, Arrêt du tabac, les méthodes qui marchent, CFES, décembre 1998.*

INDICATORS

- Drug Use in France
- Drug Users and Institutions
- Drug Supply
- Illicit Drugs in the French Departements and Countries of the European Union

DRUG USE IN FRANCE

Measuring the Extent of Drug Use

It is necessary to define "use" before answering questions about the number of users and their characteristics. There are frequently opposing figures referring to different concepts of the notion of "use," which are thus impossible to compare. Use may be characterized by two fundamental aspects: its temporary dimension and its frequency.

In order to put the extent of the different drug uses into perspective, levels of use must be clarified. There are four levels of use in the following information:

- Experimental Use - having tried the substance at least once.
- Occasional Use.
- Regular Use.
- Problem Use - refers to damage caused by this use.

These four categories establish a gradual degree of seriousness, or potential seriousness of use. The first three categories were established with indicators commonly used on an international level: use of a substance at least once in a lifetime, at least once per year, and every day or the preceding day.

These groups are not exclusive. Regular users make up a sub-group of occasional users, who are also a sub-group of experimental users. The notion of "problem" users is more transversal even though this type of user is mostly found amongst regular users.

Nevertheless, available indicators sometimes move away from these categories (refer to the diagram). The fourth category is trickier to define. It reflects definitions of harmful use and addiction while being built upon a pragmatic (possibility of measurement) yet subjective approach (ex: threshold of ten cigarettes per day for tobacco). It is consequently impossible to make comparisons between substances in this category.

This exercise provides approximate figures with a sizeable margin of error. The data presented must be viewed as a simple composition of different consumption patterns, main psychoactive substances, and their relative weight when measuring all types of drug use.

Alcohol is the most established psychoactive substance in French culture and consumption. This is the substance that the French experiment with most frequently and use on an occasional basis. When observing regular consumption, tobacco comes before alcohol. For every two individuals who experiment with tobacco, there is one "active" smoker (nearly always a regular smoker - at least one cigarette per day) and in two out of three cases is a heavy smoker (ten cigarettes and plus per day).

Alcohol and tobacco consumption are by far the most harmful. This is the case whether on a health level (alcohol and tobacco), social level (alcohol) or level of potential addiction (alcohol and tobacco).

The use of psychoactive medicines partially corresponds to use for treatment, and partially for use that is similar to other drug use. It is difficult to draw the line between these two types of use. Since there is a lack of criteria to define them, we have to refer to the only existing figures that relate to all types of use. Thus, the assessments of these figures should be taken into consideration.

Estimated number of drug users in France

Types of users	Alcohol	Tobacco	Psychotropic medicines	Illicit drugs	
				Total	incl. cannabis
> experimental users	46 millions	32 millons	///	7,1 millions	6,8 millions
> occasionnal users	44 millions	16 millions	///	2,2 millions	2,2 millions
> consistent users	10 millions	15 millions	5,4 millions	///	///
> « problem » users	3,3 millions	10 millions	///	142 à 176 000	///

➜ experimental users	alcohol	at least once in a lifetime
	tobacco	at least once in a lifetime
	medicines	at least once in a lifetime
	illicit drugs	at least once in a lifetime
➜ occasionnal users	alcohol	at least once a year
	tobacco	state they are smokers
	illicit drugs	at least once a year
➜ consistent users	alcohol	at least one glass the previous day
	tobacco	at least one cigarette per day
	medicines	regular use for at least six months that year
➜ « problem » users	alcohol	Deta test (see « methodological references» in the alcohol section)
	tobacco	at least 10 cigarettes per day
	illicit drugs	opiate users (refer to following sheet)

Note : french continental population : 58 millions (source : INSEE, 1996)

The consumption of illicit drugs is measured on a different scale than the above-cited drugs. Even though experimental use of these drugs is growing, the number of declared or noticeable users of these substances is incomparably lower than the other substances.

On the basis of this data, to which importance should only be given to the indication of the extents of drug use, the following chapters in this report will endeavour to better clarify levels of use and detect developments in prevalence trends, substance by substance. Keeping in mind the perspective of providing help in the decision-making process, we must favour research designed to provide a satisfactory measurement of changes rather than the sometimes-elusive measurement of the extent of drug use.

Methodological References

The Following are the Different Sources Used, by Substance:

Alcohol	Baromètre Santé adultes 95/96, CFES Baromètre Santé jeunes 97/98, CFES
Tobacco	Baromètre Santé adultes 95/96, CFES Baromètre Santé jeunes 97/98, CFES Enquête conditions de vie des ménages, INSEE
Medicines	Baromètre Santé adultes 95/96, CFES Baromètre Santé jeunes 97/98, CFES Enquête Santé 91/92, INSEE, CREDES, SESI
Illicit drugs	Baromètre Santé adultes 95/96, CFES Baromètre Santé jeunes 97/98, CFES

Some data, which were not available for certain age groups, were extrapolated.
(Refer to the following chapters for a description of the sources).

Illicit Drug Use Amongst Adults

Only surveys conducted amongst a representative cross-section of French adults make it possible to understand levels of use and related behaviours for these substances amongst the general population. There is no reliable method of estimating the quantities of illegal drugs that are distributed in France.
Based upon statements, these surveys encounter several problems. It is conceivable that because of the illicit nature of these substances answers given may not always be sincere. Answers are influenced by how socially acceptable it is to use a particular substance.

Moreover, in the best-case scenario in France, these surveys are conducted amongst sample selections of 2,000 individuals. This makes it difficult to account for drug use that is relatively minor compared to the entire French population. There is enough cannabis use during a given year that it can be detected by these surveys. This is not the case for substances like heroin, cocaine, or ecstasy. When the number of sampled individuals who state that they have used these drugs during the year becomes too low, it is no longer possible to draw statistically significant conclusions about use of these substances in the general population. Lastly, marginalized populations who most likely represent a good share of all drug users are not reached through standard types of surveys that are conducted over the phone or in one's home. This is the reason why other methods should be used to estimate the number of opiate and cocaine users.

Many surveys with differing methodologies have approached the question of drug use since the early 1990s, particularly concerning cannabis (see methodological references). Different methodologies were used in these surveys. We have selected those that seemed to provide the most reliable data and best framework for assessing trends.

Measurement of Declared Drug Use

In 1995, 15.8% of 18 to 75-year-old individuals stated that they had used an illicit substance in their lifetime, and 4.4% stated they had done so within the last 12 months.

In almost all cases, cannabis was the illicit drug stated by individuals under the age of 45. This is why we found it more interesting to quote declared use amongst the population of the 18 - 44-year-olds to present figures for the different substances. In 1995, nearly one-fourth of this population had already experimented with cannabis and 7.7% used it more often, on an occasional or regular basis (see chart). Experimentation with drugs other than cannabis appeared to be fairly marginal even amongst the 18 - 44 year olds.

The most rare substances are not on the chart either because they were not listed in answers that could be selected (ex: crack), or because they fell under a larger heading (e.g.: LSD in the hallucinogens).

Surveys (2) conducted amongst conscripts in army selection centres showed that a large percentage of the 18 - 23-year-old men had used illicit drugs. Although cannabis was the drug most often used, the 1996 survey showed a high rate of lifetime use of ecstasy.

Estimated prevalence of 18-44 years old who declared having taken illicit drugs

Substance	Lifetime	In the last year
Cannabis	24,3 % [21,8-26,8]	7,5 % [6,0-9,0]
Cocaine	1,7 % [1,0-2,4]	ns
Heroin	0,5 % [0,1-0,9]	ns
Ecstasy and amphetamines	1,1 % [0,5-1,7]	ns
Hallucinogens	2,4 % [1,5-3,3]	ns
Medicines	1,5 % [0,8-2,2]	ns
Inhalants	1,5 % [0,8-2,2]	ns
Other drugs	ns	ns
All substances	25,1 % [22,6-27,6]	7,7 % [6,2-9,2]

Source : Baromètre Santé adultes 95/96, CFES.

Nota : The bracketed numbers represent the standard mean of deviation for each percentage. For example, they show that one can be 95% sure that the percentage of 18-44 years old who state that they have used cannabis at least once falls between 21,8% and 26,8%.
ns : not significantly different from 0.

The results of biological tests made it possible to establish any differences in declared and real cannabis use in this survey. When testing for cannabis use within the past month, 40% of the individuals denied it, but tested positive. Fifty percent of the individuals declared they had used cannabis, but tested negative. This is most likely due to the specific context of the selection process, during which some try to hide drug use while others admit to drug use in order to be discharged. All in all, the higher rate of declaration more than compensated for the lower rate and a slightly over-estimated figure was obtained. However, the lower rate cannot be generalized.

Declared prevalence among 18-23 years old summoned to national selection centres in 1996

Substance	Lifetime	During the last month
Cannabis	40,0 %	14,5 %
Cocaine	2,5 %	0,4 %
Heroin	1,5 %	0,3 %
Ecstasy	5,1 %	1,2 %

Source : DCSSA

Changes in Declared Drug Use

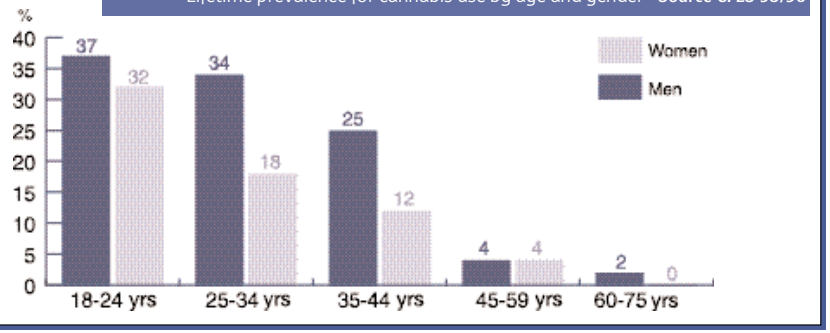
According to Baromètres Santé Adultes surveys, there was a significant increase in cannabis use from 1992 to1995. A survey conducted amongst students (n = 500) in 1978 and 1998 confirms this. The results showed that lifetime use more than doubled in this period, from 25% to 53%. Different profiles for cannabis use showed that experimentation remained stable at 13%, occasional use grew from 11% to 29% and regular use increased from 2% to 11%. This increasing trend was also detected in declared drug use in the Baromètre Santé survey of young people in 1998 (refer to section on young people and drug use). Thus, all of these surveys tend to confirm observations in the field: cannabis use is becoming normalized.

Results from the survey conducted amongst conscripts enable us to conclude that there was an increase in ecstasy use between 1995 and 1996 (1.2% vs. 0.5%, p<0.0002).

Discriminant Factors in Drug Use

Lifetime usage for cannabis is strongly linked to age and gender. The youngest individuals and men more often state that they use illicit drugs than older individuals and women surveyed.
However, it is notable that the gap between men and women is fairly small for 18 - 24 year old adults.

Lifetime prevalence for cannabis use by age and gender - ***Source CFES 95/96***



Estimate of the Number of "Problem" Opiates 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, analyzed 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.

Estimated number of « problem » opiates users

Méthode	Number of «problem» opiates users
Extrapolation from Police data	164 000
Multiplicative demography	176 000
Extrapolation from treatment data	156 000
Retro calculation of AIDS data	142 000 - 176 000

Source : OFDT

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).

Methodological References

➥ (1) Baromètre Santé adultes 95/96, CFES.
This telephone survey, conducted in December 1995, is based upon a 1993 sample of 18 - 75-year-old individuals in France. The sample was adjusted to make it similar to the total population in terms of its structure (age, gender, region of residence and housing conditions). The Baromètre Santé provides information on health-related behaviours, knowledge and attitudes.

➥ (2) Enquête sur les conduites toxicophiles dans les centres de sélection en 1995 et 1996, DCSSA.
This survey was conducted amongst 10,870 individuals in 1995 and 2,698 individuals in 1996. Individuals were questioned by doctors about psychotropic drug use and underwent a urine test. Data was then cross-referenced in order to estimate the quality of answers given. The sample was guaranteed to be a good cross-section of individuals because 95% of young Frenchmen were required to go through the military selection process.
It was no longer possible to conduct this survey after 1997, because of the phasing out of the mandatory military service system.

➥ (3) Enquête « Une génération d'étudiant », l'Etudiant, 1998.
This one-on-one survey, conducted in June, 1998, was based upon a quota sample of 500 representative individuals in the student population by subject studied, cycles and academies. It concerns the lifestyles of students; the results have been compared with an equivalent survey conducted in 1978

Different Surveys Providing Figures on Cannabis Use amongst 18 - 44-Year-Olds:

Approximately ten surveys were conducted amongst the adult general population 1990 to 1998. However, the diversity of these sources must not hide that fact that this method of gathering information is relatively weak. On one hand, some surveys ask too few questions about use. In some it is not possible to distinguish between substances, and in others, it is not possible to draw solid conclusions from the samples used. Most of the samples are made using quotas, a method which does not cover certain categories of individuals (particularly individuals who are infrequently at home). In such cases, these samples do not provide a good cross-section of the population. The majority of these surveys were conducted amongst approximately 1,000 individuals, yielding mediocre results particularly in cases where percentages are very low (which is the case for all substances other than cannabis). The examination of these different surveys has shown that it is important to carefully look at the methodology of a survey before adopting its results.

Surveys of cannabis use among 18-44 years old adults (France)

Surveys	Size	Method	Collection	In a lifetime	In the year
IFOP-CFES 1990	1 004	quotas	One-on-one	32,3 %	-
IFOP-CFES 1991	1 028	quotas	One-on-one	26,9 %	-
IFOP-CFES 1992	1 009	quotas	One-on-one	26,6 %	-
ACSF [58] 1992	20 000	Aléa [59]. 2°	Tel (CATI [60])	18,3 %	6,3 %
SOFRES 1992	1 167	quotas	Face à face	21,1 %	4,1 %
baromètre 1992	2 099	Aléa. 2°	Tel (CATI)	18,4 %	6,5 %
baromètre 1993	1 950	Aléa. 2°	Tel (CATI)	-	3,4 %
baromètre 1995	1 993	Aléa. 2°	Tel (CATI)	24,3 %	7,5 %
Démoscopie 95	1 000	quotas	One-on-one	20,3 %	-
IFOP-CFES 1996	1 005	quotas	Telephone	27,4 %	-
IFOP 1997	925	quotas	Telephone	24,6 %	-
G. Ecoute 1997	1 002	quotas	Telephone	21,2 %	6,3 %

Source : OFDT

For More Information:

- *LOUBOUTIN-CROC (J-P.), ARVERS (P.), EONO (P.), PORTRON (J-M.), SAMSON (E.), DUBIN (F.), BRODIN (C.), de CACQUERAY (L.), REY (J-L.), ABGRALL (J.), Les enquêtes de suivi épidémiologique sur les « conduites toxicophiles » dans les centres de sélection en 1996, DCSSA, in Toxibase, 4ème trimestre 1997.*
- *BAUDIER (F.) et ARENES (J.), Baromètre Santé adultes 95/96, éditions CFES, Paris,1997, 288 p.*
- *BECK (F.), La consommation de cannabis : niveau et tendances, note OFDT, 1997.*
- *European Monitoring Center on Drug and Drug Addicition, Study to obtain comparable national estimates of problem drug use prevalence for all EU member states, Country report : France, Final report, EMCDDA Project (CT.97.EP.04), à paraître.*

[58] *Sexual French behaviour analize.*
[59] *Two levels ramdom survey.*
[60] *Computer Assisted Telephone Interview.*

Alcohol Use Amongst Adults

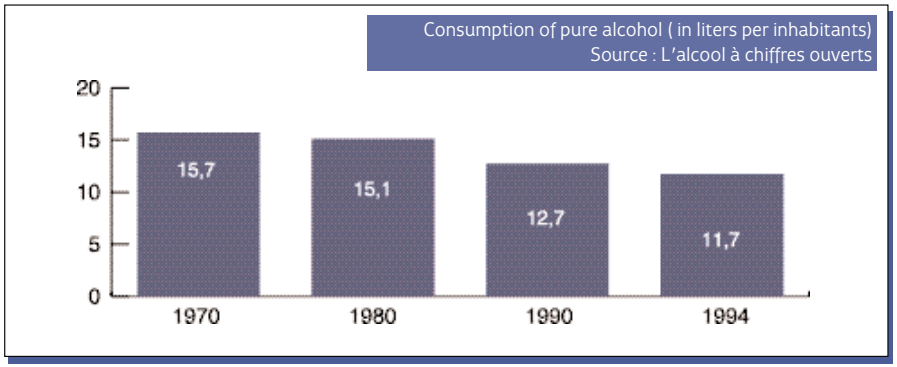
There are two types of data that make it possible to observe alcohol use: quantities of alcohol sold, and answers given by individuals questioned about alcohol use. The first type, calculated from fiscal data (refer to methodological references), make it possible to estimate quantities of pure alcohol consumed by drinkers, and to monitor changes in this use over time. However, these figures do not provide any information on the distribution of the global volume consumed by individuals who drink on an occasional basis, those who drink on a regular basis, and those who abuse and are addicted to alcohol.

It possible to better define and differentiate between various uses by interpreting data from surveys. However, it is difficult to make this observation because of the many alcoholic beverages that exist. The notion of "glass of alcohol drunk" is very subjective, and may correspond to very different quantities of pure alcohol. It is also important to remember that data provided is merely a reflection of statements made by those questioned. Statements are influenced by the effects of what alcohol and alcoholism represent and difficulties in remembering past consumption. Individuals surveyed are likely to minimise their level of alcohol use, whether it be done consciously or sub-consciously. In all the surveys, declared alcohol use is 25% to 50% less than quantities of alcohol sold per drinker.

Measurements of Alcohol Use using Sales Data

In 1994, the estimated consumption of pure alcohol per drinker (all age groups) was 11.7 litters, compared to 15.7 litters in 1970. There was a rapid decrease in global alcohol use between 1980 and 1990, a trend which continues to slow down during the 1990s (1).
According to information calculated by the INSEE, pure alcohol use apparently continued to decline from 1994 to 1996, but only slightly. However, this development should be carefully examined considering that some approximate figures were used in the calculations.

Sixty-two percent of the alcohol consumed in France is in the form of wine. The percentages for spirits and beer are much lower (18% and 15%respectively). There has been a notable change in the products used. Wine consumption has decreased by 13 points since 1970, whereas the use of spirits and beer has increased by 8 and 4 points respectively.



Consumers have turned to purchasing high quality wines (AOC and VDQS). Consumption of these wines doubled between 1970 and 1994, while the consumption of table wines was a little more than halved. Consumption of rum and brandy (cognac, armagnac, calvados) has decreased while there has been a strong increase in the consumption of whisky, gin and vodka.

Measurement of Declared Use

Level of Declared Use

Nearly all of the French have tried alcohol. In a 1996 survey, approximately 95% of 18 - 75-year-old adults stated they had consumed alcohol in their lifetime. Ninety-one percent had done so within the last year (3). Seventy-one percent also stated they had consumed alcohol within the last week. In 1998, this percentage reached 78% amongst those over 25 years of age (2).

Approximately one out of two Frenchmen affirmed having consumed alcohol the preceding day. A little over one in five stated that they drank alcohol every day. Studies conducted in 1995 and 1996 (3.4) showed that 39-45% of 18 - 75-year-old French adults stated they had consumed alcohol the preceding day. A 1998 survey showed that 54% of 15 - 65-year-olds had consumed an alcoholic beverage the preceding day (2). It is not possible to simply interpret these changes in the figures for 1995 and 1998 as a modification in behaviour because the different surveys cited were not identical.
In a sample from 1995 and 1996, nearly 23% of those surveyed stated they had consumed alcohol every day over the last week (4). In a study of wine use conducted in 1996, the same percentage (23% of those 15 and older) stated they drank wine on a daily basis (5).

In 1998, one in five 15-65 year old individuals (22%) stated they had been intoxicated at least once in the last 12 months, and 12% admitted having driven under the influence of alcohol at least once (2). These two questions were evaluated in a very subject manner, as the survey provided no clear definition of the concept of intoxication.

The percentage of individuals who used alcohol in a harmful manner (at least five glasses per day), was estimated to represent 10% of the population of individuals over 18 in 1991 and 1992 (5). Eight percent of those 18 - 75 were at risk of being alcoholics in 1995 and 1996 (3). The number of individuals addicted to alcohol is not known. However, a series of four questions asked in the Baromètre Santé survey (Deta test) make it possible to detect alcohol drinkers who are at a high risk of addiction (see methodological references).

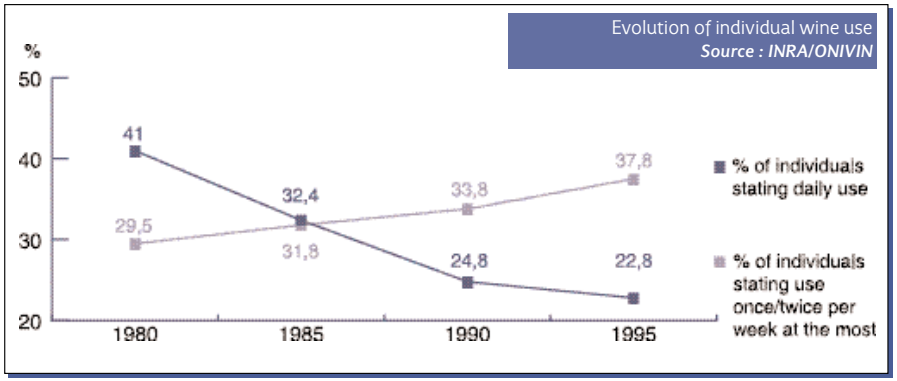
Developments

Few recent data are available with which long-term comparisons may be made.
INRA/ONIVIN surveys on wine use indicated that from 1980 to 1995 there was an apparent decrease in the number of individuals aged 15 and over who stated they drank alcohol every day (from 40% to 22.8%). On the other hand, the percentage of occasional drinkers increased from 29% to 37%.

The number of individuals who admitted having driven under the influence of alcohol within the last 12 months increased from 14% to 18% between 1993 and 1995 (4). This information was obtained from the same survey conducted two years apart. Changes were particularly strong amongst 25 - 34-year-olds where the percentage increased from 17% to 27%.

Discriminant factors in alcohol use as stated by survey participants

Evolution of individual wine use
Source : INRA/ONIVIN



The majority of alcohol drinkers are men. According to some surveys, 53% to 60% of the men stated they had drunk alcohol the preceding day compared to 25% to 45% of the women. In the 1995 Barometre Sante survey, 75% of those who drank alcohol on a daily basis were men. Men indicated they had drunk from 3.2 to 3.8 glasses of alcohol the preceding day, compared to 2 - 2.1 glasses amongst women. (3 and 4).

According to results from the above-mentioned Deta test, nearly 14% of the men drinkers could be considered potential alcoholics, compared to 3% of the women (4).
Three quaters of those who admitted having been intoxicated within the last 12 months, and 805 of those who had driven under the influence of alcohol, were men (4).

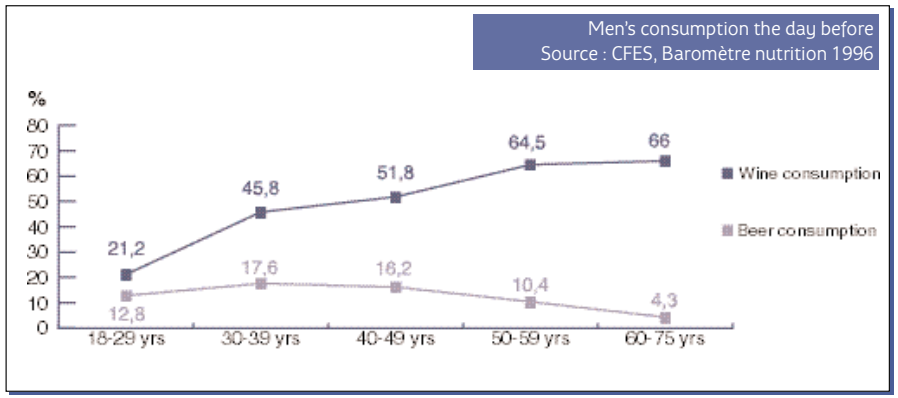
The percentage of individuals who drink wine increases with age. The percentage of those who drink other types of alcohol tends to decrease after 35 to 40 years of age. Potential alcoholics are frequently older individuals (over 35 years of age). Excessive drinking is more common amongst young people. 21% of the 18 - 29-year-old men stated they had drunk alcohol the preceding day. This percentage jumped to around 46% for men in their 30s, and 64% for men in their 50s (3). A similar profile has been observed amongst women, though all age groups use less alcohol than men.

The most highly represented age group amongst potential alcoholics was 35 - 54-year-old men (4).

Drunken behaviour was more common amongst young people (36% amongst 18 - 29-year-olds compared to 8% for the rest of the population). This was also the case for individuals who admitted having driven under the influence of alcohol (52% of those who admitted having done so were under the age of 35) (4).

Differences in use according to age may not only represent changes in an individual's behaviour during his/her lifetime, but may also represent generational changes. The habit of drinking wine on a daily basis, which at one point in time was considered normal (even amongst young people), has decreased in following generations.

There was little variation in the percentage of regular drinkers who had drunk alcohol the preceding day linked with salary and education (3). However, the level of alcohol use and salary seem to be strongly linked amongst women. A higher number of individuals who lived in rural areas (both genders) stated they drank alcohol daily (32% compared to 24% in other areas). This was also the case with professional workers or ex-workers (37% compared to 23%) (4).



Stated alcohol use amongst women increased with their level of salary in all three categories of alcoholic beverages (wine, beer and other). The number of glasses of an alcoholic beverage drunk by women in managerial positions was higher than for all other women, with the exception of those who did not work (4).

The level of stated alcohol use varies little by region. Alcohol use as stated in surveys did not confirm traditional representations of certain areas as being high use areas (Brittany, the North). However, this should be carefully considered since the number of individuals surveyed per region was fairly limited.
In the 1995/1996 Baromètre Santé survey, wine use was fairly even throughout the French territory. On the other hand, an INRA/ONIVINS survey conducted at the same time showed there were some differences. Regular wine use was less frequent, and there was more abstinence in the North, Picardie and Normandy regions as opposed to the Burgundy, Limousin, Auvergne and Midi-Pyrénées regions (which are located more to the South). According to the 1995/96 Baromètre Santé survey, there were more beer drinkers in the North, Picardy, central and greater Western regions.

This relatively homogenous level of use may seem contradictory when looking at data concerning money spent by each household on alcoholic beverages. In 1995, figures for wine, aperitifs, and brandy were clearly higher in the North than in the other regions. Other indicators, such as alcoholism-related mortality or positive blood alcohol tests, also show strong regional differences.

Associated Uses

The amount of alcohol drunk and the declared frequency of intoxication tend to be higher amongst individuals who smoke or use other illicit drugs. Smokers stated they drank 3.4 glasses the preceding day, compared to 2.4 for non-smokers (4). These figures are respectively 3.5 and 2.6 for individuals who said they had used an illicit drug during the year (4). When looking at figures for intoxication, 30% of surveyed smokers stated they had been drunk during the last year, compared to 8% of the non-smokers. Forty-seven percent had taken drugs compared to 10% of the others (4). This is only the observation of a statistically significant link that opens the question of causality between these different behaviours.

Methodological References

➥ (1) Determination of the amount of pure alcohol used per inhabitant.

Different alcoholic beverages are subject to taxation. When these taxes are collected, statistics may be calculated which may clearly monitor any changes in consumed quantities of the various alcohols. This may be done by singling out quantities of alcohol that are destined for the interior market from those which are exported. Using data on the average degrees of alcohol in different products makes it possible to calculate an equivalent quantity of pure alcohol for all the different alcoholic beverages. Fiscal services use specific methods to determine private non-taxed use. The only true source of uncertainty is the share of production purchased by foreigners (the case of British citizens who purchase alcohol in France because taxes on these products are much lower than in Great Britain). The possible margin of error is still very small.

➥ (2) Enquête alcool 09/98, IPSOS, CNAMTS, CFES.

This survey, for which quotas were used, was conducted amongst 1,500 individuals. It was carried out in preparation for the alcohol abuse prevention campaign undertaken in November, 1998.

➥ (3) Baromètre Nutrition adultes 96, CFES.

The methodology used in this study was quite similar to that used in the Baromètre Santé survey. It was conducted one month later (between January and February) by phone amongst a national sample of 1,984 French-speaking individuals. Participants were asked to very precisely recall what they had consumed within the last 24 hours. The different foods and beverages were clearly recorded. The solid context in which questions were asked helped participants to recall this information and made them feel less guilty than the health survey. Thus, the figures obtained in this survey were generally higher than those obtained in the Baromètre Santé survey.

➥ (4) Baromètre Santé adultes 95/96, CFES.

This telephone survey, conducted In December, 1995, is based upon a cross-section of 1,993 18 - 75-year-old individuals in France. The sample was adjusted to make it similar to the total population in terms of its structure (age, gender, region of residence and housing conditions). The Baromètre Santé survey provides information on health-related behaviours, knowledge and attitudes.

Individuals were asked a series of four questions which helped detect potential alcoholics: 1) Have you ever felt a need to decrease the amount of alcoholic beverages you drink? 2) Have your friends or family made any comments to you about your use of alcohol? 3) Have you ever had the impression that you drink too much? 4) Have you ever felt a need to drink alcohol in the morning to feel good?

Any individual who gives two affirmative answers to the above questions is considered a potential alcoholic. Verifications amongst populations for which it was possible to know the true habits of alcohol use showed that this test had a good capacity to predict the profiles of individuals at risk.

➥ (5) Enquêtes INRA/ONIVINS.

These five-year surveys of wine use, using a cross-section of 4,000 individuals in the French population aged 15 or older.

➥ (6) Enquête Santé 1991-1992 INSEE CREDES SESI.

This survey of individuals over the age of 18 was conducted amongst a sample of approximately 10,000 households throughout France. They were representative of a normal household (excluding rest homes). Each household was surveyed weekly about the use of medicine for a three-month period. The survey is based upon use of interviews and records.

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- *BAUDIER (F.) et ARENES (J.), Baromètre Santé adultes 95/96, Paris, éditions CFES, 1997, 288 p.*
- *BAUDIER (F.), ROTILY (M.), LE BIHAN (G.), JANVRIN (M-P.) et MICHAUD (C.), Baromètre Santé Nutrition 1996 adultes, Paris, éditions CFES, 1997, 179 p.*
- *CLEMENT (L.), DESTANDAU (S.), ENEAU (D.), Le budget des ménages en 1995, INSEE résultat n°550, 1997, 118 p.*

Tobacco Use Amongst Adults

Data on the volume of tobacco sold in France provides a fairly clear idea of the global level of tobacco use. The illegal sale of tobacco, which is probably on the increase, currently represents no more than three percent of the tobacco use in France.
Information on stated tobacco use is available in general population surveys. These surveys either focus on health (Baromètre Santé,CFES), or tobacco use and living conditions (INSEE survey of household living conditions). It is easier to observe tobacco use than the use of illicit psychotropic substances because it is less stigmatised. It is therefore possible to consider that the answers given in the surveys provide a good estimate of real tobacco use.

Any individual who smokes at least one cigarette per day is considered a regular smoker.

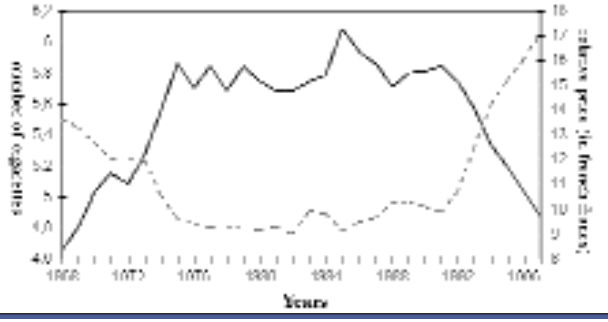
Measurement of use derived from sales data

Cigarette sales have been on the decrease since 1993. Eighty-three billion cigarettes were sold in 1997, compared to 93 billion sold in 1993. Cigarettes made up 86% of all tobacco products sold, rolling tobacco equalled 7.3 billion cigarettes, and approximately 1.5 billion cigars were sold. The cigarette market was largely dominated by mild tobacco, which comprised 68% of all sales. Light cigarette sales, which represented 7% of the market in 1980, rose to 36% in 1997.

This decrease in sales appears to be strongly linked to government action. Government authorities endeavoured to decrease tobacco use and protect the population from passive smoke by passing the Evin Law in 1991.
Strong hikes in the cost of cigarettes implemented by the government in the early 1990s seem to have had a strong impact on tobacco use as shown in the following chart. The inverse relation between the relative price[61] of a packet of cigarettes and tobacco use may be seen from 1968 to 1997.

Measurement of stated use

Cigarette use and relative price per packet - ***Sources : Seita, INSEE***



[61] *Relative price means the price of cigarettes compared to the general level of prices. The price of cigarettes increased more slowly than the cost of other goods during the period of inflation of the 1970s. In relative terms, the price of cigarettes was on the decrease.*

According to numerous sources(2, 3), 28% to 33% of the French over the age of 15 declared they were smokers in 1998 . The average number of cigarettes smoked per day varied from 13 to 19 in the different surveys. Two percent preferred smoking a pipe or cigar.

Forty-five percent of those surveyed smoked from one to ten cigarettes per day. Approximately four in ten smoked between 11 and 20. **One percent of the smokers stated they smoked more than two packets per day (2).**

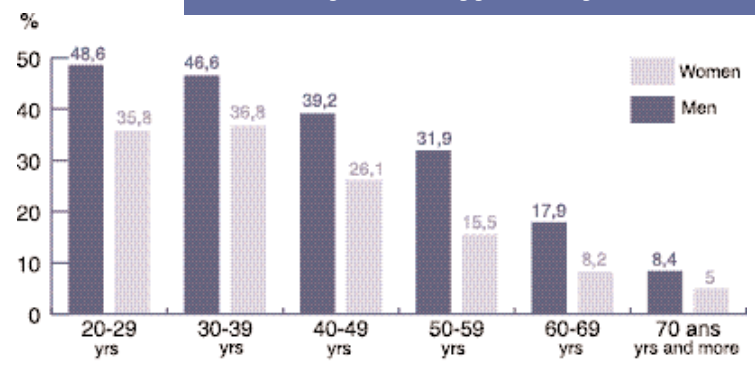
A global decreasing trend has been observed since the early 1990s, which concealed an increase in the number of women smokers. In the 18 - 75-year-age group, the percentage of smokers remained around 40% from the mid-1970s to the beginning of the 1990s. The percentage of smokers has noticeably decreased since that time, representing approximately one-third of the adult population in 1997. The impact of the Evin Law, mentioned above, is evident here.

Discriminate factors in use

In spite of an increasing number of women smokers, there are still more men than women who smoke. In 1998, more than one-third of all French men smoked, compared to one in five women. However, there has been a noticeable increase in the number of women smokers since the early 1980s (17% in 1980, 20% in 1991 and 21% in 1998). This increase may be observed amongst women of all age groups. The gaps between the number of men and women smokers are larger in the older age groups. This confirms that the behaviours of the two genders are becoming more similar.

With more than 40%, unemployed individuals make up the heaviest smoking group (1). Amongst working men in 1998, working class individuals were the heaviest smokers (3). Office positions create a more favourable environment for

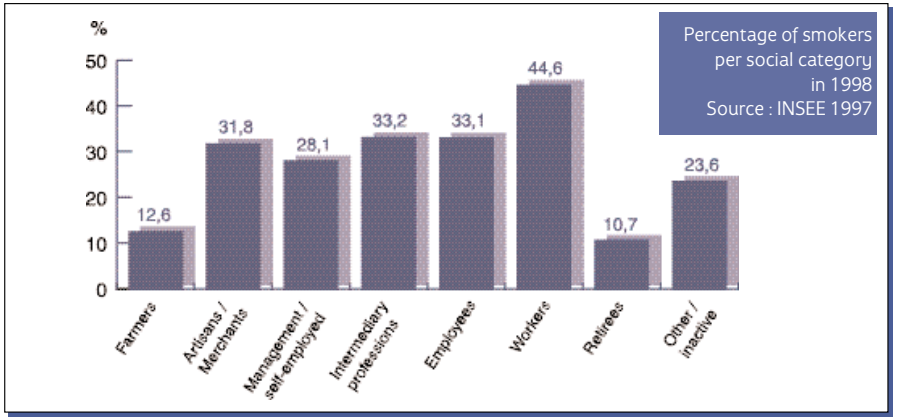
Percentage of smokers by gender and age in 1998 - ***Source : INSEE 98***



smoking amongst women (31% for women in temporary positions, 29% women in offices, 25% for working class women, and 11% for women farmers (1)). Women smokers in managerial positions were strongly differentiated from the others, as their number decreased from 27% in 1991 to 19% in 1996 (1)

The average age for becoming a regular smoker was identical for men and women (19.5 years) (1). Those who indicated they smoked relatively low quantities (less than ten cigarettes per day) said they began smoking later than the heavy smokers (on average 20 years 8 months of age). These figures should be taken relatively because some of those

Percentage of smokers per social category in 1998
Source : INSEE 1997



surveyed may have forgotten exactly when they started, particularly amongst the older smoker.

A little over one-half of the smokers had modified or attempted to modify their smoking behaviour in 1995. Out of all the smokers, 34% had reduced the number of cigarettes they smoked. This decision did not appear to be linked to age or gender. Thirty-nine percent had tried to stop smoking (those under forty were more inclined to try this). Twenty-one percent had begun smoking light cigarettes. Conversely, 15% of those surveyed indicated they had begun smoking more over the year (1).

Methodological References

➥ (1) Baromètre Santé adultes 95/96, CFES.
This telephone survey, conducted in December, 1995, is based upon a cross-section of 1,993 18 - 75-year-old individuals in France. The sample was adjusted to make it similar to the total population in terms of its structure (age, gender, region of residence and housing conditions). The Baromètre Santé survey provides information on health-related behaviours, knowledge and attitudes.

➥ (2) Enquête permanente de conditions de vie des ménages 96, 97 et 98, INSEE.
The question of tobacco use is only asked in one of the three annual surveys in a specific unit on health. It is conducted one-on-one by employees of the INSEE and is based upon a random sample of approximately 4,000 households.

➥ (3) Enquête sur le tabac IFOP-CFES 08/98.
This telephone survey, using quotas, was conducted in August, 1998. It is based upon a cross-section of 2,006 individuals (age, gender, profession of the head of the family) after stratification by region of residence and urban category.

➥ (4) SEITA : Data provided by the Seita provide information on quantities sold, and are interesting to compare with answers given by smokers. By convention, 1 cigarette = 1 gram of tobacco. Light cigarettes contain less than ten mg of tar.

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- *Seita, Revue des tabacs n°440, 1998.*
- *Tabac News – revue périodique du Centre de Documentation et d'Information sur le tabac.*
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Psychoactive Medicine Use Amongst Adults

There are four main classes of psychoactive substances presented in this section: tranquillizers and sedatives, which lead to a decrease in attention and produce a sleepy reaction; anti-anxiety medicine; anti-depressants prescribed for patients experiencing depression; and neuroleptics which are used in treating psychosis.

The same two types of data available for alcohol and tobacco are available for psychoactive medicine: sales volumes and results from surveys conducted amongst a cross-section of the French population. The limitations involved with these two sources have already been mentioned so we will only briefly cover them here: using sales data, it is impossible to differentiate between exceptional, regular and addictive use; and the declarative nature of information collected from general population surveys.

Another means of collecting data on psychoactive medicines, which normally are only available with a prescription, is to examine data from medical prescriptions submitted to the social security system for reimbursement. There are limitations involved with this data because they are collected irregularly (analysis of prescription data on a given day). Different health offices also do not provide a perfect cross-section of the population, and outpatient prescriptions are not taken into account.

We can only note that the public system for observing this type of drug use is very weak, particularly concerning abusive or addictive uses, since the various organizations within the social security system widely cover the costs of psychoactive medicines. However, there are many forms of depression and anxiety, and these pathologies are difficult to define. This makes it particularly tricky to evaluate the adequacy of prescriptions and diagnoses and thus the observation of excessive use of psychoactive medicines.

Measurement of psychoactive medicine use derived from sales data (outpatient and hospital prescriptions)

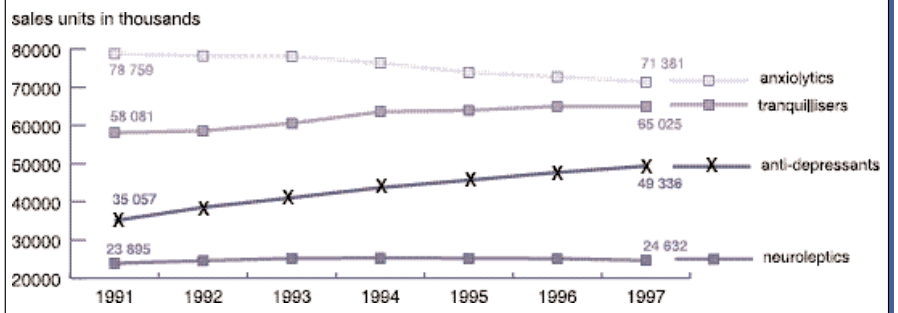
1991-1997 was marked by a strong increase in the sale of anti-depressants (+40%), a moderate increase in the sale of sedatives (+12%) and a decrease in the sale of anti-anxiety medicine (- 9%). Sales of neuroleptics developed fairly slowly during this period, increasing by three percent. Increased sales of ant-depressants appear to be strongly linked to the introduction of a new type of anti-depressants on the market[62].

The statistics shown here are based upon sales units or the number of boxes sold. The increased sale of sedatives (measured in sales units) is partly due to new packaging containing fewer pills. Variations in sales figures for the other products do not appear to have been caused by changes in packaging.

In 1997, the sale of anti-depressants represented approximately 51% of the total sales figures for psychotropic medicines.

[62] *Inhibitive factor of the recapature of the serotonine.*

Evolution of sales units / psychotropic medicines ***Source : Agence du médicament, Direction des études et de l'information pharmaco-économiques***



Measurement of stated use

Level of use stated and substances used

It is possible that the use of psychotropic medicine concerns one in ten adults. In 1995, 9% of the 18 - 75-year-old adults stated they had taken sleeping pills or tranquillizers during the week before the survey was conducted (2). It should be noted that this figure does not include the use of anti-depressants.
Of all the medical prescriptions from a given day in 1996 analyzed by the CANAM, 11% included the prescription of at least one psychotropic medication. Results from the 1991 health survey were fairly close with 11% of the adults stating they had used psychotropic medicine on a regular basis over a period of at least six months. Fifty-seven percent of these individuals had continued using these medications for at least five years.

In 1996, anti-anxiety medicine was found in two-thirds of the prescriptions analysed by the CANAM that included at least one psychotropic medicine. This was followed by sedatives and anti-depressants found in 34% and 30% of the prescriptions including psychotropic medicines. Neuroleptics were found in 8% of these prescriptions. Nearly one-fourth of these prescriptions included at least two types of substances.

Matching results from the 1991 health survey and the 1996 CANAM survey confirmed that there is an increasing trend in the use of anti-depressants (17% in 1991 compared to 30% in 1996). On the other hand, the percentage of individuals using sedatives, anti-anxiety medicine and neuroleptics was about the same in the two surveys.

Anti-anxiety medicine was most often prescribed by general practitioners who represented approximately 85% of the doctors who prescribed psychotropic medicine and in 50% to 60% of the cases initiated treatment (1,3 and 4). Psychiatrists more often prescribed neuroleptics and anti-depressants. In order to interpret these figures, one must take into account the fact that patients who may need a prescription for an anxiolytic drug most often see their general practitioner.

When looking at the total use of psychotropic medicines, it is difficult to tell which use is excessive or addictive. Until now, only the adequacy between pathologies and prescription has been looked into. In the 1996 CANAM survey, doctors who had prescribed at least one psychotropic medicine the day of the survey were asked to fill out a questionnaire on pathologies for which this medication should be prescribed. According to their answers, psychotropic medicine was used for psychological problems in 80% of the cases. In 17% of the cases, these problems had an organic context (cardiac problems that caused anxiety). In 13% of the cases, there was no context for the prescription of this medicine (organic or psychological).
We can note two elements from the CANAM survey concerning the question on addiction: the lengths of prescriptions are respected but often renewed; and it is hard to consider stopping use with older individuals, who have already tried to stop taking these medicines but failed.

Discriminant Factors in Declared Use

More women use psychoactive medicine than men, and this use increases with age.
Results from the 1995 Barometre Sante Adult survey show that 8.6% of the women compared to 3.7% of the men stated they had taken sleeping pills or tranquillizers every day of the week before the survey. The use of these medicines increases with age, but between the ages of 25 and 34, only a slightly higher percentage of women took them than men. Amongst 35 - 44-years-olds, twice as many women took psychotropic medicine as men (respectively 10.5 to 5.8%). The gap between feminine and masculine use increases after the age of 45. Amongst 65 - 75-year-olds, approximately one in four women had used sleeping pills or tranquillizers every day of the week before the survey compared to one in ten men.

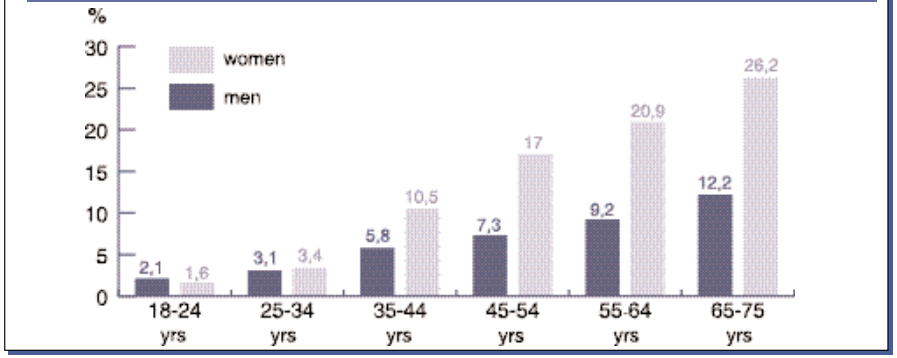
The 1991 Enquête Santé provided more detailed information about use of the different types of psychotropic medicines. Men took more neuroleptics. Women more often took anti-depressants. Elderly individuals more often took sedatives and younger individuals more often used anti-depressants.

Widows and unemployed individuals (categories used for the 1991 survey) were found to use psychotropic medicines more often than the rest of the population (2). On the other hand, relatively few well-educated individuals were found to use these substances, the opposite result when looking at all types of medicines (2).

Associated Uses

According to the results of the 1991 Enquête Santé survey, men often associated psychotropic medicine use with alcohol and tobacco use, which is much more rare amongst women. Three-fourths of the men who used psychotropic medicine also drank alcohol and used tobacco, while 60% of the women who used psychotropic medicine did not use either of these two substances.

Percentage of individuals having taken sleeping pills or tranquillisers within the last seven days by age and gender, in percentage - ***Source : Baromètre Santé adultes 95/96***



Methodological References

➥ (1) Enquête santé 1991-1992 INSEE, CREDES, SESI.

This survey was conducted amongst individuals over the age of 18 from a sample of approximately 10,000 households throughout France, which was a cross section of all regular households (excluding retirement homes). Each individual was asked on a weekly basis over a three-month period about the medicine he/she took. The survey was based upon the combination of interviews and a record booklet. A psychotropic medicine user was an individual who had taken this type of medicine at least once per week over the last six months.

➥ (2) Baromètre Santé adultes 95/96.

This telephone survey, conducted in December 1995, is based upon a cross-section of 1,993 18 - 75-year-old individuals in France. The sample was adjusted to make it similar to the total population in terms of its structure (age, gender, region of residence and housing conditions). The baromètre santé provides information on health-related behaviours, knowledge and attitudes. Definition of a user: sleeping pills and/or tranquilliser within the last seven days.

➥ (3) Sales Data.

As declared by the pharmaceutical industry to the medicine agency (provided by the Department of Pharmaco-Economic Studies and Information).

➥ (4) Enquête MSA (Mutuelle Sociale Agricole) on outpatient anti-depressant use.

This survey is a collection of all prescriptions for one or more of the five most often prescribed anti-depressants. It is a study of one day of medical services provided throughout the territory (April, 1996). Data on patients and prescriptions were filled out by medical advisors, clinical data and data relative to the length of treatment were gathered from prescribing doctors. Seventy-six health organizations participated. Of the questionnaires answered 1,979 were completely filled out and 2,423 were partially filled out. Eighteen percent of the prescribing doctors did not answer the survey.

➥ (5) Enquête CANAM (Régime d'assurance maladie des professions indépendantes) sur la consommation de psychotropes en ambulatoire.

This survey used the same protocol but in six regions of France (Centre, Ile de France, Lorraine, Midi-Pyrénées, Pas de Calais, Poitou-Charentes). It concerned any psychotropic medicine and occurred in February 1996. Of the 25,378 prescriptions examined, 2,952 that were analysed were for at least one pyschotropic medicine. Thirty-eight percent of the prescribing doctors did not answer the survey.

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Illicit Drug Use Amongst Adolescents

Adolescence is the age at which many individuals use drugs for the first time. Thus, it is essential to well observe the behaviour of the youth.

Two types of surveys make it possible to observe illicit psychotropic drug use amongst young people. As is the case with adults, the first type is conducted over the phone amongst the general population. The others are conducted in schools where students fill out a questionnaire. As the contexts and surveyed populations thus differ, the results of these two investigative methods do not always match. Individuals responding to telephone surveys may be reluctant to fully answer some questions because they are answering them within a domestic framework. It is also plausible in the second type of survey that they might exaggerate use when filling out while surrounded by their peers. Although real prevalence is probably situated somewhere in the middle of these results from both surveys, it is still likely that the percentage of illicit drug users does not fit into this measurement.

As a measure of precaution in regards to individuals surveyed, those under the age of 15 were not questioned about the most sensitive issues that include drugs (with the exception of lycéens under the age of 15 in school surveys- very small in number).

Measurement of declared illicit drug use

Using information from the different sources, one can estimate that more than one-third of all 15 - 19-year-olds have tried drugs (almost exclusively cannabis). Other substances were rarely stated. The main substances they tried were hallucinogens, ecstasy, and inhalants. The average age of usage of cannabis for the first time was just under 16, nearly one year after many young people try alcohol and tobacco for the first time. This use is in line with the fact that illicit drugs are easily accessible. Nearly one-half of all 15 - 19-year-olds stated they had been offered illicit drugs, and in most of the cases the drug was cannabis (2). In lycées, in the provinces, 42% of the young people had been offered drugs during the year. Over one-half of these individuals had tried a drug in their lifetime (3).

Survey results showed that 23% to over 30% of young people surveyed stated they had used illicit drugs within the year. In schools, particularly in Paris, figures from the self-administered questionnaires were clearly higher than those in the 1997 Baromètre Santé survey (refer to the chart below).

Frequent cannabis use concerned 14% of the young people surveyed (ten or more times in their lifetime) which represented more than one-half of all cannabis users (2). Out of the young people whose had used cannabis ten or more times in their lifetime, 81% had used cannabis ten times or more within the last twelve months (2).

Of the other observed substances, 1-6% of young people had used inhalants such as glue and solvents (according to the information sources). In the majority of the cases, these substances were only used in an experimental phase.

The use of synthetic drugs, particularly ecstasy, was also characteristic of young populations. Even they were also found to be used by young adults. In the lycée, approximately 3% of the students had taken them.
The use of other substances is less common. Hallucinogens (such as mushrooms or acid), amphetamines, cocaine and heroin were used by a small number of 15 - 19-year-olds (from 0 to 2% according to the sources). These substances do not strongly appear in the surveys, even though the rates of use amongst school age individuals are becoming significant.

Percentage of illicit drug use amongst 15-19 year old individuals within the year (according to the surveys)

Substance	CFES 97/98 (n = 2 675)	CADIS 97 (n = 9919)	INRP 98 (n = 875)
Cannabis	22,8	29,8	34,4
Cocaine	0,1	1,9	0,8
Heroin	0,0	1,7	0,2
Ecstasy	0,5	-	1,5
Ecstasy or LSD	-	3,4	-
Hallucinogens	0,7	-	0,9
Amphetamines	-	2,1	-
Medications to drug oneself	0,1	-	-
Inhalants	0,3	5,7	1,0
Other drugs	0,1	4,1	-
All substances	22,8	33,5	-

Source : CFES 97/98, CADIS 97 et INRP 98 (students from Paris)

Developments over the 1990s

Many of the indicators show an increase in illicit drug use amongst young people. Two similar surveys conducted in 1993 and 1997 amongst large samples of lyceens confirm this development. These surveys are quite similar on a methodological basis. In the first, the question was asked about the use of illicit substances in a lifetime (25% of the lycéens) (5). In the second survey, the question was asked about the use of illicit substances within the year (33% of the lycéens) (3). While the use within the year was always lower than lifetime use, we may very surely conclude that it increased between these two years. This development is mainly linked to the normalization of cannabis use. The percentage of young individuals who had used cannabis at least once globally increased over the 1990s. It was 22% amongst lyceens in 1993 (5) and over 30% in the 1997 survey (3). A survey that was repeated in Parisian lycées (1) just confirmed this development; the percentage of individuals who had used cannabis in their lifetime increased dramatically from nearly 19% in 1983 to 23% in 1991 and nearly 43% in 1998.

The most marked phenomenon concerned frequent use: the share of young people who had used cannabis at least ten times during the year increased by over one-half from 1993 to 1997 (3, 5). Surveys conducted in Parisian lycées (1) show this same trend. In 1991, 5% of the lycéens said they had used cannabis at least ten times that semester, while in 1998, 9% had used it ten times within the preceding month. This increase went along with a clear jump in the number of students who had been offered illicit substances (64% in 1998 vs. 47% in 1991).

Other, more partial information, confirmed these observations: the number of young cannabis users arrested by law enforcement services is on the increase.

Comparing figures from surveys conducted in provincial lycées in 1993 and 1997 showed that there has been a slight increase in the number of heroin and cocaine use. The use of amphetamines and inhalants has remained the same (3,5). On the other hand, it is more difficult to draw conclusions about ecstasy[63] and hallucinogens because the two surveys

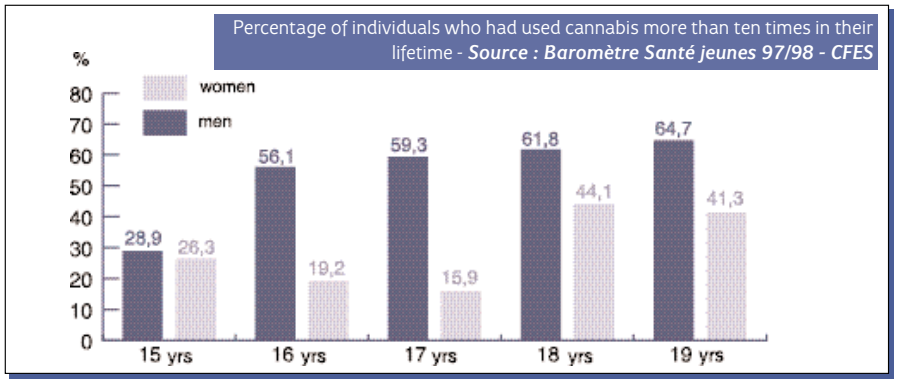
were formulated differently.

In Parisian lycées, (1) a clear increase was noted in the number of students who had used an inhalant at least once (4.0% in 1998 vs. 0.3% in 1991). This was the same for ecstasy (3.0% in 1998 vs. 0.1% in 1991) and in a lesser measure for LSD and cocaine, which remained under 2%. Meanwhile, declarations of heroin use remained quite rare.

Discriminant Factors in Illicit Drug Use

It was found that more boys than girls used these substances. In the Barometre Santé jeunes 97/98 survey, it shows that drugs are more frequently offered to boys than girls (53% compared to 45%) and boys more often accept them. Thirty-three percent of the boys stated that they had tried cannabis, compared to 23% of the girls. The latter tended to try it only once and not again. All of the surveys confirmed a much higher risk of repeated use amongst boys. The age at which young people are initiated to cannabis does not differ according to gender.

Percentage of individuals who had used cannabis more than ten times in their lifetime - ***Source : Baromètre Santé jeunes 97/98 - CFES***



The percentage of cannabis users significantly increases with age.
The oldest adolescents are the most frequently solicited (27% at 15 years of age compared to 61% at 19 years of age). At age 19, 42% had taken cannabis, compared to 11.5% at age 15 (2). Up to age 17, populations of lifetime cannabis users and users within the last 12 months are mostly similar. After this age, occasional or regular users are differentiated from those who are simply experimenting.

There was a higher percentage of cannabis users in Paris than in the provinces. Ten percent of the illicit drug users in the provinces were not found to use cannabis, but one or several other substances (3). This was the opposite for inhalants, which showed up more often in the statements made by lycéens in the provinces.

According to available results, use by populations considered "at risk," is not always higher than that of all young individuals or lyceens.

In a survey conducted amongst young people under the care of Youth Legal Protective Services (PJJ) in 1997/1998, individuals were asked, among other questions, about their use of illicit drugs (4). The grounds for caring for these young people may be linked to their behaviour (calling their social integration into question), or because of their entourage (endangering their integrity). These young individuals are characterized by early use of illicit drugs (before the age of 15). Although cannabis use is widespread, (60% have already tried it and over one-half are regular users), many of them have tried other illicit drugs. However, they did not necessarily continue this use on a regular basis. Over one-half had not taken any of these substances within the year.

A secondary analysis of the CADIS survey distinguishing between prioritary education areas (ZEP) showed that cannabis use is much lower in lycees located in ZEPs than in other types of lycees. The rate of experimentation with cannabis was 19%. However, it is amongst students in ZEPs that we find the highest percentage of frequent users of other illicit substances (at least ten times during the year).

Associated Uses

Tobacco and alcohol were often found to be associated with cannabis use (2). Three-quarters of those who had tried cannabis stated they smoked tobacco even on an occasional basis. Fifty-five percent stated they smoked on a regular basis. This behaviour was not influenced by age or gender.

More than half of those who used cannabis stated they also consumed alcohol (having drunk alcohol at lest once per week over the last 12 months) (2). Moreover, 79% of those who had tried cannabis stated they had been intoxicated at least once in their lifetime. Amongst older individuals who experimented with cannabis, 72% stated they drank alcohol or smoked tobacco on a regular basis. (either having drunk alcohol more than once per week over the last 12 months, or smoked at least one cigarette per day.

For More Information:

- *BALLION (R.), Les conduites déviantes des lycéens, Rapport d'étude OFDT, CADIS, (1999)*
- *BAUDIER (F.), JANVRIN (M-P.), ARENES (J.), Baromètre Santé jeunes 97/98, Paris, CFES, 1998, 328 p.*
- *BECK (F.), La consommation de substances psychoactives chez les lycéens, OFDT, 1999.*
- *DE PERETTI (C.) et LESELLBAUM (N.), Les lycéens parisiens et les substances psychoactives : évolutions, Rapport d'étude OFDT, INRP – Paris X Nanterre, 1999.*
- *CHOQUET (M.), LEDOUX (S.), Adolescents : enquête nationale, Paris, Les éditions INSERM, 1994.*
- *CHOQUET (M.), LEDOUX (S.), HASSLER (C.), PARE (C.), Adolescents de la Protection judiciaire de la jeunesse et santé, Étude de la Direction de la protection judiciaire de la jeunesse, MILDT, 1998, 146 p.*

[63] *Although the development of ecstasy use clearly appeared in the surveys conducted in Parisians lycées, it was also seen in surveys of toxicophile behaviours conducted amongst young men in army selection centres (1995 and 1996).*

Methodological References

The two types of survey mentioned here (at the interviewee's home or self-administered questionnaires in schools) complement each other since they make it possible to reach slightly different populations in slightly different contexts.

➥ (1) Enquête sur les lycéens parisiens et les substances psychoactives, INRP-Paris X Nanterre.
This survey was conducted in schools in June, 1998. The sample was a cross section of 875 young people from both public and private Parisian lycées. It was the third part of a series begun in 1983 and followed up in 1991 designed to measure changes in the use of psychotropic drugs over the last two decades. Students were drawn from lists by using the method of quotas, and brought together in one place per establishment to fill out the questionnaire. A member of the research team was present to manage them at that time. The questionnaires, which were similar in all three exercises, made it possible to make a good comparison of changes over time. Private schools were not included in 1983's sample.

➥ (2) Baromètre Santé jeunes 97/98, CFES.
This telephone survey, conducted in November and December 1997, was based upon a random sample of 4,115 young people representing the 12 - 19-year-old population living in France. It was adjusted to make it similar to the total size of this age group in terms of structure (age, gender, region of residence and housing conditions). The Baromètre Santé jeunes survey provides information on health-related behaviours, knowledge and attitudes of adolescents. Questions about illicit drug use were only asked of adolescents aged 15 to 19, amongst a total of 2,675 individuals.

➥ (3) Enquête sur les conduites déviantes des lycéens, CADIS.
This survey was conducted in April-May, and November-December of 1997 amongst a total sample of 9,919 lycéens in public schools. The survey was conducted in clusters, (all of the students in each of the four to six classes chosen per establishment were questioned). Each establishment was randomly selected amongst six academies chosen for their size and location evenly spread throughout the French territory (Amiens, Bordeaux, Créteil, Grenoble, Poitiers, Rennes). Most often, the self-administered questionnaire was given out by an individual from the medical profession, by a counsellor or by the head teacher.

➥ (4) Enquête sur les adolescents de la PJJ (1997/1998).
This sample was made up of all young people cared for by the Youth Legal Protective Services in 15 randomly selected départements. A total of 5,286 young people were given a questionnaire on their use of psychoactive substances. Of these, 917, or 17.3% of them filled out the questionnaire.

➥ (5) Enquête santé des adolescents 1993, INSERM-U169.
This survey was conducted in 1993 amongst a representative cross-section of young students throughout the nation. These students were in the secondary cycle of school (colleges or lycees) and were aged from 11 to 19 years (n=12,391). The rate of unanswered questions about drug use ranged from 1% to 3%. Answers were gathered from a questionnaire filled out by each student (self-administered). Questions concerned lifetime prevalence for seven types of substance: hashish, cocaine, amphetamines, inhalants, hallucinogens, and medicines used to drug oneself.

Alcohol, Tobacco and Psychoactive Medicine Use Amongst Adolescents

Two types of surveys made it possible to observe the use of alcohol, tobacco and psychoactive medicines amongst young people. As was the case with adults, the first type was in the form of phone interviews conducted amongst the general population. The other surveys were conducted in schools where students were asked to fill out a self-administered questionnaire. As there were differences in the contexts in which these surveys were conducted and the populations surveyed, the results of these two investigative methods did not always match.

Unlike the age group questioned about illicit substances, individuals questioned here ranged from 12-19 years of age. These questions were considered to be less sensitive and more in line with the behaviour of the youngest adolescents. The school surveys used here were limited to those conducted in lycées, and the majority of the population surveyed ranged from 15-19 years of age.

Although it is likely that the information gathered on psychotropic medicine use was valuable, it is possible that answers concerning tobacco and alcohol use understated actual use because of the forbidden nature of these substances (particularly amongst the youngest surveyed). Nevertheless, it is difficult to measure the value of answers given on psychotropic medicine use. An occasional smoker smokes less than one cigarette per day, and a regular smoker smokes on a daily basis. An occasional drinker has one or less glass of alcohol per week, and a regular drinker drinks more during the week. However, the psychotropic medicines taken into consideration were those used to fight nervousness and anxiety, as well as sleeping pills. No question was asked to determine whether or not this medicine had been prescribed.

■ Alcoholic Beverages

In 1997, three out of four 12-19-year-olds stated they had already tried alcohol, one in four drank at least once per week, and two out of 1,000 drank every day (3). A total of 12% of these individuals stated they had consumed an alcoholic beverage the day before the survey was conducted. They had drunk an average of 2.4 glasses, and a little over half of them had only had one glass (3). Amongst 14-19-year-old lycéens, approximately 60% stated they drank on an occasional basis and 10% drank more than once per week (4).

The most commonly chosen beverage amongst 12-19-year-olds was beer. Fifteen percent of these individuals drank beer at least once per week. Amongst those who had drunk an alcoholic beverage the preceding day, those who were drinkers of strong alcohol had the most to drink (2.2 glasses) (3).

It is difficult to detect trends as the most recent surveys available to us are not identical to past surveys on a methodological level. **Nevertheless, if we are cautious when making observations, occasional use appears to have remained stable from 1993-1997 (4-6), while there was an increasing trend in use and drunken episodes.**

Surveys of alcohol use amongst 13-18-year-old boys, conducted by the IREB in 1985 and 1996 (5), showed that the average number of glasses of alcohol consumed per month remained stable between these two dates. However, the number of glasses drunk by 15-16-year-olds doubled. The increase in this age group is nearly entirely the result of an increasing number of heavy users (over 30 glasses per month).

The use of alcohol obviously increases with age. Forty-three percent of the 18 - 19-year-olds drank alcohol once per week compared to approximately 6% of the 12-14-year-olds (3). The average number of glasses of an alcoholic beverage

drunk per month went from four (amongst 13 - 14-year-olds), to 17 (amongst 15-16-year-olds), and finally to approximately 40 (amongst 19-20-year-olds) (5).

As can be seen on the following graph, from the age of 18, boys become heavier users of alcohol than girls. **They are distinguished from the girls by showing the strongest percentage of regular drinkers.**
A little over one-fourth of the 12-19-year-olds have already been intoxicated, 34% of boys versus 21% of girls (3). Figures

Percentage of alcohol drinkers by gender ans age amongst 12-19 year old -
Source : Baromètre Santé jeunes 97/98 - CFES

on this type of behaviour increase strongly with age, and the difference between the genders intensifies over the years. Around 50% of the 15-19-year-olds had already experienced drunkenness (1, 4), compared to 40% in 1993 (6). This increase that occurred between the two survey years was particularly evident amongst those who stated they had been drunk at least three times over the year (27% in 1997 compared to 17% in 1993) (4, 6). The average age of a first drunken experience was 15½ years, with no significant difference between boys and girls. However, the subjective character of the notion of drunkenness should not be forgotten.

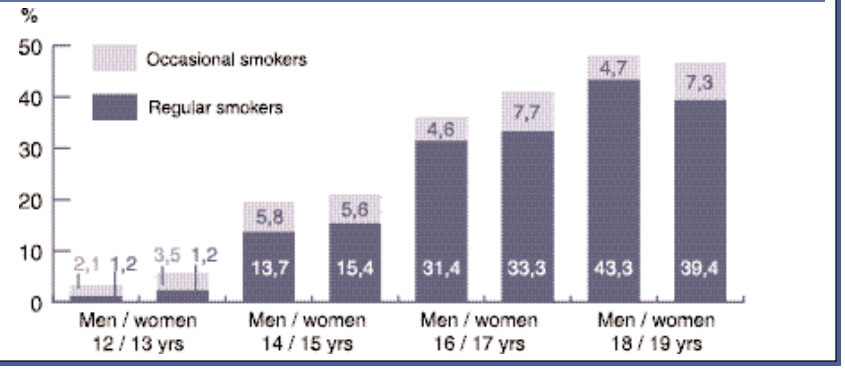
Alcohol use, whether associated with several drunken episodes over the year or not, was less frequent amongst lycée students in Prioritary Educational Zones (ZEP) than amongst other lycée students (4). Young individuals who were under the care of Youth Legal Protective Services drank alcohol on a more regular basis than the other lycée students.

■ Tobacco

Amongst 12-19-year-old individuals, 29% stated that they smoked, even on an occasional basis. Twenty-four percent smoked at least one cigarette per day and 5% smoked less than one cigarette per day (3). Amongst lycée students, approximately 50% were smokers (15% occasional and 35% regular). Amongst young people who smoked either occasionally or on a regular basis, an average of 6.8 cigarettes were smoked per day. Twenty-one percent of the regular smokers smoked over 10 cigarettes per day.

Cigarette use was found to increase with age, but there was already a considerable percentage of regular smokers amongst 14-15-year-olds. The percentage of regular smokers then increased as did the quantity of cigarettes smoked, from 3.8 cigarettes per day at age 14 to 8.3 at age 17 (3). The average age of initiation to tobacco was 15 (3).
For all of the surveyed age groups, there was no significant difference in the percentage of girl and boy smokers. From this point of view, tobacco clearly differs from illicit drugs and alcohol. Many more boys stated they had used the latter substances than girls.

Percentage of tobacco smokers by gender and age amongst 12-19 year olds
Source : Baromètre Santé jeunes 97/98 - CFES



Over the last 20 years, the percentage of adolescents who stated they smoked decreased amongst both boys and girls for all types of use. The percentage of 12-18-year-old smokers went from 46% in 1977 to 25% in 1997 (3). Amongst lycée students, the percentage of heavy smokers (at least 10 cigarettes per day) amongst regular smokers clearly decreased (3, 6).

Another positive phenomenon is that the age of initiation to cigarettes has constantly increased over the last 20 years (3). Amongst lycée students in ZEPs, tobacco use is relatively low with 26% of regular smokers, compared to 35% of all lycée students (4). Amongst the young individuals under the care of the PJJ (2), the prevalence of tobacco use is much higher than amongst other young people or students. The percentages of regular smokers were 75% for boys and 81% for girls.

■ Psychoactive Medicines

A total of 8.7% of the 12-19-year-olds had taken a psychoactive medicine over the last 30 days (3). Seven percent of the young people had taken specialized medicines for anxiety or for nerves, and 3.5% had taken hypnotics.
Over the year, 10% of the lycée students took psychoactive medicine on a more or less regular basis, while 20% took them on an entirely exceptional basis (4). These figures increased from 1993 figures (6).

As was the case amongst adults, psychoactive medicine use was strongly dominated by women. According to figures from the Baromètre Santé 97/98, 11% of girls versus 5.9% of boys had used these substances. This difference is clear for all ages of young individuals. All of the surveys indicated that twice as many girls take psychoactive medicine than boys.

The percentage of psychoactive medicine users amongst girls increase with age: 2.6% of the 12-year-old girls had taken some over the last 30 days, compared to 16.3% at age 19. No particular age-related changes have been detected amongst boys (3).

■ Associated Uses

Alcohol and tobacco use are often associated amongst 12-19 year-olds: 48% of the regular smokers had cinsumed at least 1 alcoholic beverage per week over the last 12 months (3). This behaviour, although marginal amongst 12-13 year-olds (18%), concerned more than one-half of the 18-19 year-olds regular smokers (55%) (3).

Methodological References

➥ (1) Enquête sur les lycéens parisiens et les substances psychoactives, INRP-Paris X Nanterre.
(See preceding sheet).

➥ (2) Enquête « Adolescents de la Protection judiciaire de la jeunesse », INSERM U-472, 1997/1998.
This sample was made up of young individuals under the care of Youth Legal Protection Services in 15 départements randomly drawn. Of these, 5,286 individuals were given a self-administered questionnaire about their health and use of psychoactive substances. A total of 917 of these individuals filled out a questionnaire for a response rate of 17.3%.

➥ (3) Baromètre Santé jeunes 97/98, CFES.
(See preceding sheet).

➥ (4) Enquête sur les conduites déviantes des lycéens, CADIS, 1997.
(See preceding sheet).

➥ (5) Enquête sur les jeunes et l'alcool, IREB (Institut de recherches scientifiques sur les boissons), 1996
This general population survey was conducted one-on-one in the homes of 997 13-20-year-old individuals. In most cases, the interviews were conducted without the presence of a third individual. A similar survey was conducted in 1985 amongst 13-18-year-old boys making it possible to compare alcohol use amongst boys between 1985 and 1996.

➥ (6) Enquête Santé des adolescents 1993, INSERM U-169.
(See preceding sheet).

For More Information:

- *BALLION (R.), Les conduites déviantes des lycéens, Rapport d'étude OFDT, CADIS, 1999.*
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- *DE PERETTI (C.) et LESELLBAUM (N.), Les lycéens parisiens et les substances psychoactives : évolutions, Rapport d'étude OFDT, INRP – Paris X Nanterre, 1999.*
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Perceptions, Opinions, and Attitudes of the French Toward Illicit Drugs

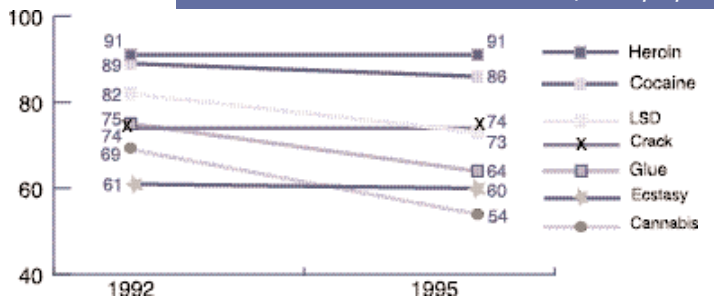
Approximately 30 different surveys, all related in some measure to drugs and drug addiction, were conducted in France between 1988 and 1998. Most of them were commissioned by the Comité Francais d'Education pour la Sante (French Centre for Health Education) (CFES), in preparation for prevention campaigns or to measure their impact, or by various press groups interested in observing the state of opinions at a particular point in time.

Considering the multiplicity of questions asked of the French in these different surveys, we find it appropriate to group them together into two major categories; 1) by how they perceive this phenomenon (types of representations of the different substances and users, level of feelings of proximity and tolerance), and 2) by their opinions on how to deal with this issue (information and prevention, repression, decriminalizing use). Even though the elements produced by these surveys are sometimes contradictory and are often difficult to compare, they nevertheless make it possible to gather large amounts of data.

Substances

Licit substances are more frequently considered to be drugs in the same capacity as illicit drugs. This perception makes it possible to establish a hierarchy in how frequently they are cited as such. Within this hierarchy, alcohol, tobacco (more and more often) and certain medicines (tranquillizers) appear well after opiates, cocaine and cannabis, but before amphetamines and inhalants. This hierarchy, determined by a pre-established list, was somewhat modified depending upon how questions are asked. Only 3% of the French spontaneously stated psychotropic medicines as drugs, but 77% cited them as drugs when explicitly offered this type of answer.

Share of the French who consider these substances dangerous
Source : Eurobaromètres 92 et 95 (French people answers)



Although most illicit substances are still perceived to be dangerous, the perception of danger decreased for certain drugs between 1992 and 1995. This was mainly the case for cannabis (from 69% to 54%). However, in a lesser measure, the perceived danger of heroin, crack, ecstasy, and cocaine, remained stable. Another question

showed that 85% of the French consider certain medicines to be as dangerous as harder drugs.

The percentage of individuals who felt that cannabis use had no serious health implications also increased from 1990 to 1996, but remained in the minority (38%).

Although the number of French who favoured distinguishing "hard drugs" from "soft drugs" slightly grew over the 1990s, there was no truly significant increase. It has mostly been noted that a fairly clear majority is still opposed to doing so (64% in 1993, 61% in 1997).

Uses and Users

When questioned about the main dangers threatening young people, drug abuse often came in first place. This was even the case in surveys that did not specifically focus upon the drug theme. Amongst the possible causes that could induce a young individual to take drugs and perceived factors of vulnerability, insecurity was cited by the majority (due to educational or professional failure, various problems, escape from reality, etc.). Another popular answer was the effects of being drawn into taking drugs by someone else (peer pressure) (18%). Breaking the law, which could be suggested as an incentive to take drugs, was ranked far below (2%). The notion of pleasure, which appeared for the first time in a 1997 survey, was selected by 7%. At the beginning of the decade, the legitimacy of experimenting with drugs was very controversial (refusal of this idea grew from 80 to 90% from 1990 to 1992).

The perception that cannabis use can escalate into using "harder" drugs was strongly set in public opinion in 1992, even though there was a strong difference of opinion between cannabis and non-cannabis users (who respectively accepted or rejected the idea at around 80%). This question has not been asked in a survey since.

An overwhelming majority of those surveyed from 1990 to 1996 considered drug addicts to be ill, but this did not stop 6 out of 10 people from finding them "aggressive and dangerous" in the mid 1990s. However, it has been noted in some surveys that when protocol does not oppose the two notions of ill and delinquent, they can co-exist. The classic distinction between ill and delinquent does not sufficiently clarify the perception that the public may have of drug addicts. Moreover, when the respondent has an additional item enabling him/her to characterise drug addiction as an escape, the opinion that drug addicts are ill loses its immutable character. Thus, we see that items proposed as answers may influence opinions.

Only a minority of the French considers occasional cannabis users to be drug addicts. In 1997, only 29% of all respondents considered someone who occasionally smokes a joint for pleasure as a drug addict. The idea that drug addicts are responsible for what has happened to them was shared by less than half of the French in 1995, a trend that has slightly declined since 1992. This item, as with many others, poses the problem of the definition of the term. An individual who wishes to distinguish opiate addicts from regular cannabis users will have some difficulty to position himself on this question.

Globally speaking, it appears that women, individuals who have completed higher education, and inhabitants of urban zones have the most tolerant attitudes toward drug use. People who have had contact with drugs or users in particular also proved more tolerant. These trends were confirmed during the 1990s. However, concerning young people, the idea of tolerance, which appears in some surveys, is not always systematic.

Prevention and care

In terms of contributions to preventive actions in the broad sense, surveys showed that **the role of the family remains of utmost importance**. Other surveys showed that family increasingly became important from 1988 to 1997, particularly as a place for dialogue. It should also be noted that the media were given more importance in 1998, as well as schools, which were considered to be privileged areas for prevention. According to those questioned, in terms of communication, the idea of information (which one may obtain within the health and social system, particularly from doctors) appears to be separate from the idea of prevention (which must come from family and schools in a smaller measure). Television also represents a conceivable means for prevention, in a less obvious manner.

Those preventive actions, which have been perceived to be most effective, combine the possibility of implementing dialogue with a certain dimension of proximity (local policies). It should be pointed out that 90% of the French agree that reinforcing preventive actions in schools is an effective way of dealing with this problem. Results tend to confirm the importance given to prevention in public opinion. However, in 1992, nearly one-third of the French felt that "talking about drugs could awaken curiosity" toward them.

Amongst the measures approved, as the early prevention actions, there is an obligation to provide drug addicts with care and access to the best medical treatment. **In 1996 and 1997, around 70% of the French considered heroin substitute treatments to be effective.** Although programmes for the medically controlled distribution of heroin and the therapeutic use of cannabis did not have the same levels of approval, support for them was fairly strong (39% for the first and 55% for the second).

Dialogue has proven to be a successful way of dealing with children who are using drugs. If a child takes the necessary steps to inform his/her parents that he/she is doing so, dialogue moves into a pole position (as it agreed with 88% of the French). In 1996, we were able to assess that the French were well disposed toward personal involvement in the fight against drugs and drug addiction (68% were willing to participate in related information sessions). However, these figures decreased when proposed actions brought them into closer contact with users (59% would participate in support groups on a regular basis and 56% would volunteer two hours per week to help an association).

Repression

There was strong approval in all of the surveys for the repression of drug dealers and traffickers (82% were in favour of this in 1996 and 94% favoured it in 1997).

The public found that coercive measures were less effective with users than information and preventive actions (around 50% were favourable of reinforcing police action). This was especially the case when proposals were seen to be to categorical (93% rejected the idea that "the only solution was to lock all drug addicts up in prison," only 6% believed that imprisoning a drug addict would enable him/her to quit drugs for good).

The majority of individuals found that urine analysis was legitimate if performed by the police. One-third felt that this was reasonable if performed by an employer and one-fourth accepted it within the framework of new employment.

What has truly become clearer now in terms of punishment is that **prosecution and punishment should be dealt to users** of heroin and cocaine (85% agreed), cannabis (~70%) or alcohol (~50%). However, this notion may be challenged when the terms in the proposal differ. Three-quarters of the respondents **disagreed with the idea that drug addicts should be punished.**

In the debate over the judicial status of cannabis, a drop in the number of opinions favouring penalization for its use was noted (from 69 to 64% from 1993 to 1997). There was a slight increase in the number of individuals favouring distinguishing between "hard" and "soft" drugs. The number of those accepting the idea that **cannabis could be freely sold was still in the minority** when compared to those who believe that this could incite its use. **Nevertheless**, this possibility **has little by little lost the marginal status it had at the beginning of the 1990s** (32% in 1998 compared to 10% in 1992).

Methodological References

Many factors make it difficult to monitor trends by simultaneously analysing the various studies conducted:

Different contexts (each survey has a particular complexion. Sometimes it is difficult to isolate terms).

Problems that evolve over time (new substances, new trends - controlled distribution of heroin, cannabis, recurrent trends - decriminalisation, detoxification, etc.)

Different protocols (collection methods, age group questioned, formulation, questions included in pre-existing surveys with a larger context: "omnibus" or implementation of an ad hoc survey, etc.)

Sampling methods (random, quotas, by clusters in schools, etc.)

When two different surveys have methodologies that make it possible to compare their results under sufficiently acceptable conditions, the noted gap for an identical question is considered significant if it exceeds a threshold value that is calculated by taking the two sample sizes into account. An agreement has been made that standard deviations for the different rates being studied will be approximated using a hypothesis of normality for a first category error (the risk of making a mistake by concluding that there has been significant change) $a = 0.05$ at the most.

In cases when it is not possible to reasonably compare data due to methodological differences, the confusing factors are underscored. Sometimes conclusions may then be drawn about methodologies to be used in future surveys.

For More Information:

- *BECK (F.), Perceptions, opinions, attitudes et connaissances de la population française en matière de toxicomanie : État des lieux et étude des évolutions depuis la fin des années 1980, Rapport OFDT, 1998.*
- *Enquête Eurobaromètre 43.0 et 43.1 (jeunes) de juin 1995, Prévention des toxicomanies : les Européens et la drogue, INRA, Office des publications officielles des Communautés européennes, Luxembourg, 1996*
- *BECK (F.), Les Français et les drogues : perceptions, opinions et attitudes 1988-1998, Tendances n°1, OFDT, avril 1999.*

DRUG USERS AND INSTITUTIONS

Treatment of Illicit Drug Users in the Health and Social System

Telephone Helpline: Drogues Info Service

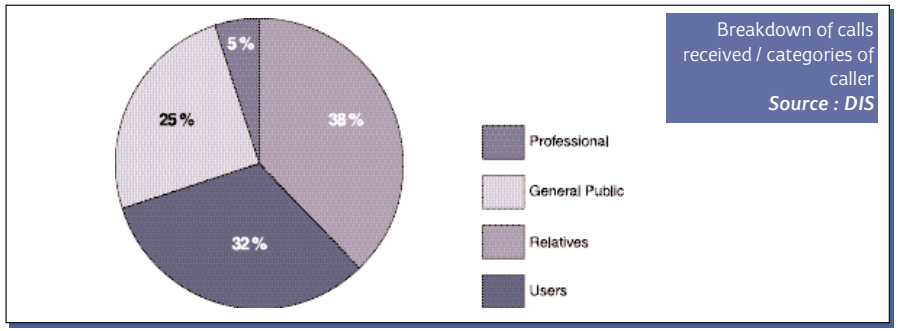
A national drugs and drug addiction helpline has been in service in France since 1991.
This service is free, anonymous, and available 24 hours per day. It may be reached by dialling a toll-free number: 0 800 23 13 13. Telephone helpline centres are located in six cities: Lille, Lyon, Marseille, Paris, Strasbourg and Toulouse.
Drogues Info Service is an interministerial service set up as a public interest group. Its main mission is composed of three parts: 1) Listening to, supporting, and counselling individuals who need help in facing problems related to drug use or the prevention of drug use; 2) Providing information on substances, their effects, use-related risks, the law, and the treatment system; 3) Orientating callers toward organisations that are fully competent in the fields of prevention, treatment, integration, and harm reduction.
Statistics may be calculated on the volume of calls, the individuals who make them, and the nature of their requests. Data generated from these activities do not provide a precise image of all individuals concerned by drugs. The information is, however, helpful in detecting certain changes particularly concerning substances. These variances may then be compared with our other information sources.

Volume of Activity

Drogues Info Service received 620,000 calls in 1998, a 24% increase over the number of calls received the preceding year. This represented a large increase as the number of calls received in 1997 had virtually remained stable. It was due to the relaunching of communication actions right at the start of 1998 and the fact that the subject was much discussed in the media. A total of 161,000 calls received in 1998 were processed. Of these, 30% were requests for help and 70% were peripheral calls (no-one on the line, caller hung up, jokes, etc.). The following analysis is only based upon the 30% of calls for help.

Categories of Callers

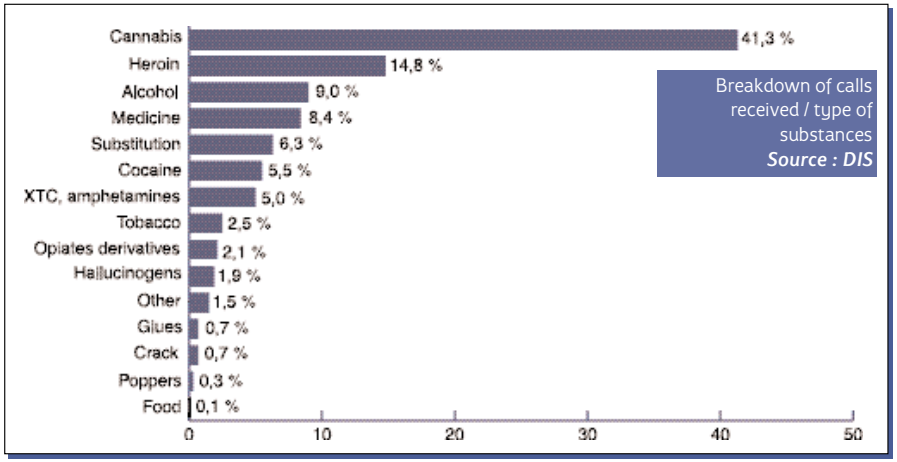
There were some variations in the categorization of callers compared to 1997, but it has not been possible to detect a real long-term trend. Thirty-eight percent of the calls received in 1998 came from immediate family members of friends of drug users (compared to 41% in 1997). Thirty-two percent were from drug users, 25% were from the general public (non-users, not close friends or relatives), a 3% increase over 1997 figures, and 5% from specialized or non-specialized drug addiction professionals. More women than men called (56%), but this breakdown varied according to the category of the call: women[64] represented 79% of the calls made by family members or friends , 65% of the calls made by professionals and 50% of the calls made by the general public. On the other hand, two-thirds of the users who contacted Drogues Info Service were men, which is consistent with the highly predominant number of male drug users.



Breakdown of calls received / categories of caller
Source : DIS

Substances Named

Cannabis was by far the most commonly cited substance, with a continually growing percentage of related calls (41% in 1998 compared to 39% in 1997 and 30% in 1995). Heroin was only mentioned in 15% of the calls made in 1998 compared to 30% in 1995. Nine percent of the calls related to medicines and 8% related to alcohol. These figures remained virtually the same as in 1995. Substitute medicines were mentioned in 6% of the cases in 1998. Medicine and alcohol appear more frequently if we refer to calls during which at least three substances are stated: medicine in 25% of the cases, cannabis in 16% and alcohol in 12% (1997 figures).
Both cocaine and ecstasy were mentioned in 5% of the cases and do not appear to have significantly increased since 1995).



Breakdown of calls received / type of substances
Source : DIS

Methodological References

Data on the number of calls received and processed is obtained from the internal telephone system. Telephone helpline counsellors fill out information sheets for each call that also provide other types of data. Answers provide information on the caller's age, gender, nature of his/her request and substances used. Counsellors are required to fill out the category of the caller, though the other sections are optional. The rates of filled-in areas noticeably vary from item to item, influencing the quality of the statistical representation.

For More Information:

- *Drogues info service, Annuaire des services spécialisés en toxicomanie, édition 1997.*
- *Drogues info service, Rapport annuel 1998 du Groupement d'intérêt public.*

[64] *Forty percent of the calls made by family members were made by the mother and 7% were made by the father.*

Drug Users Treated in Health and Social Institutions

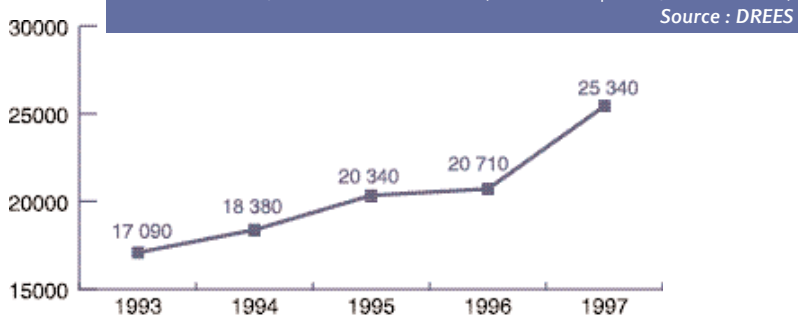
Treatment-related statistics are above all an indicator of the supply and demand of treatment. Using them is helpful in trying to gauge the number of users treated in the three categories of institutions at a given point in time. These institutions are: specialized, health, and social structures. The main difficulty in counting users is the possibility of duplication. One individual may have simultaneously or consecutively sought treatment in several establishments during a given period of time. It is even possible that one individual be counted several times by the same institution. The problem of duplication may be reduced by conducting a survey during a one-month period, but is not completely eliminated. One survey question, concerning treatment in other structures, helps reduce the possibility of duplication even more. Another difficulty is that unless drug use is the very reason for treatment, it may or may not be perceptible. Lastly, problem use (of a health or social order) is most likely to be listed because it is the most visible type of use.

When monitoring changes in the number of treated users, there are problems with variations in the survey field. This is particularly tricky in health establishments that are often subject to reorganisation. There is also fluctuation in the number of responding establishments in all three categories. It is thus necessary to distinguish between standardised data and data from constant fields.

Treatment in the Health and Social System in November

In November 1997, treatment was sought 25,338 times in the health and social structures that responded to the survey. The number of times treatment was sought quickly increased in 1997 (23%) after having grown very little in 1996 (2%). However, these differences are mainly due to fluctuations in the survey field during this period. A little more than half of the increase registered in 1997 was due to variations in the number of structures that answered the survey. **Using a constant field, the number of times treatment was sought increased by around 10% in 1997.** Conversely, this number dropped in 1996 because there were fewer survey respondents and, with a constant field, there was an increase of around 6%. The results from 1996 and 1997 confirm the previously noted trend that the number of times treatment was sought has been steadily increasing since the beginning of the 1990s.

Number of treatments in November (with the exception of double-counts) ***Source : DREES***



Much more treatment was given in specialized drug addiction centres (15,276) than in non-specialized health (8,122) or social (5,188) establishments. These are gross figures from which duplicates have not been subtracted, revealing why the sum of these figures exceeds the global figure mentioned earlier.

Treatment in Specialized Centres

Treatment given during the month of November

There was a global increase in the number of times treatment was sought in November largely due to growth in the number of treatments provided in specialized centres. If the field remained constant, this type of treatment increased by close to 10% in 1996 and 1997.
This change may be explained by an increasing number of substitute treatments. An increasing number of users directly received substitute treatment in specialised centres. This increase may also be due to the fact that regular doctors are more frequently asked to administer substitute treatments to their patients who use drugs and are sending patients to specialised centres.

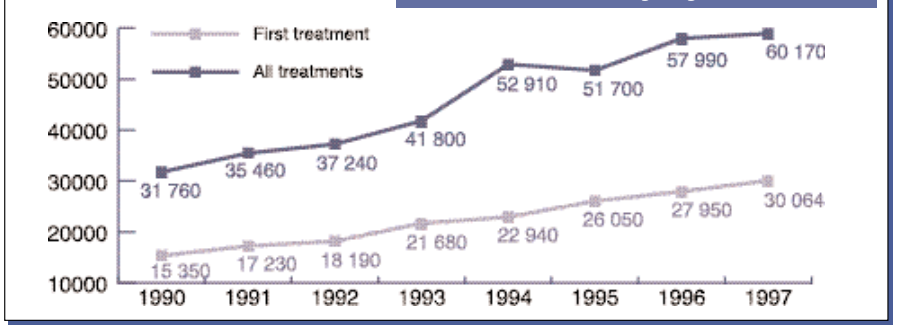
Of all the treatment provided in specialized centres during November 1997, 36% involved users who were seeking treatment for the first time. This percentage has remained stable since 1994.

Treatment given during the year

During 1997, 60,170 drug users received treatment in specialized centres. There was a moderate increase in the number of individuals treated during the year (3.7%) following an increase of approximately 10% between 1995 and 1996. If the field remains constant, the number of individuals seeking treatment dropped 9% in 1997. There is a large gap between the rate of increase in the number of individuals treated in specialized centres in November, 1997, and the number of individuals treated during the year. These different changes may also be explained by an increase in the amount of subsitute treatment given in specialised centres. If one hypothesises that substitute treatment tends to stabilise patients in specialized centres, there would be an average increased patient presence for each month of the year.

Nearly one-half of the individuals treated during the year were being treated for the first time. This has tended to remain constant since the beginning of the 1990s.

Treatments during the year - ***Source : DREES***



Origin of Treatment

In a little over half of the cases where treatment was provided in specialized centres, the users instigated it (45%). Treatment was advised by a doctor or the family in 11% of the cases respectively. A specialized drug addiction treatment centre was the instigator in 8% of the cases, and a hospital or social service instigated treatment in around 6% and 4% of the cases. Lastly, judicial measures led to treatment in 8.5% of the cases (21% of the cases when cannabis is the initial substance, and 7% for heroin).

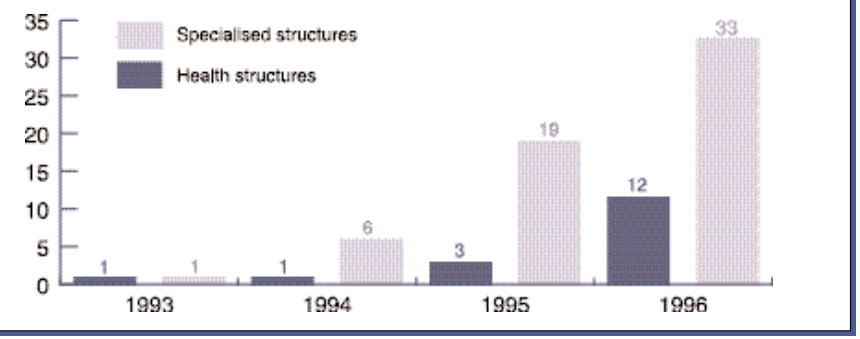
Changes in Treatment

There has been noticeable change in the breakdown of the various treatment methods linked to the introduction of substitute treatment. **In specialized centres, substitute treatment represented 32% of the cases in 1996 compared to 1.2% in 1993, while the percentage of patients who quit taking drugs decreased from 30% to close to 9%**. A similar but less definite development was noted in hospitals where the percentage of users for whom substitute treatment was provided increased from 0.7 to 12%, and the share of patients who quit taking drugs decreased from 39% to 27%.

In the 1997 survey, there was no question about the nature of treatment. Rather, a question about substitute treatment was introduced. It was mentioned by 42% of all treated patients (Subutex® 26%, methadone 14%) and **54% of those treated in specialized centres** (Subutex® 31%, methadone 21%).

Furthermore, a decrease from 28% to 20% in the number of individuals treated for somatic problems was noted in health establishments from 1993 to 1996. This was compensated for by an increase in the number of individuals treated for psychiatric problems (from 18% to 26%). These statistics, which are based upon the main type of treatment mentioned, may not provide a complete picture of the complexity of treatment that quite often has many forms.

Issuing of substitute substances (in percentage of treatments)
Source : DREES



Number of Drug Users under treatment in November 1997 and number of establishments which answered the survey

Type of establishment	Number of establishments	Number of addicts
Specialised centres	271	15276
Health care establishments	513	8122
Regional hospitals	56	2502
Hosptials	268	2363
Specialised psychiatric hospital and private psychiatric hospital working with the public	107	2634
Mental hospital	77	312
SMPR	5	311
Social establishments	538	5188
Inpatient social rehabilitation centre	336	1978
Prevention club and team	202	3210

Source : DREES

Note: *The 271 specialised establishments that answered the survey in 1997 may be broken down into 218 drug addiction treatment centres, 15 drug addiction units, 31 reception centres for drug addicts, and seven centres for housing and social rehabilitation dealing mainly with drug users.*

Methodological References

➥ Enquête Toxicomanie de novembre, SESI

Drug users who are undergoing treatment in the health and social system during the month of November, 1997 are recorded in this survey. This is done whether treatment began before or during the observation period. A certain amount of information must be filled out for each recorded individual (age, gender, substance taken, etc.). Specialized drug addiction centres also provide a global number for individuals treated during the year.
Until 1996, drug users who used illicit substances or misused licit substances on a prolonged and regular basis were recorded. Occasional users and alcohol dependent individuals were not included in the survey field.
Some modifications were made to the 1997 survey. Drug addiction units and obstetric gynaecology were added to the list of structures and services surveyed. The criteria for being included in the survey were expressed in a slightly different manner: "any individual who is completely or partially undergoing treatment for a problem with drug addiction, whether this individual be off drugs or still using drugs, and/or any individual having taken illicit substances or misused a licit substance over the last months." Individuals who are exclusively dealing with alcohol addiction are still not included in the survey field.
Some questions were deleted, particularly one concerning the nature of treatment. Others were added (origin of treatment, the addition of ecstasy to the list of substances taken). These modifications were fairly minor.
Health establishments, which fall under the category of "Public Assistance - Paris Hospitals," were only surveyed for one week. As a result, the number of treatments provided during the month was estimated using a coefficient of adjustment.
A closer analysis of the 1995 survey led to the discovery of a large error related to the annual number of treatments provided in specialized centres. This number, which accounted for 64,738 annual treatments in specialized centres - as published in the last OFDT report and the publication from the Ministère de l'Emploi et de la Solidarité[65] - was adjusted to 51,700.

[65] *La prise en charge des toxicomanes dans les structures sanitaires et sociales, novembre 1995, Documents statistiques n° 298, Service des statistiques des études et des systèmes d'information, février 1998.*

For More Information:

- *DREES (ex SESI), Les toxicomanes suivis dans les structures sanitaires et sociales en novembre 1996, Etudes et résultats n°1, ministère de l'Emploi et de la Solidarité, décembre 1998, 6 p.*
- *DRESS (ex SESI), La prise en charge des toxicomanes dans les structures sanitaires et sociales en novembre 1996, Documents Statistiques, ministère du Travail et des Affaires sociales, 1999, à paraître.*

Treatment in Specialized Anti-Alcoholism Structures

In 1997, the structures that answered the questionnaire sent out by the General Health Department (201 out of 227 legal entities) stated that they had seen 93,868 individuals. If the field remains constant, the number of these individuals increased by 9.6% in 1997 and 2.5% in 1996. Of all the individuals in 1997, 50% came in for the first time, 20% came in only once, and nearly 15% were close friends or family of a drinker. These percentages have changed little since 1994. Approximately 43% of all the individuals seen were drinkers being seen for the first time. Around 38% of these drinkers had been directed there by someone working in the medical milieu (by a hospital in a little more than one of every two cases). One-fourth of these drinkers had been directed by administrative services (alcohol road control, justice, DDASS,, etc.), 12% by social services, 4% by associations and close to one in five came upon his/her own initiative or upon the advice of a friend or family member.

Two-thirds of the drinkers seen for the first time were perceived to be alcoholics, a little over 20% were perceived to be excessive drinkers and 13% to be occasional drinkers. The latter category mainly came from individuals driving under the influence. The percentage of alcoholics has tended to increase yearly while the number of excessive drinkers has decreased. The specialized system mainly targets (more and more) those individuals who have the most serious problems with alcohol.

Source: Le dispositif spécialisé de lutte contre l'alcoolisme en 1997, informations issues de l'exploitation du rapport type: Bureau de la santé mentale, des toxicomanies et des dépendances, Ministère de l'emploi et de la solidarité, Janvier, 1999.

General Practitioners and the Treatment of Drug Users

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 not insignificant 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 users "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 tranquillizers, 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 hospitalized, 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.

Methodological References

➥ Three surveys undertaken in 1992, 1995 et 1998 by the EVAL company

In 1992, 121 general practitioners practicing in four regions with a high density of drug users (Ile-de-France, Provence-Alpes-Côte d'Azur (PACA), Nord-Pas-de-Calais and Rhône-Alpes) were surveyed.

In 1995, the sample was made up of 288 general practitioners throughout France, including 144 in the four regions covered in the preceding survey.

In 1997, this sample was made up of 300 doctors throughout France, including 124 in these same four regions.

The samples were made by drawing names from France Télécom phone lists with a pre-established replacement plan in cases of refusal to participate.

The three surveys were conducted over the phone and largely used the same questions. Doctors were surveyed about their activity the year preceding the survey. Comparisons between 1995-1997 were based on a global sample. Only a sub-analysis of the four cited regions made it possible to compare the three years. The differences mentioned here were those that were statistically significant (threshold of 5%).

For the three surveys, refusal rates were respectively 25%, 29% and 25%. Doctors who refused to be surveyed did not treat many drug addicts. Nevertheless, the final sample was representative of French general practitioners.

For More Information:

■ *BLOCH (J.), CURT (F.), MONAQUE (C.), PIRAULT (S.), Évolution de la prise en charge des toxicomanes. Enquête auprès des médecins généralistes en 1998 et comparaison 92-95-98, Rapport OFDT, EVAL, 1998, 49 p.*

Harm Reduction Indicators: Sale and Distribution of Syringes

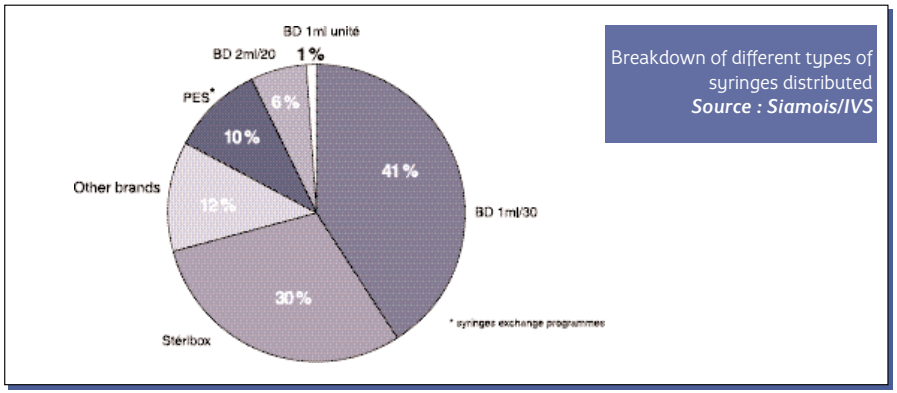
Greater access to sterile syringes is one of the public health objectives aimed at reducing the transmission of viral infections (HIV, HBV, HCV). Reducing the sharing and re-use of syringes can only happen by increasing the sale of syringes in pharmacies and those distributed by the PES (syringe exchange programme). From this perspective, prevention messages will incite drug users to only use their own syringes.

Drug users mainly use 1 ml Becton-Dickinson syringes that are either sold in the form of an individually packaged Stéribox® (prevention kits containing two syringes, two alcohol swabs, a small bottle of sterile water, a condom and prevention messages), or most often in packages of syringes designed to be used by insulin-dependent diabetics.

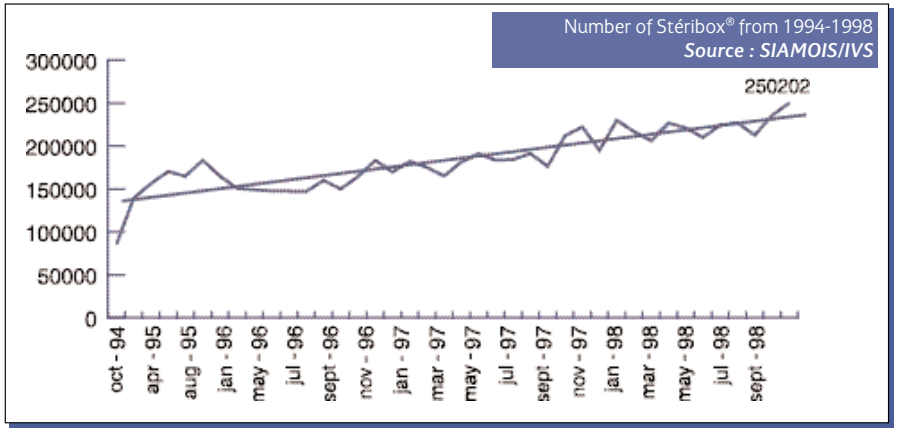
All in all, pharmacies sold an estimated 13.8 million syringes to drug users in 1997.
Of the total, 4.6 million of these were in Stéribox® kits, and 122,800 were individually packaged 1ml BD syringes.

On the other hand, using results from a national survey conducted amongst a cross-section of 400 pharmacists, the Becton-Dickinson Company estimated that 11% of the 1 ml syringes from boxes of 30 (and 16% of the 2ml syringes from boxes of 20) are sold to drug users each year; respectively 6.4 million and 921,000 syringes. Lastly, this brand, which represents 80% of the market for syringes sold in pharmacies, estimated that 1.87 million syringes made by other companies are sold to drug users each year.

In addition to pharmacy sales, front-line services called "Syringe Exchange Programmes" freely distribute syringes. Most of these are government approved and financed by the General Health Department. The others function with private funds or budgets accorded to them by local communities. Using information from all of the French syringe exchange programmes, these structures distributed an estimated 1.5 million syringes in 1996. Thus, this amount represents from 10% to 11% of the total syringes used by drug users during the year.



Breakdown of different types of syringes distributed
Source : Siamois/IVS



Sales of Stéribox® kits have moderately increased, with seasonal fluctuations, after the strong increase that followed the implementation of this product for sale in pharmacies in Fall, 1994. The sale of 1ml and 2ml syringes remained stationary in 1996 and 1997.

Using the hypothesis that the population of injecting users is stationary, these changes must be interpreted as the result of an increase in lower risk injections (less re-use and sharing) and the impact of substitute treatment that tends to cause a drop in injecting. It is not possible to evaluate the respective contribution of these two factors.

It is difficult to measure how much increasing the accessibility of syringes impacts HIV amongst drug users, but results seem to be indisputable. **Generally speaking, and until the apparition of tri-therapies in 1996, various epidemiological studies led to the supposition that the impact of this harm reduction policy contributed in decreasing, then stabilising new HIV infections amongst intravenous drug users from the beginning of the 1990s. From 1996 on, the strong drop (-36% between the 1st and 2nd semester of 1996, -31% between the 2nd semester of 1996 and the 1st semester of 1997) in the number of new AIDS cases amongst IDUs (contaminated several years before) mainly comes from the administration of tri-therapies which slow down AIDS, amongst other effects, in seropositive patients who are undergoing treatment. If there is still any impact of harm reduction on new AIDS cases declared from 1996 on, it is impossible to measure since the effects of tri-therapies are so prevalent.**

On the other hand, this increased accessibility seems to have had less impact on transmission of the hepatitis C virus, **which remains particularly prevalent amongst drug users. For an explanation of this phenomenon and for more details on HIV, HCV and HBV infections, refer to the section on morbidity amongst drug users and to related contributions in the "Trends" section.**

For More Information:

■ *Institut de veille sanitaire, Contribution à l'évaluation de la politique de réduction des risques à travers le système d'information sur l'accessibilité au matériel d'injection et à la substitution, 1999, report to be published.*

Methodological References

➥ SIAMOIS System :

The System for Information on the Availability of Medicinal Injection and Substitution Materials, initiated by the General Health Department and developed by the Health Watch Institute, was created in 1996. Its goal was to monitor trends in accessing sterile injection materials available in pharmacies, and substitute medicines. Data was transmitted by the Group for the creation and development of statistical studies for the pharmaceutical industry. By relating these data to the 20-39-year-old population, in which 80% of the drug users is found, indicators may be obtained to make comparisons on a regional and departmental level. These indicators may be compared with new AIDS cases, overdose-related deaths and arrest for drug-related offences in the same age group.

Drug Users Undergoing Substitute Treatment

The anti-drug addiction health policy, implemented over the last few years, has profoundly modified the treatment of drug users in France as substitute treatment possibilities have been made available in treatment centres and General Practionners offices.

Since its implementation on the market in January, 1996, the quick and steady growth in the sale of Subutex® is evidence of a large number of heroin addicts who have begun and continued this treatment. Since the Autumn of 1995, there has been a moderate increase in the number of individuals getting methadone in pharmacies. This moderation may be due to the fact that the framework for issuing this substance is stricter: initiation to methadone treatment in a specialized centre, with limited capacities (patients must come daily, or at least weekly); after stabilization of the user, a doctor must be seen and length of prescription limited to seven days.

There is not enough individual information to know the number of patients experiencing the benefits of the different substitute treatments. However, using certain hypotheses, an estimate may be made with information on sales from pharmacies stemming from the SIAMOIS system.
In addition, the 1997 survey conducted amongst general practitioners provides a rough estimate of the declared number of individuals who have had access to this treatment within the framework of a doctor's appointment (whether or not the treatment was taken all throughout the year). Figures on the number of individuals undergoing substitute treatment derived from this survey, which has the same limits as any other declarative survey, may not be considered perfectly reliable. However, possible bias seems to be relatively limited.
For all aspects of evaluating substitute treatments, refer to the contributions to this report related to substitution with methadone and high doses of buprenorphine (Subutex®) in the "Trends" section.

Number of Users Undergoing Substitute Treatment

In order for a substitute treatment to be effective, the prescribed dose must be taken every day. On the basis of an average dose of 8 mg per day of Subutex®, as observed in some studies (SPESUB), and assuming that the treatment is strictly followed, monthly sales corresponded to 57,100 patients per month in December, 1998. It is not possible to know how many of these treatments were prescribed by a regular doctor or in a treatment centre. For methadone, on the basis of an average daily-prescribed dose of 65 mg/day, regular doctors treated an estimated 2,770 patients per successive month in December, 1998. Nearly 4,380 individuals treated in treatment centres must be added to the above figure for a total of 7,150 patients per month undergoing methadone treatment in December, 1998 (average daily prescribed dose of 65 mg).

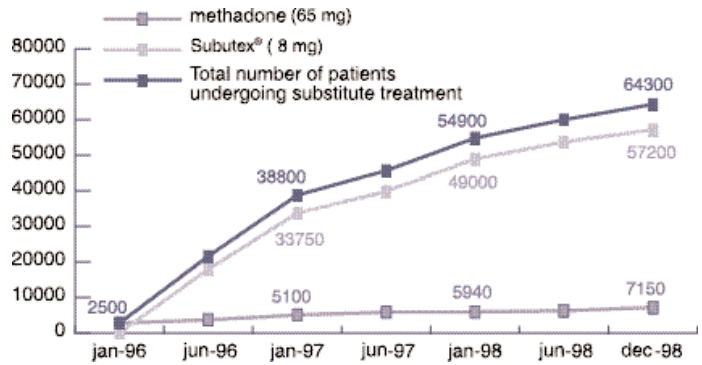
The real number of individuals receiving this medication is affected by certain phenomena: multiple prescriptions, resale or bartering of medicine acquired in a pharmacy, which leads to use outside the treatment framework. Although those working in the field observe these phenomena, they cannot be quantified. However, it is probable that a higher number of users are taking these medicines during a given period of time than the number derived from sales data (particularly for Subutex®).

Developments

Growth in the sale of Subutex® has been steady since it was placed on the market at the beginning of 1996, but seems to be slowing down: +7,500 units per month (equivalent to 8 mg bottles) for an average increase of more than 12% per month over two-and-one-half years. Not taking into account the first six months of 1996 (initial period of strongest growth), the average rate of growth is somewhere around 5% per month. However, this rate has progressively decreased to around 1.4% during the last semester of 1998.

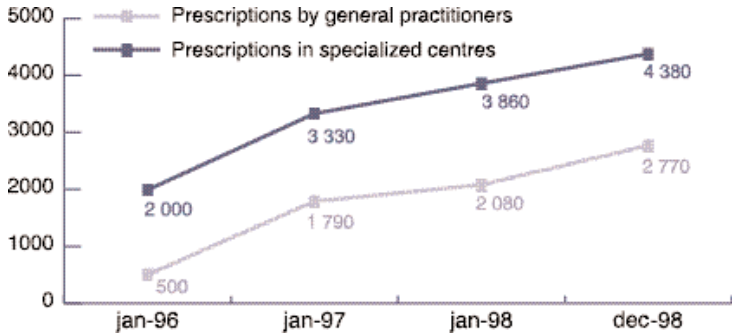
The distribution of Subutex® is mainly dependent upon general practitioners, it is not really limited by supply, and particularly depends upon changes in the demand of users.

Estimate of number of patients undergoing substitute treatment - ***Sources : SIAMOIS/IVS and DGS***



The increase in the prescription of methadone has been progressive. At the beginning, it was linked to the number of treatment places determined by the General Health Department. In spite of the increased number of centres prescribing it and the possibility of continuing treatment with a regular doctor, the distribution of methadone has been slowed down by the conditions for initiating treatment. This requires the supervision of professionals who can only treat a limited number of patients. Growth in the number of patients undergoing treatment with methadone was moderate in the second semester of 1997, experiencing a stronger increase in 1998.

Estimate of number of patients undergoing treatment with methadone (65 mg)
Sources : SIAMOIS/IVS et DGS



Comparison of the estimated number of patients taking Subutex® derived from pharmacy sales data, and the number of patients declared by general practitioners.

According to a survey conducted amongst a cross-section of general practitioners, the number of individuals to whom the buprenorphine substitute treatment was prescribed in 1997, was between 80,00 and 140,000, with an estimated average of 110,000.

Patients may change doctors during the year or see several doctors during a same period of time (multi-prescriptions). Therefore, this survey overestimates the number of patients undergoing treatment, as opposed to the estimate of Subutex® sales which largely underestimates the real number of users. Each of these estimates has methodological limits. The estimate derived from the survey of general practitioners may show bias in the randomness of the sample, or how well those surveyed remembered information. In addition, it is not possible to know the rate of double counts. Although the estimate derived from SIAMOIS is based upon complete data, it is not possible to account for changes in users.

Beyond their intrinsic limitations, these two estimates are not incompatible, but additional work is needed to know the actual number of patients undergoing therapeutic treatment.

Methodological References

SIAMOIS System :

Please refer to the presentation of the SIAMOIS system found in the section on injection materials (see prevuous chapter).

This calculation uses sales data to calculate the number of users per month undergoing substitute treatment.

Subutex® is packaged and sold in three different doses: 0.4 mg, 2 mg and 8 mg. Packages for each dose contains seven pills. Using the quantities of packages sold for each dose during a month, one can calculate the total corresponding number of milligrams of Subutex® (A). For example, the sale of one hundred 2mg packages equals a quantity of Subutex® which is equal to the product of 100 packages multiplied by seven pills multiplied by 2 mg, or a total of 1,400 mgs.

If we count on an average prescription of 8 mg per person per day (average prescription confirmed by different studies), one may easily estimate the number of milligrams taken per person during a month within the treatment framework (B) - or 8 mg x 30 days.

The relationship between (A) and (B) estimates the number of individuals taking 8 mg/day of Subutex® (assuming that the treatment is being strictly followed).

This calculation is done in a similar manner for methadone, which is packaged in bottles containing 5, 10, 20, 40 or 60 mgs of methadone, on the basis of an average prescription of 60 mgs per day per and strongly supposing that the treatment is being strictly observed. This estimate only concerns patients undergoing treatment by a regular doctor, and must be completed by adding the number of patients undergoing this treatment.

For More Information:

■ *BLOCH (J.), CURT (F.), MONAQUE (C.), PIRAULT (S.), Évolution de la prise en charge des toxicomanes. Enquête auprès des médecins généralistes en 1998 et comparaison 92-95-98, Rapport OFDT, EVAL, 1998, 49 p.*

Drug Users and the Legal System

Arrests of Drug Users

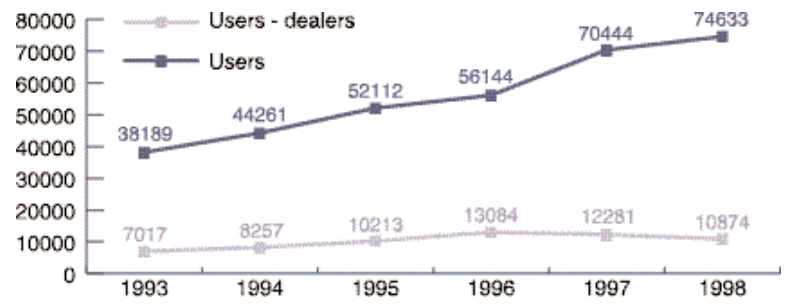
In the case of drug-related offences, police and gendarmerie services act entirely on their own initiative. Thus, it is particularly difficult to determine how much of noted changes are due to variations in the population of drug users and how much is linked to changes in the activities of these services. Strong mobilisations of police forces, as was the case during the vigie-pirate plan, could lead to an increase in related arrests, although the number of drug users has remained constant. It is thus advisable to avoid drawing conclusions too quickly about changes in the number of users when using arrest data.

Arrests

Growth in the number of arrests of users and user-dealers, was moderate in 1988 (+ 3,4%) after a particularly strong increase in 1997 (+ 20%). The number of use-related arrests nearly doubled between 1993 and 1998.

Arrests of simple users have progressed more quickly than those of users-dealers. Arrests of users-dealers represented around 12% of the arrests in 1998, a slight decrease since 1993. On the other hand, the share of simple users arrested increased from 74.6% in 1993 to 82% in 1998.

Arrests for use / use-dealing (all substances) - ***Source : OCRTIS***

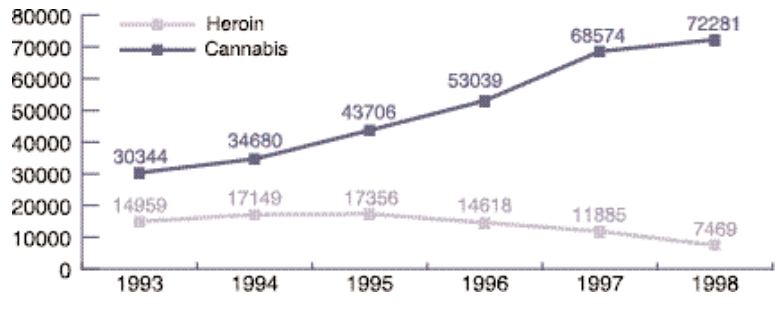


Growth in the number of users arrested, which was recorded in 1997 and 1998, includes an increase in use-related arrests of 30% and 9% respectively, and a decrease in the number of heroin use-related arrests of 16% and 37% respectively.

Between 1993 and 1998, the number of cannabis users multiplied by 2.5 while the number of heroin users dropped by half. Cannabis users represented 85% of the users arrested compared to 63% in 1993. The number of cocaine users arrested greatly increased in 1997 and 1998. This number is higher than the number of heroin arrests in many departments. All the same, they only represented a little less than 4% of arrests for drug use in 1998.

Users who do not deal drugs are less frequently held for questioning and are left free more often than before.

Arrests for use/use-dealing per substance - ***Source :OCRTIS***



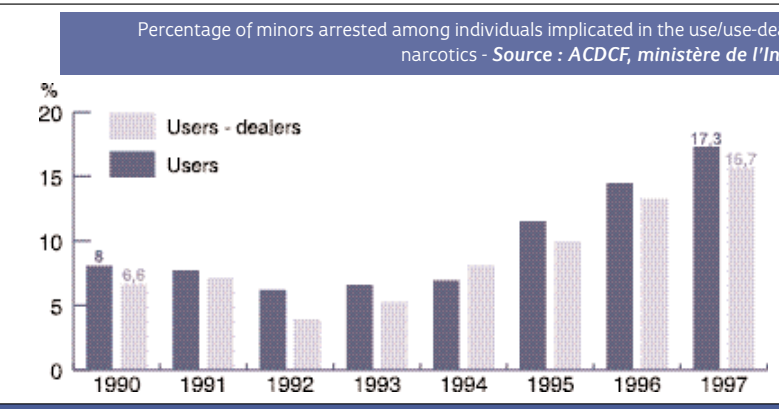
Police statistics provide certain indications about where drug users are oriented after arrest. From this point of view, it is advisable to differentiate between simple users of drugs and users-dealers, as legal consequences vary in both cases according to circular letters from the Ministry of Justice.

A little less than one-half of those arrested for using drugs (45%) were retained for questioning in 1997, compared to 60% in 1993. Police have been arresting many more users than before, but the number of users retained for questioning has remained fairly stable. The percentage of user-dealers retained for questioning, which was higher than the number of simple users in 1993, has only slightly decreased (74% in 1997).

Of all the individuals who only used drugs but were held for questioning, 97.2% were freed in 1997 (92.6% in 1993). Freeing the individuals in question does not simply mean that proceedings will be dropped. Some may be called into court later to be judged.

The percentage of minor drug users arrested has increased, while the percentage of foreigners arristed for using illicit drugs has decreased. An increasing number of minors are being retained for questioning for drug use and use-dealing. The percentages for this increase went from 6.6 to 17.3% between 1993 and 1997, for the first category, and from 5.5 to 15.7% for the second. According to figures provided by the OCRTIS, the increased number of minors and young adults under the age of 21 contributes to around 70% of the increase user arrests between 1995 and 1997. Arrests

Percentage of minors arrested among individuals implicated in the use/use-dealing of narcotics - ***Source : ACDCF, ministère de l'Intérieur***



of individuals over the age of 25 are only responsible for 6% of the increase in the number of user arrests.

The significant decrease in the percentage of foreigners amongst those retained for questioning for use and use-dealing should be noted. Between 1993 and 1997, the percentage of foreign users amongst all users dropped from 13.7% to 8.8%, and amongst user-dealers from 19% to 10.4%.

It is not easy to explain the increase of arrests in 1997. A combination of factors that may be grouped together along **two main lines** may clarify it. The first concerns possible modifications in the behaviour of police and gendarmerie services. According to an assessment[66] of how well the Ministry of Justice's 1995 circular letter on court ordered treatment was being applied, nearly all of the public prosecutors instructed police and gendarmerie to systematically report users. Following through on these instructions may have led to an increase in the number of reported arrests. In addition, internal reorganisation of police departments may also have played a factor in increasing arrests. There is a notable trend toward providing greater autonomy to public law enforcement services when dealing with drugs. The second line is drawn from the **normalization of cannabis use and changes in the context of its use**. With the state of current knowledge, it would be presumptuous to favour one or the other of these explanations.

The rapid increase in the number of individuals undergoing substitute treatment since the beginning of 1996 seems to be one of the most plausible explanations for the drop in the number of heroin use-related arrests.

The drop in the number of arrests of heroin users between 1993, and 1998, affects all age groups, but the largest decrease of all occurred amongst 21-30-year-old users, while 16-20-year-old users maintained the same percentage, and the percentage of heroin users over the age of 30 increased.

Individuals Arrested

Between 1990 and 1997, 348,652 different individuals 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 percentage of all drug-related arrests.
During this period, each individual was arrested an average of 1.3 times. There are perceptible differences between substances. Heroin users were arrested an average of 1.4 times, cannabis users 1.2 times and just over an average of once for cocaine users.
These figures confirm the generally accepted idea that a heroin user is more likely to come in contact with the police. However, it should be noted that three-fourths of heroin users who do get arrested are only arrested once. Of the 82,000 arrested heroin users, only a small grow of 7,000 individuals is arrested three or more times for drug-related offences.

It is rare for an individual to be arrested multiple times during a year. A heroin user is arrested an average of 1.1 times during the year compared to 1.05 times for a cannabis user.

Police arrested the same individuals slightly more in 1997 than in 1993, but this variation only had a slight influence on the global increase in the number of individuals arrested.
It is possible to gauge the number of individuals who switched from taking cannabis to heroin by observing data on individuals who were successively arrested for cannabis use in 1990. Of the 19,361 cannabis users arrested in 1990, three-fourths had no more contact with the police between 1990 and 1997. The number of individuals arrested for heroin use after initially being arrested for cannabis use rose to 1,443, or a little over 7% of the cannabis users arrested in 1990. Forty percent had been arrested several times.

[66] *SAGANT (V.), Bilan de l'application de la circulaire du 28 avril 1995 concernant l'harmonisation des pratiques relatives à l'injonction thérapeutique, Synthèse et analyse des rapports des parquets, janvier 1997, ministère de la Justice*

Methodological References

➥ Aspects de la criminalité et de la délinquance constatées en France par les services de police et de gendarmerie, Service central d'étude de la délinquance de la Direction centrale de la police judiciaire(Central Department of the Study of Delinquency, Central Police Headquarters).
These statistics provide information on the number of arrests for drug-related offences reported to the public prosecutor. Police and gendarmerie services use identical grids when recording information used to establish these statistics. Information covers events, not individuals. Some users may have been arrested several times during a year. A large share of drug-related customs offences is not counted because they are never reported to the public prosecutor.
It is difficult to qualify drug-related offences for use, use-dealing or trafficking because of a lack of rigorous criteria. Therefore, it is inevitable that methods of recording data between the different services are not identical from year to year.

➥ Fichier national des auteurs d'infraction à la législation sur les stupéfiants, OCRTIS(National Database of Perpetrators of Drug-related Offences).
The OCRTIS receives figures provided by police and gendarmerie services. A large share of the reports prepared by police services concerning drug-related offences is also sent to the OCRTIS. These reports are used to requalify certain data provided by the police, which explains some differences in the statistics. The national gendarmerie and police services from Paris and the surrounding area directly feed information to the FNAILS so it is not possible to conduct the same requalification process as used on the other data. The latter sources probably tend to overestimate figures related to drug trafficking. As was the case with the criminal investigation department, the FNAILS does not take into account unreported customs offences. The substance mentioned is the main substance used by the arrested individual. Before 1993, there were large gaps in figures concerning use and use-dealing provided by the OCRTIS and the Criminal Investigation Department. The progressive reduction of these gaps, between 1988 and 1993, led to an increasing phenomenon, resulting in an artificial growth in the number of arrests. This gap between the two statistics became quite small from 1993 on.

➥ Etude du fichier FNAILS : exploitation sur une base individuelle (study of FNAILS Database: using data on the basis of individuals)
Information from this study was used to change the FNAILS database into an anonymous individual database for the period 1990-1997. It thus became possible to no longer list events, but individuals arrested for drug-related offences, and to avoid double-counting. When interpreting data from this individual database, the fact that data on individuals arrested before 1990 is not included should be taken into account. The number of multiple arrests tends to be reduced because of this limited period of time. It should also be remembered that this analysis only concerns drug-related offences. Cases with individuals arrested for non-drug-related offences are not taken into account.

For More Information:

- *OCRTIS, Usage et trafic de stupéfiants : Statistiques 1998, ministère de l'Intérieur, 1999.*
- *ENSAE Junior Etudes, Étude du fichier FNAILS des interpellations pour usage de stupéfiants au niveau de l'individu, Rapport OFDT, 1998, 41p.*
- *BARRÉ (M-D.), Toxicomanie et délinquance, du bon usage de l'usager de produits illicites, Guyancourt, CESDIP, Étude et données pénales n° 70, 1994, 212 p.*
- *AUBUSSON de CAVARLAY (B.), Arrestations, classements, déferrements, jugements, Guyancourt, CESDIP, Études et données pénales, n°72, 1995, 249 p.*

Court-Ordered Rehabilitation Treatment

As seen in the first part of this report, the prosecution has three possibilities when dealing with an arrested user: close the case, pursue, or order treatment.

The latter, which had more or less become obsolete at the end of the 1970s, was revived in 1987. The importance and interest of this measure were reaffirmed in 1993 and 1995 interministerial circular letters sent to the prosecutors. Do not forget that the last circular letter recommended that the prosecutors use court-ordered rehabilitation treatment for heroin and cocaine users, cannabis-addicted users, or users who took cannabis with other substances. Minors and repeat offenders may also be affected by this measure.

The subject of court-ordered rehabilitation treatment has remained a controversial measure about which much has been written, particularly over the last few years. Limited figures are available on court-ordered rehabilitation treatment, only providing partial elements in understanding current developments. They far from provide the answers to all the questions that could be asked about the true effectiveness of this measure, or its adaptability to current changes in drug use.

Rehabilitation treatment ordered by magistrates

After experiencing strong growth between 1992 and 1995, the number of sentences to court-ordered rehabilitation treatment stagnated in 1996 and slightly decreased in 1997.
It may appear that the drop in the number of court-ordered rehabilitation treatments in 1997 is related to the drop in arrests of heroin users in 1996 and 1997. However, this measure also concerns many cannabis users, of which more are being arrested every year. This decrease may not simply be explained as a result of the drop in the number of individuals arrested for heroin use.
Developments in the number of cases where receiving treatment is an obligation (suspended sentences or probation accompanied by obligation to treatment), which may be partial substitutes to court-ordered treatment, could also be an element of explanation. Nevertheless, it seems that this type of measure is little used.
Lastly, it is possible that within the framework of the current diverse practices of prosecutors, this measure has reached its limits.

The sentencing of court-ordered rehabilitation treatment has remained fairly concentrated on a geographical level, in spite the fact that this level has grown considerably over the last 15 years. In 1981, 92% of all court-ordered rehabilitation treatment was sentenced in Courts of Appeal in Paris and Versailles. The share of these Appeals Courts in the percentage of court-ordered rehabilitation treatments dropped to 40% in 1996. This expansion slowed in 1996 and 1997.

In 1997, only 18 départements sentenced over 100 court-ordered rehabilitation treatments, which came to 76% of the total number of court-ordered rehabilitation treatments sentenced that year. These départements are situated in geographical areas where most of the drug addiction-related indicators reach high levels (North and North-Eastern borders, the region surrounding Paris, the South-East). It is not possible to compare arrests and court-ordered rehabilitation treatment as the geographical fields are not identical for the two statistics. On the other hand, it is possible to compare the number of court-ordered rehabilitation treatments sentenced and the number of drug-related offences in the same Court of Appeals. These two indicators jointly evolve from one department to the next. However, the relationship between these two numbers is not constant. The sentencing of court-ordered rehabilitation treatment more than proportionately increases when the number of convictions goes up[68]. Extreme cases of this are found in Paris, with more than 2,000 court-ordered rehabilitation treatments for 4,500 convictions, and in Bastia with 4 court-ordered treatments for a little less than 200 convictions. The concept of court-ordered rehabilitation treatment seems to have been relatively well accepted in areas where there is much drug use, and rarely resorted in areas where there is little drug use.

[67] *Circulaires interministérielles du 15 février 1993 sur la lutte contre la toxicomanie et l'injonction thérapeutique, et du 28 avril 1995 sur l'harmonisation des pratiques relatives à l'injonction thérapeutique.*

Court-ordered rehabilitation treatment undergone

Nearly 70% of the individuals ordered to undergo treatment in 1997 did indeed contact the treatment system. This percentage has remained stable since 1995. In fact, there is another area where data is lost which is not measurable at this time. This loss occurs between the time at which the court order is handed down, often during a phone conversation between the prosecutor and criminal investigators, and the time at which the user is directly informed of the order by the magistrate. A certain number of users do not appear when summoned. As the statistical record often coincides with the notification of ordered rehabilitation treatment measuring that lapse proves impossible.

As a rule, any drug user who has been notified by a court order to undergo rehabilitation treatment must be seen by the Department of Management for Health and Social Action (DDASS), which then directs him/her into a treatment structure. There is a measurable lapse in the system here as well (30%), both on the level when the DDASS must be contacted, and when contact should be made with the health system. On the other hand, no information is available on fully completed court-ordered rehabilitation treatments.

Court-ordered treatment sentenced and carried out

	1993	1994	1995	1996	1997
Number sentenced (1)	6 149	7 678	8 630	8 812	8 052
Number of individuals directed towards the DDASS (2)	4 591	6 500	7 220	7 294	6 628
Number carried out (3)	4 064	5 760	6 072	6 331	5 723

Sources : (1): Cadres du parquet, (2) et (3): DGS

Treatment ordered for heroin users only represents a little less than 36% of the treatments undergone in 1997.
In 22 of the 83 départements in which the court may order treatment, this measure is mainly used for "hard" drug users. On the basis of the 36% just mentioned, a connection may be established between the number of treatments ordered for heroin use (approximately 3,000) and the number of arrests for heroin use (9,000), which gives us a percentage of one-third. In the past, some départements have justified the rarity of court-ordered rehabilitation treatment because of the frequency at which use-related offences are committed[69]. There is no available information necessary to rigorously verify this explanation.

Sentencing non-addicted cannabis users to court-ordered rehabilitation treatment seems to be occurring on a more general basis, and tends to be done to encourage prevention. In 1997, nearly 60% of the court-ordered rehabilitation treatment undergone (in other words having led to contact being established with the treatment system) concerned cannabis users.
The assessment of the application of a 1995 circular letter relating to court-ordered rehabilitation treatment brings to light two concepts used in applying this measure to cannabis users. Some prosecutors attempt to distinguish between cannabis users according to their state of addiction, and save court-ordered rehabilitation treatment for the most highly

[68] *SIMMAT-DURAND (L.), L'usager de stupéfiants entre répression et soins : la mise en œuvre de la loi de 1970, Etudes et données pénales n°77, CESDIP, 1998.*
[69] *RABORD (M.), L'injonction thérapeutique, Échanges santé social, n°81, mars 1996.*

addicted. Other prosecutors use court-ordered rehabilitation treatment for cannabis users with the objective of providing information, prevention, and socio-health treatment.

When compared to the number of cannabis users arrested, the percentage of those users sentenced to undergo court-ordered rehabilitation treatment represents a very small percentage of the individuals arrested for using this substance. Yet, the question must be asked here as well, before establishing any connection between these figures, whether all arrested cannabis users should be considered potential candidates for court-ordered rehabilitation treatment.

According to the assessment of the application of a circular letter from April 28, 1995 relating to court-ordered rehabilitation treatment, this measure was little used for minors in 1995, and did not develop in 1996.

The assessment[70] of court-ordered rehabilitation treatments by the Ministry of Employment and Solidarity in 1997 reported that relations between prosecutors and the DDASS were continually improving with the development of formally established methods for creating dialogue (convention on objectives and protocol of court-ordered rehabilitation treatment) or informal methods (regular meetings for dialogue).
In 37 départements, general practitioners who have signed a contract with the DDASS give treatment. In 26 départements, it is given by a court-ordered rehabilitation treatment unit set up on the premises of the DDASS or a local office near the court. In 16 départements, the services of a specialised drug addiction treatment centre are contracted by the DDASS. The average length of treatment lasted around five months in 1997, but could vary between one appointment and one full year of treatment.
Credits worth 12 million francs were assigned for court-ordered rehabilitation treatment in 1997, up 4% compared to 1996.

Methodological References

➥ The definition of two terms will be reiterated:
Court-ordered rehabilitation treatment handed down: except in rare cases that are systematically referred to the prosecutor, this order is generally given while the arrested user is still on the premises of a police station. The order is the result of a telephone conversation between the police and the prosecutor.
Notification of court-ordered drug rehabilitation: Once rehabilitation has been ordered, the police give the user a summons to appear before the departmental court where the notification of court-ordered rehabilitation is given by a deputy public prosecutor.
➥ Cadres du parquet, SED.
Annual activity statements from the court of appeals, départemental courts, and police courts. These statements give a total number of cases for which drug rehabilitation treatment is ordered over a yearlong period in France.
The notion of court-ordered rehabilitation sentenced and officially declared to the Ministry of Justice has not been clearly defined. It seems to more or less correspond to the number of notifications of court-ordered rehabilitation treatment, but this may not always be the case. As Mr. Setbon shows in his evaluation of this type of treatment, sometimes there are figures for notifications of treatment. Other times, figures for orders handed down and sometimes there is a figure that differs from the other two.
➥ Suivi des mesures d'injonction thérapeutique, DGS (Monitoring Court-Ordered Treatment Programmes, DGS).
Each year, départemental health and social action organizations provide an assessment of court-ordered rehabilitation treatment programmes in their department. This information is then summarized by the SPE office at the Ministry of Employment and Solidarity.

[70] *SAGANT (V.), Bilan de l'application de la circulaire du 28 avril 1995 concernant l'harmonisation des pratiques relatives à l'injonction thérapeutique, Synthèse et analyse des rapports des parquets, ministère de la Justice, non publié.*

For More Information:

- *Circulaire CRIM-93-3/SDJC du 15 février 1993 relative à l'injonction thérapeutique, ministère de la Justice, ministère de la Santé et de l'Action humanitaire.*
- *Circulaire du 28 avril 1995 relative à l'harmonisation des pratiques relatives à l'injonction thérapeutique, ministère de la Justice, ministère des Affaires Sociales, de la Santé et de la Ville, ministre délégué à la Santé.*
- *RABORD (M.), L'injonction thérapeutique, Échanges santé social, n°81, mars 1996.*
- *SIMMAT-DURAND.(L.), et autres, L'usager de stupéfiants entre répression et soins : la mise en œuvre de la loi de 1970, Guyancourt, CESDIP, Études et données pénales n°77, 1998, 503 p.*
- *SETBON (M.), L'injonction thérapeutique, Evaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés, CNRS, Groupe d'analyse des politiques publiques, 1998, 144 p.*
- *SAGANT (V.), Bilan de l'application de la circulaire du 28 avril 1995 concernant l'harmonisation des pratiques relatives à l'injonction thérapeutique, synthèse et analyse des rapports des parquets, ministère de la Justice, non publié.*

Convictions for Illicit Drug Use

Court-ordered rehabilitation aside, arrested drug users may see their case closed, may be issued a warning (most frequently), or may be prosecuted. If there is sufficient evidence, proceedings may be started. Most of time, when users are prosecuted they are convicted.
There are several different ways in which one may appear before the court:

- Immediate appearance
In this case, the arrested individual is most often held until the trial, which occurs shortly after arrest.
- Summoned by a criminal investigator (OPJ)
The charged individual is freed after arrest, whether he/she had been retained for questioning or referred to the prosecutor. A criminal investigator directly gives the court summons. The individual cannot ever claim to have not received notification of the court date.
- Direct citation
The charged individual is also free in this case, but is later notified by a bailiff of the court summons.
- After investigation
As a rule, cases involving trafficking are investigated. There may be a small or large number of users implicated in these cases.

Legal statistics are not classified in the same way as those of police. They distinguish between many offences that may be grouped into seven main categories (refer to chart 2). It is not possible to establish an exact correspondence between the two classifications, thus it is difficult to set up a connection between arrest figures and convictions.

When the prosecutor decides to commence proceedings against an individual arrested for a drug-related offence, he must choose the offence corresponding to the act committed by that person. In the majority of these cases, prosecutors use several offences at the same time. In 1996, prosecutions and convictions involving three or four offences were quite frequent. There has been an increase in the number of offences related to a particular conviction since the beginning of the 1990s. From the judges' point of view, this multi-incrimination makes it more possible to support the facts. However, this severely complicates the observation of changes in the phenomenon, even more so because qualification practices are not the same for the different prosecutors. In the face of the three simple statistical categories for arrests, we see the appearance of many intermediary cases amongst convictions, for which use may be associated with holding-purchasing, transporting or trafficking drugs.

Legal statistical booklets generally present convictions in terms of the main offence committed (refer to methodological references). However, this type of statistic only gives a very partial image of convictions for drug use. A more detailed analysis of drug-related convictions may be made by looking at associated offences.

Convictions for main offences

There were 6,530 convictions for drug use as the main offence in 1997, a figure which remained relatively stable in the medium term, given a few annual fluctuations.
The drop in the number of convictions for 1995 were linked to the presidential amnesty whose effects, although smaller, were still being felt in 1996. Therefore, when looking at chart 2 we have the impression that changes in the number of these convictions, which sharply contrast changes in the figures for use-related arrests, were stable. Convictions for use represented 28% of all convictions for drug-related offences, a percentage that dropped compared to 1992.
When statistics are broken down by main offence, they only give a very partial idea of the offences punished in the convictions. As we will see, use-related offences appear much more frequently than one would think when looking at the figures on convictions presented in the following chart.

Arrests and convictions for use (main offence)

	1992	1993	1994	1995	1996	1997
Arrests for simple drug use(1)	41 549	38 189	44 261	52 112	56 144	70 444
Convictions for illicit drug use (2)	7 374	8 157	6 201	4 670	6 751	6 530
Total convictions for drug-relatd offences(2)	21 851	22 530	20 580	20 661	23 840	23 980

Source : (1)OCRTIS, (2) Annuaire statistique de la Justice

Convictions for associated offences

Here we look at all convictions involving at least one use-related offence. There were 15,685 of them in 1997, a comparable figure to that of 1996, but clearly higher than the 1991 one. Does this indicate that more users are being convicted? In order to answer this question, one must distinguish between cases with conviction for use alone and cases when use is associated with other offences.

Convictions for use only

There were 3,368 convictions for use only in 1997. Compared to 1991, the number of these convictions has dropped, especially as a percentage of the total convictions containing at least one use-related offence (see chart). Conversely, convictions for use only remained stable between 1996 and 1997.

In 14% of the cases of conviction for use only, hard prison time was sentenced in 1997 (compared to 24% in 1991). The average length of imprisonment ranged from 3.5 months to 2.4 months between 1991 and 1997[72]. A 1991 study[73] looks at sentencing involving hard time for use only. Half of the individuals had already been convicted over the two preceding years, frequently for theft or possession of stolen goods. Drug users with no legal past were convicted in 9% of the cases, and one out of two times when users did not attend the hearing.

In 35% of the cases, the drug user was given a deferred sentence, frequently linked to probation during which the user agreed to a detoxification treatment, or to be medically monitored (70% of the cases involving deferred sentences in 1995). Individuals were fined in one-third of the cases, 7% received an alternative sentence, and 6% were sentenced to an educational measure.

[72] *Latest available figures on sentensing.*
[73] *TIMBART (O.), L'usage des stupéfiants dans les condamnations, Infostat Justice, n°38, juillet-août 1994.*

Convictions for use and other drug-related offences

A total of 10,075 of the convictions involved use and other drug-related offences. Amongst these convictions, there is a distinguishable and growing group of individuals convicted for use and offences related to selling drugs.
The number of convictions linking use and trafficking[74] and use and transporting multiplied by four or more between 1991 and 1997. The number of convictions involving use and supplying doubled.
The percentage of sentences to hard prison time is higher amongst these convictions than for convictions for use only (21% of the convictions compared to 14% for use only), but the percentage of partially deferred sentences (prison time and deferred sentence) noticeably differ: 0.6% for use only compared to 37% for use and trafficking, and 21% for use and transporting.

Since 1991, the trend has moved towards more severe sentencing of use associated with transporting or trafficking drugs. The percentage of individuals sentenced to hard time is increasing. The average length of imprisonment lasted 16.8 months in 1997, compared to 18.3 months in 1996 and 16 months in 1991.

In all likelihood, convictions for use and supply target the category of users-dealers in police statistics. The average length of imprisonment would thus be around 10.8 months.

Associating use and trafficking or transporting most likely punishes the activity of "ants" (individuals who attempt to cross borders with small quantities of drugs). Sentencing for this is much less severe than for trafficking alone, or trafficking associated with other offences than use.

Unlike the preceding group, the number of convictions associating use and holding-purchasing has seen little growth. In 1997, the structure and length of sentences handed down for use and holding-purchasing were fairly similar to sentencing for use only. A significant fact is that the average length of hard time decreased from ten months in 1991 to 4.8 months in 1997. The latter average was raised by several cases in which individuals received very long sentences. Thus, it may be thought that convictions for use only and for use and holding-purchasing often target the same behaviours and groups of individuals.

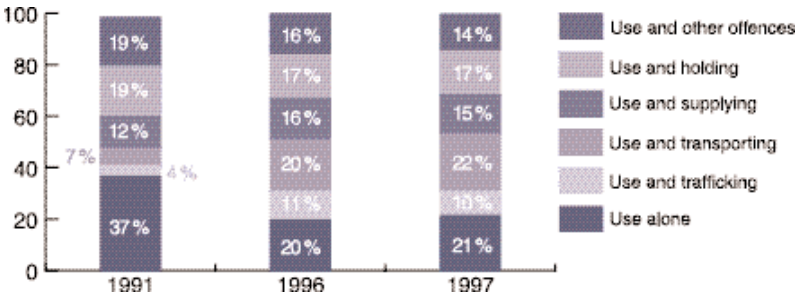
Convictions for use and other crimes not linked to drugs

Lastly, in 1997, there were 2,242 convictions associating use and other crimes not linked to drugs. The number of these convictions is on the rise, but its relative share decreased compared to 1991.
In a large share of these cases, use was associated with theft or possession of stolen goods (nearly two-thirds of the cases in 1995). The percentage of individuals sentenced to hard time is particularly high for convictions associating use with crimes (33% in 1997), clearly down from 1996. This percentage is inflated by the number of individuals in France convicted for use and illegal presence who are systematically sentenced to hard time in prison. However, the percentage of hard time in prison sentences has decreased since 1991. The average length of sentencing, 7.5 months in 1996, has been on the increase since 1991.

Eventually, the main part of the increase in convictions for at least one use-related offence is due to an increase in the number of convictions for use associated with trafficking, transporting, or supplying drugs (in other words, offences for which users are as a rule involved in the drug trade). In the broad sense of the term, convictions for use only, or use associated with other crimes, have remained at a fairly stable level.
It is also difficult to know if this change comes from the fact that more users are involved in the drug business (more users are being used to transport drugs and cross borders) or if prosecutors have modified their practices when qualifying situations by using two offences, use and trafficking, where before they only would have retained a use-related offence.

[74] *The term «trafficking» used here, indicates importing and exporting narcotics substances.*

Breakdown of convictions that include at least one use-related offence per associated offence - ***Source : SDSED***



Convictions for use, out of all convictions related to drug offences

Types of offence	1991		1996		1997 (1)	
	number of convictions	number of % convictions	number of %convictions		%	
Use	11 505	100	15 493	100	15 685	100
Use alone	4 242	36,9	3 019	19,5	3 368	21,5
Use and drug-related offence	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 transporting	761	6,6	3 109	20,0	3 478	22,2
Use and supplying	1 431	12,4	2 505	16,2	2 377	15,1
Use and holding	2242	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 drug-related offence	2 199	19,1	2 393	15,5	2 242	14,3

(1) Temporary data

Source : SDSED, ministère de la Justice

Convictions for use, out of all convictions related to drug offences.

In 1997, there were 27,483 convictions of at least one use-related offence. Of this total, **15,685 sentences punished at least one use-related offence, which was then present in a little more than one-half of all convictions containing a drug-related offence.**
Use only represented around 12% of the 27,483 convictions mentioned above. Use associated with offences related to

selling drugs represented 36%, and use associated with other crimes represented around 9% of the these convictions. The ratio between convictions for use and arrests[75] for use and using-dealing was 19% in 1997, or a little less than one in five arrested individuals. This figure decreased compared to 1991 (23.6%). ¤

Methodological References

Legal statistics come from the national record of convictions. Convictions by main offence list all of the convictions recorded during the year, and only mention the first punished offence of the conviction. As a rule, this offence is the most serious, with a few exceptions. Sometimes, offences are written in the order of events provided in the report. In statistics concerning the main offence, a large share of the use-related offences remains hidden when they are not the first offence on the list of offences committed. It is possible to list all of the convictions that include at least one use-related offence by reviewing associated offences. This is the case in spite of where the offence appears on the list. This also helps to bring to the forefront the most frequently associated offences and sentencing for each case involving association.

Convictions should not be confused with convicted individuals. One individual may be convicted twice in a year and would be counted twice in statistics.

For More Information:

- *Les condamnations 1996 et 1997, Études et Statistiques Justice, n° 11 et 13, Paris, Sous-direction de la statistique, des études et de la documentation, ministère de la Justice, 1999.*
- *TIMBART (O.), Les infractions à la législation sur les stupéfiants, Études et statistiques Justice 4, Sous-direction de la statistique des études et de la documentation, Paris, ministère de la Justice, 1995, 112 p.*
- *TIMBART (O.), L'usage de stupéfiants dans les condamnations, Infostat Justice n°38, Sous-direction de la statistique, des études et de la documentation, ministère de la Justice, 1994.*
- *Annuaire statistique de la Justice, édition 1999, Sous-direction de la statistique et des études et de la documentation, ministère de la Justice, 1999.*

[75] *We are refering to statistics from the Ministry of the Interior, for 1991-1996, which appear to be more consistent than those provided by the OCRTIS.*

Imprisonment for Illicit Drug Use

Imprisoned individuals may fall under two distinct categories: individuals being held temporarily upon waiting for a court decision; and individuals retained after conviction .

The only statistics we have for individuals imprisoned for use-related offences concern the main offence committed. This means that an individual imprisoned for a use-related offence may also be imprisoned for other offences. Symmetrically speaking, individuals imprisoned for other offences (linked to drugs or not) may also be prosecuted or convicted for a use-related offence. As was the case with convictions, this approach of using the main offence committed only gives a partial idea of imprisonment for a use-related offence. However, we do not have any figures that could help us to count the number of imprisoned individuals by the different associated offences.

A constant decrease was observed in the flow of temporary imprisonment for drug use between 1993 and 1997. The number of this type of incarceration dropped from 1,200 to 700 during this time.

For other drug-related offences, the entry flow into prisons remained fairly constant, with a slight decreasing trend.

Number of individuals imprisoned for main offence of use

	1993	1994	1995	1996	1997
Number of individuals imprisoned over the year	1 213	1 034	892	870	700

Source : SDSED, ministère de la Justice

On January 1, 1998, 450 people were listed as having been incarcerated for use as a main offence (of which 197 had been put on remand). As was the case for the 700 individuals entering prisons in 1997, we do not know how many were convicted for use alone and how many were convicted for use associated with other offences. The number of individuals imprisoned after being prosecuted for trafficking, as well as charged and convicted for use, is also unknown. Since there is no study on the associated offences of these prisoners, it is difficult to get a clear idea of how many individuals were imprisoned for use. All we can do is note the funnel effect through which we go from over 70,000 individuals arrested for use only in 1997 to 700 convictions for drug use as a main offence. The number of individuals imprisoned after being convicted of an offence for use only is probably well under 700. On the other hand, the number of individuals arrested after a conviction that included drug use is clearly higher.

Number of individuals imprisoned for main offence of use on Jan.1-1998

Number of individuals on remand	197
Number of individuals imprisoned	253

Source : SDSED, ministère de la Justice

Methodological References

➥ National Prisoner Database, SCERI.

Information in this file is helpful in detecting the number of individuals imprisoned during a given year (between January 1, and December 31). The only offence taken into account is the first on figuring on the committal order. As was the case with convictions, this offence is not necessarily the most serious offence. It may also be the first offence recorded.

It is also possible to know the number of individuals in prison at a given date in time by reviewing these files. This number is the result of entry and exit flows in prisons over a year-long period and over preceding years.

For More Information:

■ *Statistiques trimestrielles de la population prise en charge en milieu fermé. Situation au 1er janvier 1998, n°74, Service de la communication, des études et des relations internationales, Direction de l'administration pénitentiaire, ministère de la Justice, 1998.*

Figures on Offences for Driving Under the Influence of Alcohol

The role of alcoholism in many of the offences committed seems to be important. In D. Barbier's book on the dangers of alcohol, figures cited since 1985 show that alcoholism is a factor in nearly 20% of these offences, and in 69% of the cases involving involuntary manslaughter. These figures are to be confirmed and updated.

The only official data available today refer to driving-related offences that involve alcohol excess. This type of offence does not appear in police statistics, other than in terms of positive results obtained during road alcohol tests which of which there were more than 132,000 in 1996. This figure corresponds to a rate of positive tests of 1.7%. This rate is 1% for prevention testing, and 4% or 5% for tests conducted following an accident.

Number of tests and convictions for driving-related offences due to excessive drinking

	1988	1990	1992	1994	1996
Number of positive tests (1)	111 510	116 613	119 601	129 910	132 283
Convictions for driving under the influence	86 022	94 812	101 469	102 914	97 252
Involuntary injury by drunken driver with incapacity to work under a 3-month period	4 891	4 931	5 256	4 488	3 990
Involuntary injury by drunken driver with incapacity to work over a 3-month period	1 459	1 289	1 095	865	698
Involuntary homicide by drunken driver	759	671	660	530	515

Source : SDSED, ministère de la Justice

(1) Observatoire national interministériel de la sécurité routière, Bilan Annuel, 1997.

On the other hand, the number of convictions for driving-related offences due to alcohol or worsened by it is known. According to a study conducted by the Ministry of Justice concerning driving under the influence of alcohol, there were 102,000 convictions in 1996. Around 97,000 were for driving under the influence, and 5,000 were for bodily damage caused by drunken drivers.

The number of arrests for driving under the influence has been on the increase since 1988, a development that seems to be linked to the increased activity of reporting services. Conversely, a tendancy to decrease is observed as far as convictions for bodily damage is concerned.

In 65% of the cases involving driving-related offences committed by drunken drivers, they receive a one-year prison sentence that is totally deferred in nine out of ten cases. Actual imprisonment is obviously more frequent in cases where there has been bodily injury, and goes up to 57% for cases involving death.

Sources :

Bilan annuel, Statistiques et commentaires, année 1997, Observatoire national interministériel de la sécurité routière.
RIZK (C.), SALLE (G.), *La conduite en état alcoolique et sa répression, Infostat Justice n°52, décembre 1998.*
BARBIER (D.), *La dangerosité alcoolique, Paris, Presses universitaires de France, 1998, 127 p.*

Illicit Drug Users Seen in Institutions: Characteristics and Types of Use

Age, Gender, Professional Integration and Health Coverage of Drug Users

The socio-economic characteristics of drug users are measured through the prism of health and law-enforcement institutions. These two types of institutions tend to be in contact with specific populations: the former for those who have health problems, and the latter for those who are likely to cause public problems. The selective effect is critical when analyzing the various characteristics.

Age of Users

From the point of view of age, two groups may be identified from amongst arrested users and from those who seek treatment in the health and social system:

- **Opiate users** essentially use heroin. Their average age is 28 to 30 and is increasing yearly. Cocaine and crack users who have been arrested or are seeking treatment, are lesser in number, and in an age group related to opiate users.
- **Cannabis users**, whose age centres around 22 years old for arrests, and age 25 for treatment. The average age of ecstasy users is comparable to that of cannabis users.

Users who were treated in specialized centres for the first time in November, 1997 were younger (28 years old) than those in contact with these institutions (around 31 years old).

Age of users and substance

	Heroin	Cocaine	Cannabis	Ecstasy***
Treatments* (1)	30,3	29,4	25,5	22,8
Arrests ** (2)	27,8	29,2	21,8	23

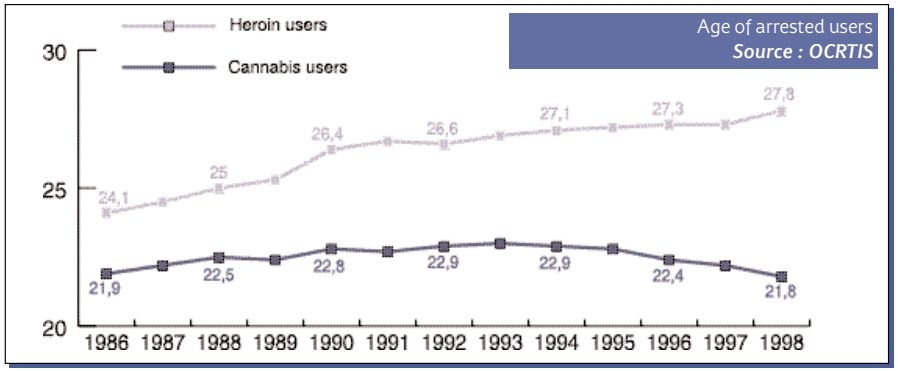
Source : (1)DREES, (2)OCRTIS

** data 1997 ** data 1998 *** the arrests concern with ecstasy and amphetamines*

The average age of individuals who died from an overdose in 1998 (the majority of whom were opiate users), and the average age of individuals seen in drug addiction units in November, 1997, was in both casex 30 years.
Amongst those individuals arrested for heroin and cocaine use, the average age was slightly higher in 1998 than in 1997. It decreased for individuals arrested for cannabis use, and remained stable for ecstasy. In cases where treatment was sought, there was a recorded increase in the average age of these individuals for all substances.

Changes in average age over a long period of time varied by substance. Between 1986 and 1998, the average age of individuals dying from overdose ranged from 25 to 30. The average age of those arrested for heroin use ranged from 24 to nearly 28. The average age of arrested cannabis users was around the same level in 1998 (21.8) as in 1986 (21.9).

The age of individuals treated in the health and social system during the month of November, varied from 26.7 in 1988 to 28.9 in 1997.



Age of arrested users
Source : OCRTIS

Gender of Users

A strong majority of the illicit drug users seen in institutions are men. The percentage of men is particularly high amongst drug users who have been arrested. This figure has been slowly increasing since the beginning of the 1970s. This percentage went up to 91% of the users arrested in 1998 compared to 87% in 1986 and 79% in 1972. Men even represent 93% of the cannabis users arrested compared to «only» 85% for heroin users. The percentage of male users who died of an overdose, which fluctuated between 80% and 85% since the end of the 1980s, reached 87% in 1998. In 1996, 90% of the individuals convicted for illicit drug use were male[76].

The population of individuals treated in the health and social system includes more women, who represented 23% of those seeking treatment in 1997. Nevertheless, the percentage of men has been on the increase since the end of the 1980s, with a rise from 73% to 77% of the treatment given between 1989 and 1997. From this perspective, users seeking treatment in specialized centres for the first time are not differentiated from all users treated in specialized centres.

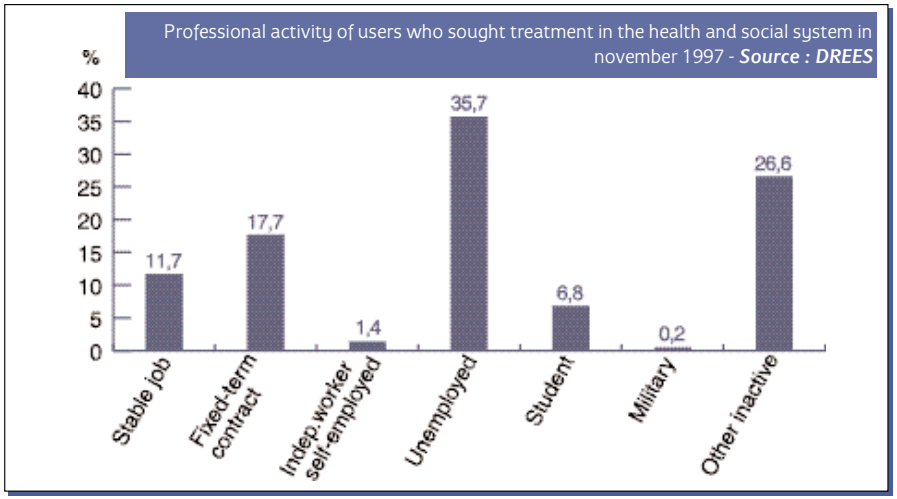
The differences in distribution between men and women in the two types of institutions may probably be explained due to selection bias per category of institution. Police are most likely to arrest men than women. However, women are possibly less hesitant to seek treatment in a health institution than men[77].

Users who sought treatment in drug addiction units in November, 1997 are broken down as follows: men 86%, women 14%. Thus, this distribution matches the figures observed amongst the people being detained for heroin use, or the amount of overdose-related deaths.

Professional Integration

Amongst the individuals treated in the health and social system in November, 1997, 69% were «inactive», a category which according to the classification grouped together unemployed workers, students, and other inactive individuals. This distribution has remained fairly stable since the end of the 1980s. The breakdown between active and inactive individuals in November, 1989 and November, 1992 was identical to the one observed in 1997.

[76] *Latest known figures.*
[77] *Women more easily seek psychiatric help than men, observation made by A. Debourg and P. Petit in a research report, Usage de drogues, injonctions thérapeutiques et consultations spontanées, Octobre, 1998.*



Professional activity of users who sought treatment in the health and social system in november 1997 - ***Source : DREES***

Amongst users who sought treatment in specialized centres for the first time in November, 1997, the percentage of students or unpaid trainees is higher than users being treated but not for the first time (respectively 9% compared to 2%). On the other hand, the percentage of unemployed individuals who had already had a job, was smaller amongst those being treated for the first time (26% compared to 30%). With just these slight differences, the structure of professional activity of the two groups is fairly close.
Using the same definition as in the November survey, we find that of the users who have been arrested, 67% are inactive. This may be broken down into 41% with no stated profession and 26% students. The split between active and inactive individuals is thus fairly close in the two sources. On the other hand, the number of students arrested was much higher.

The percentage of those with no profession dropped from 58% to 41%, while the percentage of students increased from 18% to 26% between 1997 and 1998. The essential part of the increased number of users arrested is linked to growth in the number of arrests of students (+ 19,000), working class individuals (+ 11,000), those with no stated profession (+ 4,266) and office workers (+ 3,224).

Social Coverage

In 1997, as has been the case for several years, a little over 6% of those who sought treatment in the health and social system had no social security coverage. Amongst them, there is a high percentage of individuals under the age of 24 years (44%). The percentage of these individuals who received RMI (minimum welfare payment) went from 26% to 27.5% between 1995 and 1997. Variations in the number of answers to this question prompt us to be careful when identifying the true significance of this weak increase.

For More Information:

- *Usage et trafic de stupéfiants : Statistiques 1998, OCRTIS, ministère de l'Intérieur, 1999.*
- *Les toxicomanes suivis dans les structures sanitaires et sociales en novembre 1996, Direction de la recherche, des études, de l'évaluation et de la statistique (DREES), Études et résultats n°1 décembre 1998, 6 p.*
- *GREMY (I.), Suivi de la toxicomanie et des usages de drogues en Ile-de-France, ORS Ile-de-France, 1998.*

Methodological References

➥ Enquête Toxicomanie de novembre, DREES (ex SESI).
In this survey drug addicts who were undergoing treatment in the health and social system (specialised drug addiction treatment centres, hospitals, health centres which are not specialised in drug addiction), are recorded. This is done whether or not the treatment began before or during the month of November. Drug addicts who were treated were regular users of illicit substances or misused licit substances. A particular drug addict may have been treated several times in the same or different establishments, sometimes even simultaneously.
➥ Fichier national des auteurs d'infraction à la législation sur les stupéfiants, OCRTIS.
Information on illicit drug use-related arrests is listed in this file. All illicit toxic substances are included, be it for occasional or regular use. Events, not individuals, are listed. Some users may have been arrested several times in a one-year period.
Overdose-related deaths are accidental deaths that are directly or indirectly linked to drug use as noted by police and gendarmerie services.

Age, gender and social integration of individuals treated in a specialized anti-alcoholism structure

The age of nearly two-thirds of the individuals seeking treatment in the various anti-alcoholism structures run between 30 and 50. Individuals in the 20-39 year age group represent 45%, the 40-59-year-olds 47%, and those of 60 and over stand closer to 6%. The age structure has not experienced any major changes for several years. However, there is a slight aging trend for this population.

More than three-fourths of the individuals who make contact with anti-alcoholism structures are men. This distribution has remained stable over the last few years.

More than one-half of these individuals have no stable activity. Amongst those whose age and situation could enable them to work, 36% have no consistent professional activity. A little over 12% of the new individuals seeking treatment have no stable place of residence.

Substances Taken and types of Use

The effect of institutional selection, mentioned in the last section, also has an impact on the observation of the consumption of different substances. It is difficult to describe the complexity of consumption behaviours using statistics from health or law-enforcement institutions. The consumption of certain substances such as cocaine or ecstasy, are difficult to measure with the existing observational system.

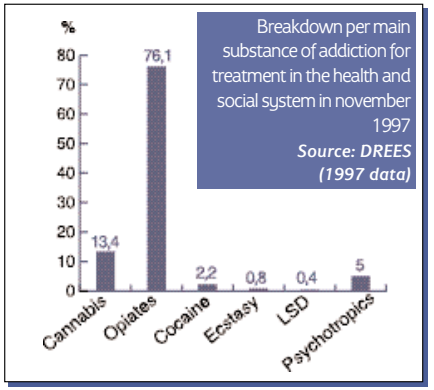
Substances at the origin of treatment

Situation in 1997

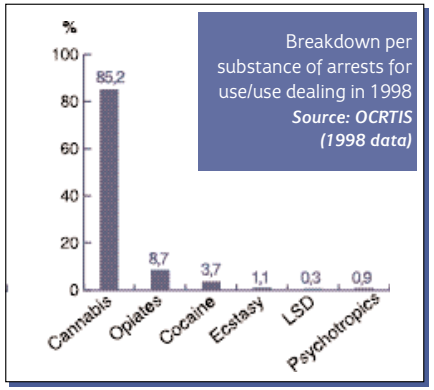
In November, 1997, opiates were at the origin of treatment in three out of four cases in the health system[78]. Cannabis was implicated in 13% of these cases. This distribution is nearly symmetrical to that observed for use-related arrests. A total of 80% were cannabis users and 14% were heroin users.

In the health and social system, heroin was at the origin of treatment in 69% of the cases. Cases involving other opiates were fairly rarely seen (codeine derivatives in nearly 4% of the cases, non-prescribed buprenorphine in 2%). The share of other substances at the origin of treatment was very small (3.3% for cocaine and crack, 2.7% for benzodiazapines, and 0.8% for ecstasy. The breakdown of substances used by individuals seen in prison treatment centres (ex-prison treatment units) in November, 1997, did not differ from those used by individuals treated in the health system.

The percentage of heroin users who sought treatment for the first time in specialized centres in November, 1997 was lower than the percentage of heroin users who had already had contact with these institutions. (62% compared to 78%). On the other hand, the percentage of cannabis users in the first group was much higher than in the second (19% compared to 6%).



Breakdown per main substance of addiction for treatment in the health and social system in november 1997
Source: DREES (1997 data)



Breakdown per substance of arrests for use/use dealing in 1998
Source: OCRTIS (1998 data)

[78] *The question about substances at the origin of treatment does not exist in the questionnaire sent to social establishments. In 1996, social establishments still answered this question in terms of the main substance at the origin of addiction, a notion which was fairly identical to that which was chosen in 1997.*

Global figures[79] on the substances at the origin of treatment in the health and social system include differences between types of establishment. Opiate users (whether undergoing a substitute treatment or not) are for the most part treated in specialized centres (78%) and health establishments (67%). However, they are in the minority in social centres (37% in 1996). Individuals treated in social centres are more frequently users of cannabis as the main substance (nearly 50% of the treatments) than in the other types of establishment.

Cannabis is at the head of the list of drugs taken within the last month, followed by heroin and alcohol. In 30% of the cases for which treatment was provided, no substance was stated.

In 1997, a question concerning substances taken in the past month was introduced. In 10% of the cases, no answer was given or the question was answered with "do not know". A total of 37% of the respondents answered that treatment was provided for cannabis use, 23% for heroin use, 20% for alcohol, and 9% for cocaine and crack (substances cited in first, second, or third place).

Developments

Amongst arrested users, the percentage of cannabis users jumped from 67% to 85% between 1995 and 1998, while the percentage of opiate users (almost heroin only) dropped from 28% to around 9%. The percentage of cocaine users, which varied between 1.5 and 2.5% for several years, approached 4%.
On the other hand, the breakdown of treatment by addictive substance, or substance at the origin of treatment, changed little between 1995 and 1997. The decrease in the number of treatments linked to heroin was inversely proportionate to the increase in the number of substitute treatments. All in all, the number of treatments linked to opiate addiction remained stable or slightly increased.
It may be noted that over a long period of time, the number of treatments for opiate use in specialized centres has remained stable. However, there has been an increase in the amount of treatment for cannabis use in health establishments. There, the percentage of treatment for cannabis increased from 12% in 1989 to 21% in 1996, then dropped to 17% in 1997. This change may be paralleled with the rise in the percentage of psychiatric or psychological treatment given in health establishments (refer to information on treatment in the health and social system). In social establishments, the percentage of cannabis users treated has remained stable since 1989 (around 50%).

All during this period, the percentage of other substances remained fairly low. We will, however, note the relative importance of the use of benzodiazepine and other tranquillizers amongst the clientele in health establishments, which appeared as the main substance taken in 6% to 8% of the treatments. Treatment for cocaine use, from year to year and despite the type of establishment, does not represent more than 1% to 3% of the cases.

Treatments in specialized establishments per substance at the origin of treatment (in %)

	1989	1993	1995	1996	1997
Opiates	80,9	81,5	86,7	86,1	82
Cannabis	13,9	11,3	8,6	9,4	11,5
Cocaine and crack	1,8	3,3	2,3	2,1	3,3
Benzodiazepines and tranquillisers	3,4	3,9	2,3	2,4	2,2
Total	100	100	100	100	100

Source : DREES

[79] *We have chosen to include the following in the category of opiate users: heroin users (whose percentage decreases as the number of individuals undergoing substitute treatment increases), users of codeine derivatives, morphine and other opiates, methadone and buprenorphine (wheter within the framework of substitute treatment or not).*

Treatments in health establishments per substance at the origin of the treatment (in %)

	1989	1993	1995	1996	1997
Opiates	76,0	74,2	66,2	65,9	69,5
Cannabis	11,8	13,0	19,4	21,8	17,9
Cocaine and crack	3,2	3,5	4,2	3,2	3,9
Benzodiazepines and tranquillisers	7,4	8,0	8,3	7,5	6,4
Total	100	100	100	100	100

Source : DREES

Substances used and polydrug use

The concept of polydrug addiction, or polydrug use, which is often discussed, is still fairly unclear. In this section, we will first refer to the definitions used in the November survey. Up until 1996, any use of drugs associated with the main substance of addiction could be considered polydrug use. Since 1997, it has been necessary to distinguish between treatment administered for two substances at the origin of treatment, and the use of several substances over the past month. Thus, there are two types of polydrug use that may be measured: polydrug addiction in the first case, and polydrug use in the second. The latter may include both regular or occasional drug use. As a result of the different definitions, 1997 figures and past figures may not be directly compared.

In over one-half of the treatments administered in 1997, two substances were cited to be at the origin of treatment (54%). Cocaine is the substance most often cited as second (20% of the polydrug users) followed by cannabis (19%) and alcohol (16%). Benzodiazepines ranked fourth (12,5%).

In 35% of the cases for which treatment was administered, the use of more than one substance was cited. Most often, questionnaires were filled out after the fact, and not in the presence of the patient. The number of unanswered questions concerning the use of a second or third substance may reflect that there was no other drug use, or that there was a lack of information on associated uses. Thus, one should be cautious when looking at these figures.
In 1997, alcohol as an associated substance came in second or third position, followed by cannabis, benzodiazepines and cocaine. This hierarchy has not changed since the 1996 report.

We find that defining polydrug use, on the basis of substances at the origin of treatment, or drug use in the past month, is already better than the very broad definition used in the past (use of several substances in the past with no established limits). However, the notion of polydrug use should be looked into more in depth. "Polydrug use" may be the symptom of simultaneous addiction to several substances, and this term should probably be reserved for such cases. The use of multiple substances may also be the result of a need for users to try other substances because the one they have been taking no longer satisfies them enough. However, in many cases, polydrug use is also a way of balancing use as a result of a shortage in the main substance taken or negative side effects experienced. Thus, this does not always represent a specific behaviour different from the addictive use of a particular substance, but a way of managing addiction. The increasing number of psychotropic substances and their availability, and the quick dissemination of information and rumours, may make it increasingly difficult for the user to cope with his addiction and create a need of resorting to large mixture of substances. Although this will remain difficult to measure, the particular problems raised by this trend should be clearly defined.

Intravenous injection

Of all the individuals treated in the health and social system in November, 1997, **14% were presumed to be currently taking drugs intravenously as a mode of consumption**. Current or past use of injection was mentioned in 50.7% of the cases involving treatment. However, information on injection practices was not given in 14% of the cases (reported as unanswered, or "do not know"). If the measurement remains limited to those who answered yes or no to the question about injection, **we find that an estimated 59% practice this activity**.

Disparities between types of establishments, which have already been mentioned, were found concerning substances. Of the total, 62% of the individuals treated in specialized establishments, 54% of those treated in health establishments (55% in drug addiction treatment units), and 20% of those treated in social establishments had already taken drugs intravenously. The percentage of unanswered questions most likely explains the gap between specialised centres on one hand, and health establishments and drug addiction treatment units on the other.

Percentage of individuals practising intravenous injection treated in november 1997 (in %).

	Specialized centres all together	Health establishments	Social establishments	Specialized centres in prison	Total
Unanswered/don't know	9,4	15,7	25,3	15,5	14,1
Yes currently	17,0	13,4	8,2	9,6	14,4
Yes previously	45,2	41	11,5	45,4	36,5
No, never	28,4	34,5	55,0	29,5	35

Source : DREES

In the specialized centres, individuals treated for the first time in November, 1997 used injection less often than those who had previous contact with these institutions (14.3% compared to 17.7% for current use of injection, and 32.9% compared to 46.6% for former use of injection).

Between 1996 and 1997, the percentage of users who were currently using injection decreased (17.8% in 1996 compared to 14.4% in 1997, in proportion to all treatments administered), while the percentage of individuals who formerly injected drugs increased (most particularly in health establishments).

The slight increase in the percentage of intravenous drug users in 1997 should thus not be negatively interpreted. There are fewer individuals taking drugs intravenously today and more individuals who formerly used this form of taking drugs). Looking at this over an extended period of time (since 1993) a slow decrease has been noted in the percentage of injectors amongst individuals undergoing treatment. The high level of unanswered questions (unanswered, or "do not know") and wide variations in this level, lead to caution when considering these changes.

In 1997, the average age of intravenous drug users was 30.6 compared to 26.7 for non-injectors. The age of those who did not answer was in between. A total of 80% of the heroin users (substance at the origin of treatment) had taken or were taking drugs intravenously, compared to 56% of those treated for cocaine use and 18% of those treated for cannabis use. This last observation seems to indicate that for some who were treated for cannabis use, this substance was associated or was being associated with the use of opiates or other injectable drugs.

Evolution in percentage of injectors treated during the month of november

	1993	1995	1996	1997
% of intraveinous drug users (all establishments) (percentage of yes/no answers)	63,1	59,1	57,3	59,2
No answer (all establishments)	15,4	11	9,1	14,1
% of intraveinous drug users (specialized establishments) (percentage of yes/no answers)	72,1	70	67,1	68,7
No answer (specialized establishments)	9,3	7	5,9	9,4

Source : DREES

Methodological References

➥ Enquête Toxicomanie de novembre, DREES
(Refer to methodological references in the section on treatment in the health and social system - previous chapter).

➥ Fichier national des auteurs d'infraction à la législation sur les stupéfiants, OCRTIS.
(Refer to the sheet on use-related arrests - previous chapter).

For More Information:

■ *Les toxicomanes suivis dans les structures sanitaires et sociales en novembre 1996, Études et résultats n°1, DREES, ministère de l'Emploi et de la Solidarité, décembre 1998.*

Health Situation of Drug Users

Morbidity

Many drug users are still being contaminated with the HIV, HCV, and HBV infections that have remained the essential cause of health problems in this category of the population. Several surveys provide data on the prevalence of the three viruses amongst drug users (in other words, the percentage of seropositive users compared to all of the drug users surveyed). Prevalence figures account for any changes in the epidemic up until the time the survey is conducted. Any prevalence that maintains a high level may result from a strong transmission of the virus in the past, even though transmission has become lesser evident today. It is more difficult to measure the effects of the current rate of seroconversion. There is practically no data on this, and current changes in the epidemic may only be indirectly described.

Data on prevalence most often come from surveys based upon statements made by participating individuals. Some rare surveys, based upon limited samples, provide data from biological tests. Comparing these data with stated rates of prevalence show matching results for HIV and a clear under-estimation of the declared prevalence of HCV. According to their objectives and how they are conducted, each survey tends to target a specific population of drug users (injectors or non-injectors, located in a particular geographical area), which for the most part explains the different rates of prevalence noted in the various surveys.

AIDS cases must be declared, and changes in the number of these cases are very clearly monitored (mandatory statement made by doctors). Until recently, the knowledge of new AIDS cases provided an indirect, delayed indication of changes in this epidemic. Until the advent of tri-therapies in 1996, various epidemiological studies left room for supposition that the impact of harm reduction policies contributed in the decrease, then stabilization of new HIV infections amongst intravenous drug users, phenomena observed at the beginning of the 1990s. Starting in 1996, the large drop in the number of new AIDS cases amongst intravenous drug users (resulting from infection which occurred several years before) are mainly due to the effects of tri-therapies which slow down the development of AIDS amongst seropositive subjects undergoing treatment.
There is still little information, today, on the other aspects of morbidity amongst drug users.

HIV and AIDS

Prevalence of HIV infection

Current Level
- All Users

The stated rate of HIV prevalence amongst all drug users treated in specialized centres was around 12.1% and 15.8% in 1997[80]. It appears that the serological status of these individuals seems to be better and better known, but there is still a high number of individuals for whom this status is unknown (27%). The fairly complete character of the survey conducted in specialized centres, the fact that it has been repeated over several years, its national coverage and the large number of individuals taken into account, lend particular importance to the figures it produces. Nevertheless, these figures only concern the population seen in specialized centres, which is not fully representative of all drug users. Data on prevalence amongst individuals treated in hospitals were not taken into account. Of the départements that answered the survey, those in which AIDS patients were treated tended to overestimate figures for HIV prevalence.

[80] *For an explanation of how these two values were calculated, refer to the table on changes in HIV prevalence amongst users treated in specialized centres.*

The survey conducted amongst general practitioners, which was also based upon all of France, provided compatible results with those from the November survey (17%[81]). It should be noted that 70% of the doctors in the sample who treat drug users systematically prescribe an HIV test. Local surveys conducted in Toulouse (saliva tests) and in the Vaucluse provide fairly close results (respectively 15% and 14%).

- First Treatment

HIV prevalence amongst individuals treated for the first time in specialized centres during the month of November, 1997 ranged from 7% to 11%. On average, individuals coming into contact with a specialised centre for the first time have not been taking drugs as long as all of the other users. Therefore, their risk of being infected is lower. However, HIV prevalence amongst these users is still at a fairly high level.

- Intravenous Drug Users

Certain results and studies are more specifically based upon drug users, of which a very high percentage uses injection to take drugs. Related figures are normally higher than in preceding surveys.

Amongst intravenous drug users treated during November, 1997[82], HIV prevalence was approximately 15% and 18%. This year also seems to mark a levelling of the decreasing prevalence for HIV amongst intravenous drug users.

The results of a 1998 survey of a given week, conducted amongst drug users, who were injectors frequenting syringe exchange programmes, showed that 20.3% were seropositive (amongst those who knew their serological status). The survey was conducted by the Health Watch Institute at the INSERM.

On the other hand, HIV prevalence amongst residents of inpatient treatment centres in 1998 (see CESES survey in the methodological reference section) was much lower than in the two preceding surveys (11.2% the first semester of 1998, compared to the high value of the margin in the November survey). It can also be restated that 90% of this population were injectors in 1993 and 80% were so in 1998.

Developments

HIV prevalence amongst users treated in specialized centres in 1997 clearly decreased between 1994 and 1996, and appears to have stabilised amongst all users and intravenous users. There is a need for confirmation of the latter trend.

In the CESES survey, HIV prevalence dropped rapidly between 1993 and 1995, from 21% to a little under 12%. After a few weak fluctuations, the rate in 1998 was only slightly lower than the 1995 rate.
A multi-centric study conducted by the IREP in 1995 showed an important drop in seropositivity amongst injectable drug users until 1995: 40% in 1987, 34% in 1990, 20% in 1995.

The drop in HIV prevalence from the end of the 1980s to 1995-1996 may be due to changes in the number of AIDS-related deaths amongst drug users, which had been strongly increasing until these years. It also may be explained by decreased sharing of syringes, and more generally a decrease in the number of risks taken by drug users. The marked decrease in the number of these deaths from 1996 on may partly explain the stabilization in prevalence in 1997.

Stated HIV prevalence in specialized centres (%)

	1993	1994	1995	1996	1997
All users					
% of HIV positive	14,3-20,3	14,8-19,8	13,2-17,2	11,8-15,3	12,1-15,8
% of unknown HIV status	33,6	31,2	26,4	24,9	27,2
Injectors					
% of HIV positive	nd	18-23	16-20	15-18	15,5
% of unknown HIV status	nd	nd	nd	nd	17,3

Source : DREES

[81] *Standard deviation associated with this estimate is [15-19].*
[82] *For an explanation of how these values were calculated, please refer to the methodological references.*

Discriminant Factors

Existing studies bring to light the wide selection of prevalence data on a local level. There is not only one epidemic, but several of varying sizes in the different regions. In 1997, HIV prevalence amongst those treated in November was particularly high in Corsica (31%), in Provence Côte d'Azur (21%), and in Ile-de-France (19%). However, it was much lower than the national average in the following regions: Lorraine (3%), Nord Pas-de-Calais (3%), Champagne-Ardennes (3%), Picardie (4%), Basse-Normandie (4,5%) and Alsace (5%). In the IREP survey, prevalence was lower in the Northern and North-Eastern parts of France due to the late development of the epidemic in these regions. It was much higher in the Parisian suburbs and in Marseille. In a study coordinated by GT69, based on 1996, prevalence amongst users seen by general practitioners was globally around 7%-8%, with 2%-3% in the Northern départements and the Rhone, and 25% in the Seine-Saint-Denis département.

The average age of HIV positive drug users treated in specialized centres in November, 1997 was 34 compared to 30 for HIV negative individuals. The average age of individuals for whom serological status is unknown is around 28. For those 25 - 29 years of age, rates of prevalence run from 7-9% compared to 16%-19% for 30-34-year-olds, and 27% amongst users aged 35 or older. The percentage of individuals for whom serology is unknown varies little between the age groups. Prevalence amongst residents of inpatient treatment centres spans from 11% amongst the 25-34-year-olds to 22% amongst individuals over the age of 35. Naturally, prevalence tends to increase with age as users have been exposed to a lower risk of being infected for a longer period of time. Also, the low rate of prevalence amongst the youngest users is most likely the result of being exposed to a lower risk of infection amongst individuals who started using drugs in the early 1990s because of harm reduction measures. A large majority of intravenous drug users no long share syringes on a regular basis, and even when they are shared, a decrease in the epidemic reduces the risk of transmission. The epidemic in not completely under control in areas where it developed first and most, as the infection may also be sexually transmitted. In the GT69 survey, nearly one-fourth of the seropositive individuals stated that they used no condom when having sex. The regional dimension of the epidemic is in itself strongly linked to the period during which drugs were first used. The results of a multi-centric IREP survey show that in Marseille, where HIV prevalence is the highest, only 6% of the users surveyed began taking drugs after 1989. At the opposite extreme, in Lille and Metz, where rates of prevalence are the lowest, over 50% of the users began taking drugs after 1989.

Most of the studies do not show an association between HIV prevalence and the gender of users. Nevertheless, the study conducted amongst residents of inpatient treatment centres shows that HIV prevalence is constantly higher amongst men than women. The gap in this particular study still needs an explanation.

New AIDS cases

The number of new AIDS cases amongst drug users is on the decrease. This drop was particularly strong in 1996 and 1997. However, during the first semester of 1998, the total number of new cases seems to have stabilised. A similar drop in the number of new AIDS cases was recorded amongst homosexuals, which appears to have continued into the second semester of 1998. The number of new cases diagnosed amongst heterosexuals has also been on the decrease, but slower than amongst drug users and homosexuals from whom the spread of infection peaked in the mid-1980s.

The effectiveness of associating several anti-retroviral medications is largely responsible for the decrease in the number of new AIDS cases in all of these transmission groups, and particularly amongst drug users.
Compared to declared cases amongst heterosexuals, the percentage of cases in which an individual who is not aware of being seropositive develops AIDS, is much lower amongst drug users. This means that there is good access to testing. The fairly good knowledge drug users have of their serological status has enabled them, like homosexuals, to benefit from new associations of anti-retroviral medications that appeared in France in 1996.

Number of newly declared AIDS cases (AIDS among drug users)

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996*	1997*	1998* 1er semestre
Total	342	639	906	1 079	1 217	1341	1 489	1 370	1 308	947	419	188

Source : IVS

** adjusted for reporting delays data*

Hepatitis C

For a general reminder of information on hepatitis C, please refer to the boxed section at the end of this chapter. A quick statement on why prevalence data on HBV are not mentioned here is also given at the end of this chapter.

There is a strong percentage of individuals for whom the serological status for hepatitis C is unknown in the surveys, which causes us to recommend that not too much importance be given to the weak variations in figures on prevalence. Only the major trends should be taken into account.

Prevalence

Level

- All users

The rate of HCV prevalence amongst users treated in specialised centres in November, 1997 was around 52%-66%. Serological status is unknown in one-third of the cases.

In the study conducted amongst general practitioners, 67% of the doctors surveyed stated that they systematically prescribed serological testing for hepatits C, and 23% did so occasionally. **The estimated prevalence of HCV infection amongst users treated by general practitioners in 1997 was 31%**. An explanation of this figure, much lower than in other surveys, must be given.
In the survey conducted in Toulouse in 1996, HCV prevalence as measured by a biological test (saliva) was at 67%. This confirmed that there was underestimation of seropositivity declared by users who stated they knew their serological status. 35% of the individuals who stated they were seronegative showed positive results in the saliva test. Prevalence amongst non-injectors was 13%. This result was compatible with results from the November, 1997 survey.

- Intravenous drug users

During the month of November, 1997, HCV prevalence amongst users treated in specialized centres was between 62 and 70%. Amongst users who stated they had never taken drugs intravenously, the prevalence for HCV infection was between 10 and 20% in 1997. This prevalence, which is clearly higher than that of HIV (between 4 and 6%), must be explained. This is particularly necessary since it appears that HCV is not sexually transmitted. Individuals who had subsequently forgotten they had occasionally or even rarely injected may explain part of the reason for this high rate of prevalence.

In the CESES survey conducted in 1998, HCV prevalence was around 63% amongst intravenous drug users. These figures are compatible with figures from the November 1997 survey.

As for the one-week survey conducted amongst users who frequented PES in 1998, HCV prevalence was at 61.7% amongst users who knew their status.

Developments

HCV prevalence has been on the increase since 1994. However, this increase is not necessarily a reflection of developments in the epidemic, but may be the result of better knowledge of serological status. The increasing trend, which needs to be confirmed, seems to have levelled out in 1997.

Knowledge of HCV serological status improved between 1994 and 1997. It was unknown in one-third of the cases in specialized centres in 1997 compared to one-half of the cases in 1994.

Discriminant Factors

Stated HVC prevalence in specialized centres (%)

	1993	1994	1995	1996	1997
All users					
% of HVC positive	41- nd	43,5-66,4	45,7-65,5	48-64,8	52,3-66,3
% of unknown HCV status	59	49,5	40,7	35,5	34,7
Injectors					
% of HVC positive	nd	51-81	53-70	57-69	62-70
% of unknown HCV status	nd	nd	nd	nd	24,8

Source : DREES

In the November 1997 survey, there were also large regional differences in HCV prevalence. Regions ranking high in prevalence were the following: Corsica (63%), Languedoc-Roussillon (60%), l'Ile-de-France and Alsace (59% and 58%). At the other extreme, prevalence in Brittany, Champagne-Ardenne, Picardie and Lorraine was under 40%. In the 1995 IREP survey, HCV prevalence was at 42% in Lille and 52% in Marseille.

With information from the same survey, the age of HCV seropositive users treated in specialised centres was just over 32 compared to 29 amongst seronegative users. HCV prevalence was 46% amongst 25-29-year-olds, 60% amongst 30-34-year-olds, and 66% amongst those 35 and older. Prevalence amongst residents of inpatient treatment

[83] *For an explanation of how these values were calculated, please refer to the methodological references.*
[84] *Standard deviation associated with this estimate is [29-33] for hepatitis C and [21-25] for hepatitis B.*
[85] *Methodological references.*

centres during the first semester of 1998 was 57% amongst the 25- 34-year-olds, and 70% amongst those 35 or older. As was the case with HIV, this link between the level of prevalence and age may in a large measure be due to older users having been exposed longer, and younger individuals not knowing their serological status as well. The decrease in prevalence according to the time at which one began using drugs was much smaller that for HIV. This may be attributed to the massive size of the epidemic, the strong viral charge of HCV and its stronger resistance to the exterior. The characteristics of this virus make its transmission possible even when syringes have not been shared or when a user re-uses his/her own personal syringe.

Prevalence of HIV and HCV infection in recent studies

	November Specialized structures	General practitioners EVAL	Multi-centric study IREP	Ceses	Study PES	GT69	Bello	RVH Vaucluse	Ares 92
HIV									
% sero-positive	16	17 [15-19]*	20	11,2	20,3	8	15	14	29
% unknown status	27	nd	12	7,1	15,4		nd	nd	25
HCV									
% sero-positive	52	31 [29-33]*	48	53	61,7	61	67	49	81
% unknown status	34,7	nd	28	11,3	21,9	18	nd	nd	37
Population	In treatment centres	By general practitioners	Injectors	Users in inpatient centres	Users frequenting PES (syringes exchange programs)	By network doctor	Users seen in various health and repressive structures	Patients treated by general practitioners for substitution	Treatment by general practitioners
Types of data	Stated by treatment centres	By doctors	By users	By users	By users	By general practitioners from biological testing	Saliva tests among users	By doctors	By doctors
Number of individuals surveyed	15 279	Estimate of all users treated by general practitioners	1 703	2 062	1 004	689	249	197	95
Year	1997	1997	1995	1998 (1er sem.)	1998	1996	1996	1997	1996
Geographical area	All of France	All of France	Paris and parisian region, Lille, Metz, Marseille	All of France	All of France	Départements du Nord, du Rhône et de la Seine-Saint-Denis	Toulouse	Vaucluse	Hauts-de-Seine

Source : OFDT

** Reliability interval linked to the estimate.*
The prevalence ratios are expressed in percentage of the serological status known (positive + negative).
The " unknown status " category cover the no-answers, test not carried out, test carried out, and results unknown.
The prevalence figures of this chart give a superior limit for HIV and an inferior limit for HCV (see Methodological References).

Associations between infections

HIV positive users are also very often infected with HCV.

This percentage is very high both in the November and the GT69 surveys HIV positive users recruited in the street do not state that they are HCV positive as often, but this is probably because they often do not know their true serological status.
The prevalence of HIV and HCV co-infection amongst those treated in November, 1997 is at least 12%. The low level of HIV prevalence in the Nord and Rhône départements explain the lower figure from the survey coordinated by the GT69.

Association between HIV and HCV infections among drug users

	«November» study	PES study	IREP	GT69
% HCV among HIV	82-85*	70	47	93
% co-infections (HIV and HCV) among those whom serology is known (1)	12	15	12	8
% Known serology	62	81,3	67	73
Number of treatments and/or individuals	15 279	1004	1 703	689
Populations	by specialized centres	Users frequenting PES	Injectors	Mainly injectors
Year	1997	1998	1995	1996
Type of data	declarative	declarative	declarative	biological tests

Source : OFDT

(1) Number of HIV and HCV seropositive individuals amongst all those who knew their serological status.
** Both markers refer to the assumptions that helped calculating HCV prevalence, here amongst HIV seropositive users (see Methodological References).*

Other aspects of morbidity

The other aspects of morbidity for drug users are not as well known, not often measured, or not in a heterogeneous manner.
Doctors surveyed in a study conducted by the EVAL reported cases of tuberculosis amongst 2% of their patients who used drugs, and sexually transmitted diseased amongst 8%. Septicemias were mentioned for 5% of the users in the IREP survey, venous infections in 14% of the cases in the ARES92 study, and more generally antecedents to infections in 23% of the cases in the GT69 study.

Dental problems are the most common problem of drug users met on the streets according to the IREP survey (52% of the cases).

Overdoses, suicide attempts, and psychiatric problems are important features of morbidity amongst the most addicted individuals, aspects that we are not able to clearly measure and monitor.

Methodological References

➥ Enquête novembre du DREES

Please refer to the section on treatment in the health and social system for a description of the general framework of the study.

Concerning prevalence data for HIV and HCV, the results of the study are presented in the form of a marginal value.

In the case of HIV, the value of the upper limit was calculated by adding the number of seropositive individuals to the number of all individuals for whom serological status was known (seropositive and seronegative). The value of the lower limit was calculated by adding the number of seropositive individuals to the number of all individuals having answered the question (only unanswered questions were excluded). The high value here corresponds to the hypothesis that individuals who had or had not taken the test, but did not know the results were split amongst seropositive and seronegative individuals just as individuals who knew their status. The low value corresponds to a second hypothesis: respondents who did not know their serological status were all seronegative. Individuals who did not know their serological status were on average younger, and it appears likely that they would be less infected than those who knew their status.

In the case of HCV, the lower value of the margin corresponds to the number of seropositive individuals for whom serological status is known (seropositive and seronegative). To calculate the high value, all individuals who did not answer that they were seronegative were presumed to be seropositive (individuals not having been tested, or who did not know their results were considered seropositive). The number of seropositive individuals was added to the number of all individuals having answered the question (excluding unanswered question). Considering the size of the epidemic, there is reason to believe that individuals who did not know their status were proportionately more infected than those who knew their status.

➥ Enquête sur la prise en charge des usagers de drogues par les médecins généralistes (EVAL)

(refer to the section on general practitioners and treatment)

➥ Enquête du CESES (Centre européen pour la surveillance épidémiologique du Sida).

This survey has been conducted every semester since 1993 in specialized inpatient drug addiction centres (N=2,062). A questionnaire designed to gather individual and anonymous data is sent to each centre. Collected variables include information on the demographic characteristics of drugs users, their knowledge of drugs, HIV, HCV and HBV testing, and on the knowledge of serological status. Clinical information is requested for seropositive individuals. This questionnaire is filled out by the personnel of inpatient treatment centres using information provided by the residents.

➥ Enquête sur les programmes d'échange de seringues (PES survey)

This study was conducted from 30/03/98 to 5/04/98 by the IVS and the INSERM in 60 PESs amongst users who came to get sterile syringes (N=1,004). There was a 50% rate of participation. The anonymous questionnaire was self-administered or possibly with the help of a member of the PES. It was based upon individual characteristics, history of drug addiction, substances taken, risky practices (injection, unprotected sex) and HIV, HBV and HCV tests and their results.

➥ Étude multicentrique de l'IREP

This survey was conducted in five areas in 1995 (Marseille, Paris, Parisian suburbs, Metz, and Lille) amongst intravenous drug users (N=1,703). Users were usually recruited on the street, and some were recruited in specialized treatment structures. It was not possible, given the framework in which the survey was conducted, to base the constitution of the sample in a random manner. The sample was made up by seeking to find the greatest diversity possible for situations and subjects. Statistical analyses of these results showed the main factors of risk for the individuals who participated for HIV, HBV, and HCV.

➥ Enquête Toxicomanie Hépatite C (GT69)

These surveys were conducted in three departments in 1996 (Nord, Seine Saint-Denis and Rhône). The patients, who were users or ex-users of "hard" drugs, were partly recruited by general practitioners who were members of the City-Hospital-Drug Addiction Network, partly in hospitals in which drug users were treated for their infectious (N = 1,302 of which 662 were from general practitioners). The recruiting was spread out over one year. The statistical analysis showed the main factors of risk for the three viruses as well as for co-infections.

➥ Enquête ARES92 (Dr Bacle)

This prospective survey was conducted amongst 21 doctors who treated drug users in their offices, in health centres, or specialised centres in the Parisian suburbs, in 1996. Each doctor was asked to include the first 15 patients seen between October 1st and December 31, 1996. The criteria for inclusion were addiction to an illicit drug, substitute treatment, and the use of codeine (N=95). Monitoring lasted six months and one year.

➥ Enquête sur les patients sous substitution dans le Vaucluse (Dr Bry)

This survey was conducted among 12 general practitioners in a city-hospital-network located in the Vaucluse region. It was based upon 197 different patients who had undergone substitute treatment for over six months.

➥ Enquête sur la prévalence du VIH et du VHC à Toulouse (Dr Bello)

This survey was conducted in 1996 amongst users who frequented seven treatment structures in Toulouse. A saliva test was used to determine antibodies for HIV and HCV. Users who accepted participation in the survey (N=249) also filled out a questionnaire. Statistical analyses identified factors of risk for HIV and HCV.

To say that the prevalence of a virus in a population may be fully determined from declarations of anti-body testing would be a misnomer. Nevertheless, for viral infections such as HIV, for which contamination nearly systematically implies carrying the virus, one may consider that detected antibodies alone are a reflection of current infection. This is even truer since in cases where anti-HIV antibodies are discovered, there is systematic confirmation of seropositivity by searching for direct viral markers (viral RNA). In the case of HCV, the declared prevalence of HCV from data obtained through testing for anti-HCV antibodies, also reliably corresponds to the number of individuals infected by the virus, whether it be chronic or acute.

Given the multiplicity of possible serological states that may be encountered during HBV infection (acute Hepatitis, past Hepatitis now healed, vaccinated individual, chronic carrying of the virus), it is not possible to ignore HBV prevalence data gathered from the statements of users. Data may provide serological markers that may be as different as viral antigens (Ag HBs), which give direct evidence of the virus (acute infection, or chronic carrying), or HVB antibodies, which, according to their type, may show contact with the HBV virus (anti-HBC antibodies) or of vaccination (anti-HB antibodies). Thus, we feel that a large number of drug users, included in prevalence figures have, in fact, been healed. From the point of view of public health, it is most important to estimate the percentage of individuals carrying the virus (both ill and healthy), the percentage of those formerly infected but now healed, and those who have been vaccinated. As these estimates are based upon the testing of specific markers not classically distinguished in declarative data, HBV prevalence data gathered in most of the surveys do not provide information that may be clearly interpreted.

The hepatitis C virus (HCV) was identified at the end of the 1980s It is the agent responsible for most non-A non-B cases of Hepatitis. It is mainly transmitted during direct contact between contaminated blood and the blood of the "receiver." Intravenous drug use currently appears to be a major factor in contamination. As there is no vaccination, prevention is

the only way to avoid infection. The acute phase of the disease often includes few symptoms and is not very apparent. Therefore, an estimated three-fourths of the individuals who are HCV seropositive do not know it. In nearly 20% of the cases, acute hepatitis is spontaneously healed, and in 80% of the cases, becomes chronic. Amongst the chronic forms of this disease, 20% turn into cirrhoses within a 15-year period. On an annual basis 3% to 5% lead to terrible complications: severe hepatic insufficiency or cancer[86].

The results of a study on HCV[87] morbidity indicate that with an equal source of contamination, post-transfusion cases of Hepatitis more frequently seem to develop into cirrhosis than secondary cases of Hepatitis due to intravenous drug addiction. These differences may be partly linked to a different HCV genotype in the different contamination modes.

For More Information:

- *EMMANUELLI (J.), LERT (F.), Enquête sur les usagers fréquentant les programmes d'échange de seringues, Rapport OFDT, 1999.*
- *SIX (C.), HAMERS (F.), BRUNET (J-B.), Enquête semestrielle sur les infections à VIH, VHC, VHB chez les résidents des Centres de soins spécialisés pour toxicomanes avec hébergement. Rapport global sur les 10 semestres d'enquête, juillet 1993 à juin 1998, Centre européen pour la surveillance du Sida, 1999.*
- *BELLO (P.Y.), PASQUIER (C.), GOURNEY (P), Prévalence de la contamination par le VIH et le virus de l'hépatite C et identification des facteurs de risques associés chez des usagers de drogues de Toulouse, Bulletin épidémiologique hebdomadaire n° 20/1998, 19 mai 1998.*
- *CHOSSEGROS (P.), Enquête toxicomanie hépatite C, GT69, Rapport d'enquête, 1998.*
- *Expertise collective INSERM, Hépatites virales. Dépistage, prévention, traitement, Paris, Les éditions INSERM, 1997, 265 p.*
- *IREP, Étude multicentrique sur les attitudes et les comportements des toxicomanes face au risque de contamination par le VIH et les virus de l'hépatite, rapport de recherche, IREP, Paris, décembre 1996.*

[86] *CHRONIQUE (C.), GOZLAN (A.), TCHAKAMIAN (S.), GUIGNON (N.), HAURY (B.), NADAL (J.-M.), PARAYRE (C.) , RUFAT (P.), THELOT (B.), Le recours aux soins hospitaliers pour hépatite, in Informations rapides avr. 1998 ; 99, SESI, ministère de l'Emploi et de la Solidarité.*

[87] *ROUDOT-THORAVAL (F.), PAWLOTSKI (J-M.), DHUMEAUX (D.) et le groupe d'étude de la prévalence et de l'épidémiologie des hépatites C, Épidémiologie et morbidité du virus de l'hépatite C en France - étude de 6 664 patients atteints d'hépatite chronique, in BEH 1996 ; 5 : 20-21.*

Figures on Morbidity Linked to Alcohol and Tobacco

This section includes the first outline of alcohol and tobacco-related figures on morbidity given within the framework of the OFDT report. These figures came from a national survey of hospitals conducted in 1991 and 1992. Pathologies linked to alcoholism or the use of tobacco, and treated by regular doctors are not taken into account here.

Hospital doctors who assess factors of risk gather data. It is likely that statements made by patients whose state of health is not systematically the reason for looking into these factors, are not as dependable. Thus, smoking-related risks have probably been underestimated, particularly amongst young people, because this has long been considered a simple behaviour, and its health-related consequences occur much later.

■ Alcohol

Some 13% of the individuals who were fully hospitalized on an average day in 1991-1992 (or 59,000 patients) suffered from alcoholism, whether they had been hospitalized for this reason (13,500 patients) or another.

A survey conducted in the Yvelines département confirms this, showing an estimated prevalence of 13% for excessive alcohol use amongst hospitalized patients. Amongst individuals aged 36 to 55, excessive alcohol use was diagnosed amongst 45% of the men and 19% of the women. 10% of the hospitalised individuals under the age of 25 had a problem with excessive alcohol use. The Reynaud-Parquet Report concluded that when using available data, it might be estimated that 10% of the men undergoing hospitalization are there due to alcohol-related complications. This percentage is 5% amongst women. Harmful alcohol use, which needs to be treated, involves 20%-30% of the men hospitalized and 10% of the women.

Some surveys conducted in the early 1990s show that patients at risk of alcoholism and/or already suffering from an alcohol-related pathology represent 20% of the patients in general medicine[88].

The main alcohol-related illnesses were mental problems (29%), tumours (12%), circulatory-related diseases (12%), trauma or poisoning (8%) and digestive illnesses (8%). These were followed by respiratory and nervous system problems. Tobacco is also implicated in tumours and respiratory problems. It should be noted here that vascular illnesses provoked by alcohol are slightly different and less frequent than those caused by cigarettes. Alcohol-related cardiac problems are for the most part high blood pressure, cardiac insufficiencies, illnesses in cardiac muscles (myocardiopathies) and problems with heart rhythm. Vascular cerebral accidents most often occur from haemorrhaging rather than from problems due to blood not reaching the tissues (ischemia).
Individuals hospitalized for alcoholism suffer from an average of three illnesses (including the main alcohol-related illness).

■ Tobacco

[88] *REYNAUD (M.), PARQUET (Ph-.J.), Évaluation des dispositifs de soins pour les personnes en difficulté avec l'alcool, Rapport de la mission, Direction générale de la santé, Direction des hôpitaux, novembre 1997.*

No individuals are listed as being hospitalized for addiction to smoking, which hospital doctors do not generally state to be an associated diagnosis. Addiction to smoking is only reported to be a factor of risk. According to the survey, this factor concerned 16% of the individuals who were hospitalised on a given day.

The most frequent reasons for hospitalization for individuals aged 40 or older at risk of addiction to nicotine were circulatory illnesses (22%), mental problems (15%), respiratory illness (12%) and tumours (8%). These individuals were hospitalised more often than individuals who were not at risk of addiction to nicotine, tumours or respiratory problems. ¤

Sources :

- *COM-RUELLE (L.), DUMESNIL (S.), L'alcoolisme et le tabagisme chez les hospitalisés, CREDES, biblio n°1164, février 1997, 173 p.*
- *PARQUET (Ph-J.), REYNAUD (M.), Evaluation du dispositif de soins pour les personnes en difficulté avec l'alcool, Rapport de la mission, Direction générale de la santé, Direction générale des hôpitaux, novembre 1997.*

Mortality and illicit drug use

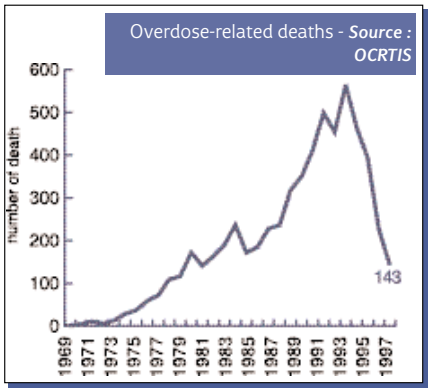
It is impossible to obtain global knowledge of mortality amongst drug users without conducting a cohort study. The only two current sources of information relating to mortality amongst individuals in this population concern overdose-related deaths and AIDS-related deaths of intravenous drug users. Overdose-related deaths, which are characterized as violent and suspicious, lead to a police investigation during which information about the context for drug use is recorded. Figures provided in OCRTIS data are most likely underestimated as doctors choose to avoid legal procedures in order to spare the victim's entourage added grief, and to authorize burial before the police has been able to conduct an investigation. Figures on AIDS-related deaths of drug users, as shown in National Public Health Network data, have also been underestimated by about 20%.

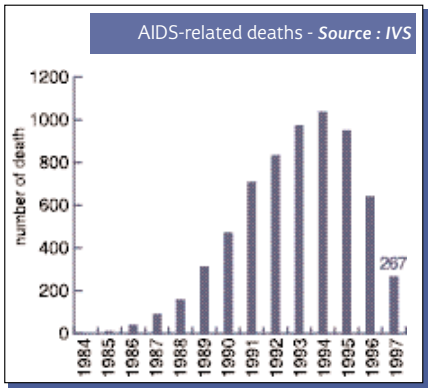
The INSERM provides some information on other causes of death amongst drug users, but drug addiction does not generally appear as an associated cause of death on the death certificate. Thus, the description of the phenomenon provided here is somewhat limited.

Between 1994 and 1998, the number of deadly overdoses dropped sharply from 564 to 143. This decrease came on the heels of a nearly steady increase that began in the early 1970s and continued until 1994. We should mention that amongst the various factors used to explain these developments are the implementation of substitute treatment and harm reduction policies, as well as a growing disinterest in heroin on the part of drug users.

The average age of fatal overdose victims was 30 in 1998, versus 25 in 1986.

The number of drug users who died of AIDS dropped over two-thirds between 1994 and 1997 (1,037 in 1994 and 267 in 1997). This decrease came after the number of these victims rose continually between 1986 and 1994. Similar developments have been observed amongst all AIDS deaths despite the way in which the individual was infected. In 1997, the percentage of intravenous drug users who died from AIDS represented approximately 25% of all AIDS-related deaths.





The observed drop in the number of AIDS-related deaths, at equal proportions amongst all categories of AIDS patients, is largely due to new treatment possibilities.

The average age of drug users who died from AIDS was 36 in 1997, versus 35 in 1996, and has continually increased over the last several years.

In most cases, deadly overdose occurs after an individual has taken heroin, but there is an increasing number of these deaths related to polydrug use (the combined use of heroin, alcohol and particularly medicine). Sixty-four percent of the overdose-related deaths in 1997 were attributed to heroin and 29% to medicine. The latter has clearly increased compared to the early 1990s (around 7% in 1990 and 1991).

Number of overdoses-related deaths

Overdoses	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Total	318	350	411	499	454	564	465	393	228	143
➜ Heroin	275	302	368	460	408	505	388	336	164	92
➜ Medicine	22	27	31	31	44	50	68	49	56	41
➜ Cocaine	7	5	5	0	1	2	4	6	6	9
➜ Solvents	11	12	6	6	1	6	4	1	1	1
➜ Undetermined	3	4	1	1	0	1	1	1	1	0

Source : OCRTIS

In most cases, deaths caused by taking medicine are the result of several medicines being taken simultaneously. Nevertheless, traces of the following drugs have frequently been detected: Subutex®, (13 cases), Tranxène® (6 cases), Skénan® (5 cases), as well as Rohypnol® and Méthadone® (4 cases each). There is current controversy over the dangerousness of Subutex®, particularly when injected or taken with other medicines (most notably with benzodiazepines or alcohol). For more details, we refer you to information provided on Subutex® found in the "Trends " section.

In 1998, overdose-related deaths remained concentrated to a limited number of departments; 70% of all overdose-related deaths occurred in nine departments. In order, these regions were: Paris, the Nord, the Hauts-de-Seine, the Seine-Saint-Denis, the Val-de-Marne, the Val-d'Oise, the Essonne, the Bouches-du-Rhône and the Rhône. Regional differences globally corresponded to those observed for most of the drug use-related indicators in such data as treatment, arrests, the sale of Stéribox® kit and Subutex® (please refer to the section titled " Geographical Approach to Drugs in France ").

For More Information:

- *Surveillance du Sida en France (situation au 31 mars 1997), BEH n°/1997, RNSP, 1997.*
- *Usage et trafic de stupéfiants : statistiques 1998, OCRTIS, ministère de l'Intérieur, 1999.*
- *Tendances de la mortalité chez les toxicomanes. Étude bibliographique sur les enquêtes de cohortes, ORS Ile-de-France, mars 1997.*
- *LECOMTE (D.), HATTON (F.), MICHEL (L.), LE TOULLEC (A.), Décès par usage de stupéfiant en Ile-de-France, BEH 35/1994, RNSP, 1994.*

Methodological References

➥ INSERM unité SC8 (registre national des causes de décès).

Since 1968, division SC8 at the INSERM has recorded all causes of death in the French territory. The latter are identified using information recorded on the death certificate and by code, according to the CIM-8 (1968-1978) and the CIM-9 (until 1997). Three causes are mentioned on the death certificate: immediate cause, main cause and morbid state that led to death. Drug addiction may be detected using three CIM-9 codes: drug addiction, drug abuse and drug-related psychoses.

➥ Institut de veille sanitaire (décès par Sida).

It is mandatory to report AIDS-related deaths. The Health Watch Institute counts AIDS deaths (per year when death occurs) and the cause of infection by the AIDS virus. As a result of the delayed reporting of these deaths, data are adjusted. Twenty percent of these deaths are not reported.

➥ OCRTIS (décès par surdose ayant fait l'objet d'une procédure judiciaire).

Cases where death occurred under suspicious circumstances are subject to investigation (crime, accident, suicide, sudden death, and overdose, often involving a young individual). In cases where the suspected cause of death is overdose-related, the OCRTIS receives a telex at the outset of the investigation, and the cases are added to a computerized file. The report will be recieved later by the OCRTIS. This is a nominative database.

Figures on Alcohol and Tobacco-Related Mortality

In this section, we will present figures on mortality linked to the use of these two substances. It is difficult to compare these figures to those relating to deaths linked to drug use. Only overdose and AIDS-related deaths are taken into account in the case of illicit substances. There is no information on the consequences of hepatitis C and other pathologies on mortality. In addition, a rigorous comparison would require the examination of mortality by age. It is also very important to be careful when looking at comparisons of mortality related to tobacco and alcohol as the evaluation methods were not identical for the two substances. Moreover, a large number of deaths may be attributed to both alcohol and tobacco.

■ Tobacco

At the end of the 1990s, tobacco use was considered to have caused the deaths of 60,000 people per year, or one in nine deaths. It is considered that one of every two regular smokers who began smoking during adolescence will die because of tobacco. Half of these deaths will occur before age 69.

In 1995, these deaths were broken down as follows:
- 31,500 from cancer
- 13,700 from cardiovascular disease
- 11,000 from respiratory illness
- 3,800 causes related to tobacco use

The breakdown by gender is very uneven. In 1995, tobacco-related deaths concerned approximately 56,600 men (or 21% of male mortality amongst all age groups) and 3,100 women (or 1% of female mortality amongst all age groups). Relatively speaking, the most affected age group was 45-64-year-old individuals of which 29% of male deaths and 4% of female deaths could be attributed to tobacco.
The level of tobacco use (average daily dose) and how long the individual smoked were very significant factors of risk for morbidity.

It is possible to estimate that there will 165,000 premature deaths per year by 2025 by looking at changes in use over the past decades. This figure corresponds to a doubling in the number of deaths amongst men and a tenfold increase in deaths amongst women.

■ Alcohol

There are two distinguishable categories when looking at alcohol-related mortality: mortality resulting from pathologies that are related to alcoholism, and mortality linked to driving under the influence of alcohol.

Mortality resulting from pathologies that are related to alcoholism
In 1996, there were 23,438 deaths related to the chronic ingestion of alcohol, amongst individuals over the age of 15. Of these deaths, 2,397 were from psychosis and alcohol addiction, 8,960 were from cirrhosis of the liver, and 12,081 were from cancer of the upper aero digestive tracts (VADS: lips, oral cavity, pharynx, œsophagus, larynx). These figures, derived from INSERM statistics on the causes of death in France, only take into account the main cause of death as recorded on the death certificate. This mortality affects approximately 55% of the cases involving individuals under the age of 65.

Alcohol-related mortality affects men (7.2% of deaths) much more than women (1.9%). It refers to individuals in management positions much less than employees and working class individuals (5% compared to 46%)

There are strong regional differences in alcoholism-related mortality rates. These are much higher in the North and Northwest (Nord-Pas-de-Calais, Brittany, Upper Normandy, Picardy).

Lastly, the risk of cancer of the upper aero digestive tracts increases with tobacco use, even when this use is moderate (less than 9 cigarettes per day).

The death rate from alcoholism has been steadily dropping amongst both genders since 1979. This change has mostly been due to a drop in the number of cirrhosis-related deaths. Alcohol addiction has also decreased, but in a smaller measure. Cancer of the upper aero digestive tracts has decreased significantly amongst men, but less significantly amongst women, as tobacco use, which is also a factor of risk for cancer, has been increasing amongst women.

Mortality linked to driving under the influence of alcohol
Information on the presence of illegal levels of alcohol during accidents involving bodily injury may be drawn from surveys conducted by the INRETS (National Research Institute on Transportation and Security). Using information on known levels of alcohol (78% of the cases), 27% of the drivers presumed to be responsible for a deadly accident had an illegal level of alcohol in their system in 1995. This rate went up to 45% amongst drivers responsible for a deadly accident involving only one vehicle. This survey also showed that illegal levels of alcohol were mentioned in 34% of all deadly accidents. A 1995 road safety board assessment showed that 8,412 individuals were killed in accidents that year. If we hypothesize that cases for which unknown alcohol levels are broken down the same as cases for which those levels are known, and we apply the above-mentioned rate of 34% to the figure of 8,412 deaths, we find that 2,900 individuals were killed in accidents involving illegal levels of alcohol.

Some deaths are indirectly linked to alcohol: work-related deaths, illnesses aggravated by alcohol use (cases in which the exact responsibility of alcohol are unknown). This explains why much higher figures (40,000 and 50,000 deaths attributed to alcohol) are frequently cited. The latter figures must be clarified and confirmed.

Sources :

- *Conférence de consensus de l'ANAES (Agence nationale d'accréditation et d'évaluation en santé).*
- *GOT (C.), WEILL (J.) (dir.), L'alcool à chiffres ouverts, Seli Arslan, Paris, 1997.*
- *HILL (C.), DOYON (F.), SANCHO-GARNIER (H.), Epidémiologie des cancers, Médecine- Sciences Flammarion, Paris, 1997.*
- *La santé en France 1994-1998, ministère de l'Emploi et de la Solidarité, Haut comité de santé publique, septembre 1998.*
- *Sécurité routière, Bilan annuel, statistiques et commentaires, année 1997, Observatoire interministériel de sécurité routière, Paris, 1997.*

SUBSTANCES SUPPLY

The Turnover of Illicit Drugs, Alcohol, and Tobacco

The economic weight of an illicit substance is by definition difficult to measure. Using bits of data on the number of users, hypotheses on the frequency of use and average prices, we may attempt to determine the turnover of illicit drug use. There are national accounting data or data from industry professionals on the turnover of alcohol and tobacco. In order to make it possible to compare the three figures, we must refer to the prices paid by users. In other words, turnover figures for licit substances sold in the national market must include all taxes paid on these substances.

Turnover for Alcohol

According to the INSEE, the total figure for sales of alcoholic beverages to French households[89] rose to 92.9 billion francs in 1997. This figure includes all taxes charged for this type of beverage. On the other hand, alcohol exports and sales in the Café-Hotel-Restaurant sector (CHR) were not included. Thus, figures on how much French households spent for alcohol were reduced by the total figure for use in cafes, hotels and restaurants. In this report, it was not possible to determine the share of total turnover represented by the sale of alcoholic beverages in this sector.

In 1995, annual expenditures for alcohol per household (not including hotels, cafes and restaurants) were as follows: 1,581 francs for wine (58.71% of the total), 766 francs for aperitifs, brandies and liqueurs (28.44%), 299 francs for beer (11.10%) and 47 francs for ciders (1.75%). This came to a total figure of 2,693 francs. Meals eaten out represented an average expenditure of 6,273 francs per household. If we assume that at least 10% of these expenses were for alcohol, the budget for alcohol per household would increase by one-fourth. The total amount of money spent by households on alcoholic beverages most likely surpassed 100 billion francs in 1997.

According to the Entreprise et Prévention association (think tank and initiative group of beverage producers), alcohol was taxed 20 billion francs in 1994[90] (18 billion in indirect taxes, and 2 billion francs in tax discs). In total, the specific tax weight on alcoholic beverages reached 21 billion francs. The VAT (20.6%) must be added in order to obtain the total tax pressure on alcohol.

Turnover for Tobacco

In 1997, the turnover of tobacco sales (in its different forms) rose to 75.3 billion francs. This figure includes sales of tobacco to households throughout the national territory. It includes margins for the different middlemen (6% for the tobacconist, and 3.24 francs for the distributor), as well as the tax burden.

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[89] *Tableaux de l'économie française , INSEE, 1998.*
[90] *According to «Entreprise et Prévention» (French professional organization), these figures have not fundamentally changed since this date.*

In 1995, the global tax burden on cigarettes was 76%. This global tax burden includes the VAT (20.6%), taxes for the annexed budget of social agricultural services[91] and taxes for the having the right to smoke. It should be noted here that the last two taxes are calculated from the sales price. Taxes on the right to smoke are broken down into a specific tax unit set at 36.6 francs per 1 000 cigarettes sold, and a proportional tax unit currently at 54.5% (1997 data). This is calculated so that the global cost for the right to smoke and for the type of tobacco most sold reaches 58.3% of the sales price (refer to following chart). It has been noted that because of the specific tax unit, the cost for the right to smoke is lower for a more expensive package of cigarettes and vice versa.

Normal tax rates for tobacco in continental France, august 1, 1995

Types of product	Taux
Cigarettes	58,3 %
Cigars	28,9 %
Tobacco (loose)	54,0 %
Other types of smoking tobacco	46,7 %
Tobacco (snuff)	40,2 %
Tobacco (chewing)	27,5 %

Source : INSEE (1997)

In 1997, the State collected 40.6 billion francs in taxes from granting the right to smoke.

If we attempt to break down this turnover by price and average quantity, the 6,998 tons of tobacco sold on the French market corresponded to 95 billion cigarettes smoked in 1996. The average unit price was approximately 0.79 francs.

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.

[91] *Tax established at less than 1 %.*

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[92] (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[93].

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.

Frequency of use among cannabis users in Amsterdam

Rythm of use	% among experienced users having used it during the year
Daily	17
Once per week or more / not daily	31
Once per month	15
Once per year / less than once per month	37
Total	100 %

Source : Cannabis use in Amsterdam, COHEN (P.), SAS (A.), Cedro, 1998

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[94]. 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;

[92] *COHEN (P.), SAS (A.), Cannabis use in Amsterdam , Cedro, 1998.*
[93] *INGOLD (R.), TOUSSIRT (M.), Le cannabis en France, ed. Anthropos, Paris, 1998, 173 p.*
[94] *See "Measuring the extent of Drug use" ("Drug use in France" chapter).*

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

Estimated turnover of cannabis in France

Rythm of use / year	% of users / year	Number of users	Number of grammes of cannabis used each time	Number of occasions used / year	Number of tons used	Corresponding expense (millions of francs)
Daily	17	374 000	0,5	365	68,26	2 388,9
Once per week or more / not daily	31	682 000	1,5	52	53,20	1 861,8
Once per month	15	330 000	0,5	12	1,98	69,3
Less than once per month	37	814 000	0,5	6	2,44	85,4
Total	100	2 200 000			125,87	4 405,5

Source : OFDT

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. According to the assumptions retained, the quantities seized should be 10% lower than the quantities sold. 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[95]. 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[96], 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.

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.

A study conducted by Peter Cohen and Arjan Sas is based upon a questionnaire filled out by cannabis users who had been detected in a general population survey in Amsterdam. This 1994 survey was based upon over 4,000 individuals who were questioned about their use of cannabis. Their names and addresses were retained. Of those questioned, 29% stated they had used cannabis at least once. The researchers decided to limit themselves to experienced cannabis users who were defined as having used cannabis over 25 times in their lifetime. They then asked the 535 individuals who met these criteria to fill out a more in-depth questionnaire about their use of cannabis. Two hundred and fifty accepted, and 216 were finally surveyed. Statistical comparisons of those who refused showed that the two groups did not significantly differ from the point of view of cannabis use, age, gender, etc.

For More Information:

- *COHEN (P.), SAS (A.), Cannabis use in Amsterdam, Cedro, 1998.*
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[95] *Section relating to harm reduction indicators.*
[96] *R.INGOLD, op.cit.*

The Fight Against Illicit Drug-Related Money Laundering

It is particularly difficult to determine the total amount of money laundered by drug traffickers. Some estimates have been produced on a global level using data from narcotic substances that have been seized. However, it is not possible to determine the amounts of money to be laundered from the sale of drugs in France using this very global calculation. We can try to avoid this problem by attempting to estimate the demand for narcotic substances and the total corresponding expenditures. As we have seen, this estimate is based upon many different assumptions. Only part of this drug turnover corresponds to money that must be laundered. Indeed, part of this sum is used at the intermediary levels, either to cover costs related to their activity (economists speak of intermediary use), or for personal expenses. With the current state of knowledge, it is difficult to determine what fraction of the turnover remains to be laundered once the intermediary expenses have been paid.

The indicators mentioned here are not related to amounts of capital to be laundered, but to the activities of service is involved in fighting drug-related money laundering.

TRACFIN (Processing of Information and Action against Clandestine Financial Circuits), which was created in the early 1990s at the Ministry of Economics and the Budget, is responsible for receiving and processing statements of suspicious activity sent by financial organisations, and for transmitting files which reveal events that may involve drug trafficking or organised criminal activity to the legal authorities.

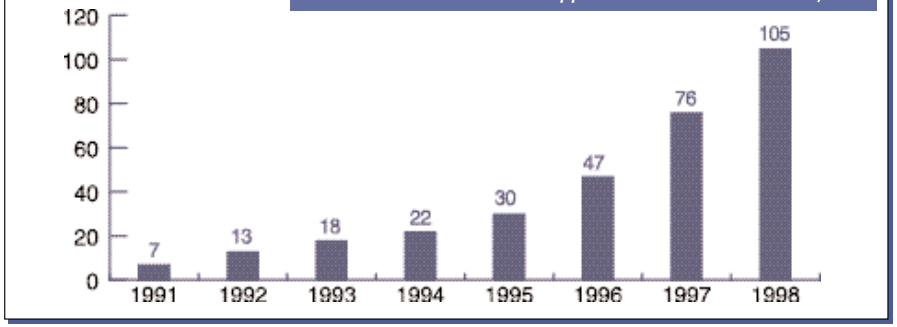
The number of these statements received by TRACFIN (1,213 in 1997 or nearly 100 per month) is growing. Since February 1991, TRACFIN has received over 4,880 statements of suspicious activity. This increasing trend, which continued in 1998, seems mostly due to more effective collaboration between the banking and financial services concerned. A large majority of these statements prove to be unfounded after verification, and only a dozen files have actually been sent to the legal authorities. In addition, these statements are based upon money laundering for all crimes and not only for drugs.

Banks transmit 69% of these statements. Their share has been decreasing in favour of certain professional sectors that are becoming more and more aware (such as money changers and insurance companies).

The number of files sent to the legal authorities has rapidly grown, with 76 files in 1997 that globally represented a sum of 750 million francs, compared to 47 files in 1996 and 30 in 1995.

Around 1,600 investigations were conducted in 1997, and since TRACFIN was created, 213 cases were brought to court. At the end of 1998, there had been 34 definitive convictions for money laundering. Twenty five of these were since 1993 (according to figures provided by the Ministry of Justice).

Number of cases transmitted to the legal authorities 1991-1997
Source : Rapport d'activité de la douane, 1997



Methodological References

➥ TRACFIN, ministère de l'Économie et des Finances et ministère du Budget

Information for this text came from a release sent out by the Ministry of the Budget when the 1995 assessment of customs actions was presented.

➥ Le cadre législatif : principaux textes récents

Law n° 96-392 enacted on May 13, 1996, relating to the fight against laundering and the trafficking of narcotics, and to international cooperation in seizing and confiscating criminal substances.

Law n° 93-122 enacted on January 29, 1993 relating to the prevention of corruption and transparency in economic affairs and public procedures.

Law n° 90-614 enacted July 19, 1990 relating to the participation of financial organizations in the fight against the laundering of capital from drug trafficking.

Decree made on May 9, 1990 , which created a unit responsible for processing information and action against clandestine financial circuits (TRACFIN).

For More Information:

- *Blanchiment de l'argent lié à la drogue, in Drogues et Toxicomanies : Indicateurs et tendances - édition 1995, DGLDT-OFDT, Paris, 1995.*
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- *La lutte contre le blanchiment de capitaux, Groupe d'action financière, la Documentation Française, Paris, 1990.*
- *KOPP (P.) (éd.), L'économie du blanchiment, Association d'économie financière, Paris, 1995.*

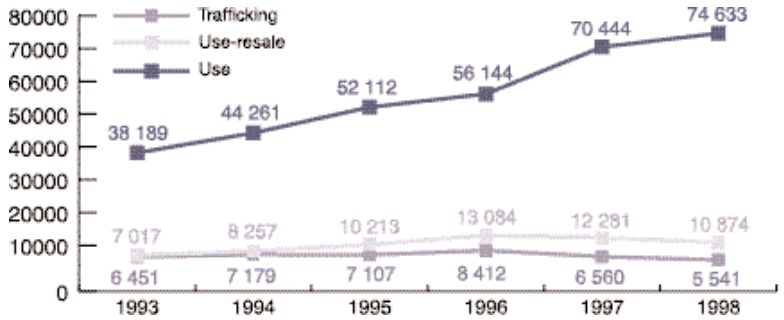
Drug Trafficking: Arrests, Convictions, and Incarcerations

Arrests

The number of arrests for trafficking

The number of drug traffickers arrested strongly dropped between 1996 and 1998, falling from 8,412 to 6,560 in 1997 and 5,541 in 1998. In 1998 the number of arrests was about the same as in 1991/1992.
Arrests for trafficking represented 6% all arrests for drug-related offences in1998, compared to 11% in 1992.

Evolution in number of arrests for use, use-resale, and trafficking - ***Source : OCRTIS***



Arrests by type of trafficker

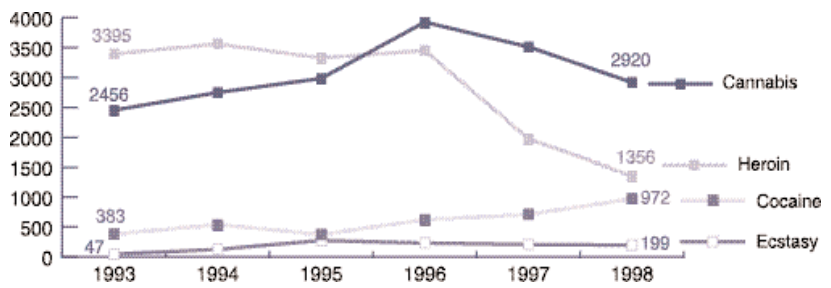
Drug traffickers arrested in 1998 were broken down into international (around 23%) and local (77%). The share of local traffickers has fluctuated between 75 and 85% since the middle of the 1980s. However, it should be noted that nearly the entire drop in the number of arrested traffickers from 1996 to 1998 was due to a decrease in local trafficking.

Arrests of traffickers by substance

In 1998, a little over one-half of the traffickers were arrested for trafficking cannabis (52%). This percentage was slightly lower than in 1997 (53.5%). The number of heroin traffickers dropped from 33% to 24% from 1997 to 1998, while the number of cocaine traffickers (and crack) decreased from 12% to 17%. Arrests of ecstasy trafficker represented a much smaller percentage of all arrested traffickers (3%).

Developments between 1993 and 1998 were characterized by a strong decrease in the number of heroin traffickers (starting in 1997). After strongly increasing between 1993 and 1996, the number of cannabis traffickers also dropped

Arrests of traffickers per implicated substance - ***Source : OCRTIS***



sharply. The number of cocaine traffickers arrested, which fluctuated between 200 and 500 since the middle of the 1980s, recently began to increase. Arrests of ecstasy traffickers have remained stable since 1995.

The contraction of the heroin market, which had already been already perceptible on the level of user arrests since 1995, was strongly felt by traffickers beginning in 1997. This trend seems to have continued in 1998. The probable change from trafficking heroin to trafficking other substances such as cocaine has become perceptible in the number of arrests for trafficking this substance.

Convictions linked to the drug trade

As was the case for use-related convictions, police and judicial statistical terms were different. Thus, it was impossible to clearly know the judicial follow-ups for trafficking-related arrests.

In judicial statistics, the term trafficking is reserved for cases involving the importing or exporting of narcotic substances. Traffickers arrested by the police may also be convicted for offences relating to selling, transporting, providing and supplying, obtaining, acquiring or using narcotics. In most cases, arrested traffickers are convicted for multiple offences. The trend is toward an increasing number of offences for each conviction handed down. The average number of drug-related offences in cases involving conviction for at least one ILS (drug-related offence) rose from 1.8 to 2.6 between 1991 and 1996. In the section on use-related convictions, we noted that a trafficking-related offence might be associated with a use-related offence. Practices for incriminating an individual are not unified, and may be very different for one prosecutor to the next.

Convictions by main offence

The most rapidly increasing number of offences relate to selling, using and transporting narcotics. The number of trafficking-related offences has increased more slowly. We have already been able to detect this development in the level of offences associated with use.

These figures, presented by main offence committed, only provide a partial picture of offences linked to the drug trade for which individuals are punished when sentenced. Many of the convicted individuals (which the figures refer to in the preceding chart) were sentenced for associated drug use.

Number of convictions for main offence relating to the drug business

Types of offence	1992	1993	1994	1995	1996	1997
Convictions for narcotics trafficking (import-export)	2 196	2 128	2 450	2 706	2 429	2 193
Convictions for selling, using, transporting narcotics	2 182	2 284	2 173	2 652	3 378	4 016
Convictions for supplying, providing narcotics	2 272	2 034	2 307	2 595	2 863	2 523
Convictions for holding-purchasing	7 563	7 699	7 294	7 910	8 263	8 595

Source : Annuaire statistique de la justice 1999

Convictions for drug-related offence (not including use)

Level

We do not have as detailed of data on associated offences for this type of conviction as we do for use-related offences.

In spite of this, to attempt to assess the number of convictions for trafficking the figure for all convictions including at least one drug-related offence in 1997 (27,483) may be compared to all 1997 convictions including at least one use-related offence (15,685). The difference gives us a figure of 11,798 convictions, including at least one drug-related offence that didn't include use.

This number of convictions (excluding use), exceeds the 7 to 8,000 arrests of traffickers as recorded by the OCRTIS in 1995 and 1996. This means that amongst the 11,798 convictions that excluded use, we find not only the traffickers counted by the OCRTIS but other categories as well: users-dealers, users only, or individuals arrested for other crimes.

Of all of the convictions which excluded use, 2,559 included a traffic offence in 1996, 3,845 convictions included a transporting offence (not associated with trafficking), 3,187 convictions included an offence for supplying or offering (not associated with the preceding offences), and lastly there were 2,193 convictions for holding-acquiring (not associated with any of the preceding offences).

Changes

Outside of use, convictions for at least one drug-related offence increased very little between 1991 and 1997. As may be seen on the following chart, most of the increase in the number of convictions for at least one drug-related offence was due to an increase in the number of convictions that included use.

Number of convictions for drug-related offences and non-use

Types of offence	1991	1996	1997
1.Convictions with at least one drug-related offence	22 699	27 426	27 483
2.Convictions with at least one use-related offence	11 505	15 493	15 685
3.Drug-related offence not involving use (3 =1-2)	11 194	11 933	11 798

Source : SDSED, ministère de la Justice

Incarcerations for trafficking

Prison statistics use different terms than judicial statistics. Trafficking takes on the general meaning for this term.
Figures relating to incarceration are only provided by main offence committed. An individual incarcerated for trafficking may also be prosecuted or charged for use. An individual may also be imprisoned for offences involving theft and use. If use is not the first offence cited, this individual will not be counted amongst those incarcerated for a drug-related offence.
Incarceration statistics include both individuals being temporarily held, and individuals incarcerated after being convicted (the case of individuals not temporarily held before being tried).
Les incarcérations recouvrent à la fois des mises en détention provisoire et des incarcérations suite à condamnation (cas des personnes qui ne sont pas en détention provisoire avant leur jugement).

The flow of prisoners

In 1997, nearly 10,600 individuals were incarcerated for a main offence involving drugs. Two-thirds were incarcerated for trafficking and 700 individuals were imprisoned for a main offence involving use. This figure has been steadily decreasing since 1993. The number of individuals imprisoned for trafficking-related offences abruptly dropped in 1997 after having remained stable between 1993 and 1996. This last development may be compared to the decrease in the number of arrests of drug traffickers.

Flow of imprisonments for drug related offences

Types of offence	1993	1994	1995	1996	1997
Trafficking	7 845	7 726	7 991	7 842	6 869
Supplying	686	1140	1053	987	910
Other drug-related offences (excluding use)	2 091	2 158	2 653	2 244	2 115
Use	1 213	1 034	892	870	700

Source : SDESD

The number of prisoners on a given date

At the beginning of 1998, there were 10,547 prisoners incarcerated for a drug-related offence, of which half had been convicted and half had been charged. The number of prisoners convicted for a drug-related offences has been decreasing since 1996, dropping from 6,550 to 5,160 between the 1st of January 1996, and the 1st of January 1998. The number of prisoners convicted for drug-related offences represented 21% of all prisoners on January 1st 1994, and dropped to around 18% on January 1st 1998.

For a large majority of these prisoners, the main offence leading to conviction or temporary incarceration was trafficking. However, as we have already seen, some of these prisoners held for trafficking, supplying or other offences, may also have committed a use-related offence.

Number of individuals present in prison establishments for drug offence on january 1, 1998

Types of offence	Number of individuals on remand	Number of imprisoned individuals
Trafficking	4 019	3 753
Supplying	329	292
Other drug-related offences (excluding use)	942	862
Use	197	257

Source : SDESD

Methodological References

➥ Fichier national des auteurs d'infraction à la législation sur les stupéfiants, OCRTIS (National database of perpretors of drug-relatd offences)

Information on drug use-related arrests made throughout the year is found in this file. Events, not individuals, are listed. Some users may be arrested several times during the same year. (See file on use-related arrests).

➥ Casier Judiciaire National(National record of convictions), SDSED

Drug-related offences (ILS) for which an offender has been sentenced and convicted are listed in this database. Because of frequent associations between the different qualifications of offences in any particular case leading to conviction, the number of offences mentioned is higher than of convictions. (See sheet on convictions for use).

➥ Fichier national des détenus(National prisoner database), SCERI

The flow of individuals incarcerated during the year (individuals entering prison between January 1st and December 31st) is recorded in this file). Only the offence listed at the top of the committal order is taken into account. As was the case for convictions, this offence is not necessarily the most serious committed. It may also be the first offence noted.

This database may also be used to determine the number of incarcerated individuals at a given date. This number is a result of the flow of prisoners entering or exiting prisons during the year, and preceding years.

For More Information:

- *Les condamnations 1996 et 1997, Études et statistiques justice, n° 11 et 13, Sous-direction de la statistique, des études et de la documentation, ministère de la Justice, 1999.*
- *Usage et trafic de stupéfiants : statistiques 1997, OCRTIS, ministère de l'Intérieur, 1998.*
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- *Annuaire statistique de la justice, édition 1999, Sous-direction de la statistique, des études et de la documentation, ministère de la Justice, 1999.*

Seizures of Illicit Drugs

Seizures of narcotic substances depend as much upon the circulation of the latter as upon police, gendarmerie, and customs activities. Large seizures may result in wide fluctuations from one year to the next, making it particularly tricky to analyze seized quantities over time.

In 1998, quantities of seized cannabis stabilized at a rather high level. The number of seizures of has continually increased, particularly for small quantities. On the other hand, quantities of seized heroin and the number of these seizures have dropped, confirming a trend that has been occurring for several years. As was the case with arrest data, the number of seizures of cocaine is smaller than for heroin, but has been continually increasing yearly.

Seizures of narcotic substances

Types of substance	1996		1997		1998	
	Seized quantities	Number of seizures	Seized quantities	Number of seizures	Seized quantities	Number of seizures
Cannabis*	66 861	27 320	55 122	34 266	55 698	40 115
Heroin	617	4 865	415	3 924	344	3 113
Cocaine	1 742	1 213	844	1471	1 051	1 688
Crack	11	244	16	228	25	334
LSD	74 780	190	5 983	171	18 680	154
Ecstasy	349 210	644	198 941	628	1 142 226	608
Amphetamines	128	91	194	163	165	158

Quantités exprimées :
en kg pour le cannabis, l'héroïne, la cocaïne, le crack et les amphétamines
en doses pour le LSD et l'ecstasy

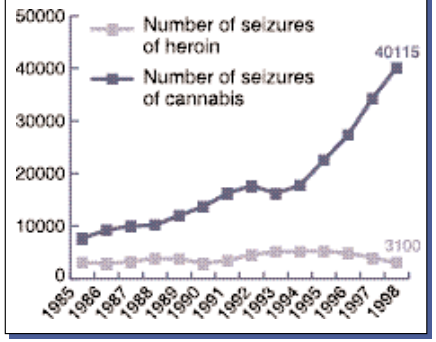
Source : OCRTIS

** comprend l'herbe et la résine de cannabis. Sur les 55,7 tonnes de cannabis, on compte 52,2 tonnes de résine et 3,5 tonnes d'herbe*

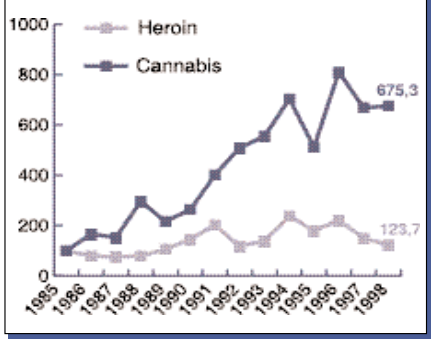
In the long term, looking beyond annual variations, there has been an increasing trend in the quantities of seized drugs for all substances. However, this increase has been stronger for cannabis than heroin. Between 1985 and 1988, the average annual rate of growth for quantities of seized heroin was 8% compared to 20% for cannabis. Quantities of seized heroin fluctuated between 200 and 300 kgs per year from the mid-1980s to the early 1990s, then between 400 and 600 kgs. Quantities of seized cannabis fluctuated between 10 and 20 tons in the first period, then between 40 and 60 tons in the second. Seized quantities of cocaine, which were very low in the mid 1980s, rapidly grew until 1990. Excluding the outstanding seizure that occurred in 1994, seized quantities fluctuate between 800 and 2 000 kgs per year.

When looking at the increased quantities of drug seized in France, questions may be asked about the role of drugs transiting through the country. Sixteen tons of cannabis resin destined for the domestic market was seized in 1998. This level was comparable to 1992 and 1995.

Number of seizures of cannabis and heroin
Sources : OCRTIS



Evolution of quantities of heroin and cannabis seized - ***Sources : OCRTIS***



The origin and destination of seized drugs have changed very little over the last few years. Since the early 1990s, the share of countries producing drugs is clearly on the decline amongst the countries from which drugs are acquired.

Most of the cannabis still comes from Morocco. Some arrives directly in France. More and more frequently, it arrives via Spain from where the largest amounts of seized cannabis resin came in 1998 (33 tons). Two-thirds of the quantities seized were transiting through France toward the Netherlands (first of all), the United Kingdom, and other Northern European countries, as well as to Italy.

Heroin almost always comes from South-western Asia (Afghanistan, Pakistan). The main country through which it transits before entering France is still the Netherlands (31% of the quantities seized in 1998). Amongst the other countries that regularly appear here, are Belgium (22 kgs in 1998), Spain, Thailand (11 kgs) and Turkey (7 kgs). Two very large seizures transiting through France, totalling 83 kgs, were from heroin originating in Hungary. This country had never before appeared amongst the countries of origin of drugs seized. In 1997, the main countries of destination were the Netherlands, Spain, and the United Kingdom. Unlike cannabis, a large share of the seized quantities was destined for the French market. This percentage dropped in 1998, with 43% of the quantities seized versus 66% in 1997.

South American countries have traditionally come in first position amongst countries that supplied cocaine. Nevertheless, Spain, a country that has long been used by South American drug traffickers, was at the top of the list in 1998 (252 kgs). Columbia, which often tops the list of countries from which drugs are acquired, was passed by Argentina (83 kgs) and Venezuela (82 kilos) with an amount equal to that of Surinam (65 kgs).

France is also a country of transit for cocaine. All throughout the 1990s, large quantities seized were on their way to Italy, Spain, the Netherlands and other neighbouring European countries.

Analyzes conducted on seized substances provided some indications about the composition of the various substances that are currently being circulated. However, these analyses are not systematically carried out. The results may not be representative of all of the substances being circulated, or even the substances seized.

Analyzed samples of heroin have tended to be more and more diluted since 1995. The rate of purity is lower, just as there have been smaller quantities seized. The most frequent substances used to cut drugs were caffeine, found in nearly 90% of the samples, and paracetemol. Most of the samples of chloral hydrated heroin[97] contained between 80% and 90% caffeine. For basic heroin[98], the rate of caffeine is lower (between 30% and 40%). Paracetemol is being used more and more, in stronger and stronger concentrations.

On average, the purity of cocaine samples that have been analysed is very high (generally over 70%). Mannitol is the most commonly encountered cutting substance, along with saccharose, lactose and lidocaine.

The scientific police laboratory in Lyon has not received enough samples of ecstasy or amphetamines to provide results on these substances.

Methodological References

➥ Fichier national des auteurs d'infraction à la législation sur les stupéfiants, OCRTIS (National database of perpretators of drug-related offences)
It is not always possible with current judicial procedures to find out the country from which seized substances are acquired. Moreover, when this is known, it does not always correspond to the country of production. Indeed, drugs seized in France were often destined to transit through or be redistributed in

For More Information:

■ *Usage et trafic de stupéfiants : statistiques 1997, OCRTIS, ministère de l'Intérieur, 1998.*
■ *L'action de la Douane : bilan 1997 et perspectives, ministère de l'Économie et des Finances, 1998.*

[97] *Chlorhydrate heroin, which comes in the form of white powder, is the injectable form of this substance.*
[98] *Not easily dissolved in the blood, basic heroin («brown sugar») is designed to be smoked. Nevertheless, it is often injected after being heated and mixed with acid (for example : citric acid).*

ILLICIT DRUGS IN THE FRENCH DEPARTMENTS AND COUNTRIES OF THE EUROPEAN UNION

Geographical Approach to Illicit Drugs in France

The drug situation is not the same throughout the French territory. Some areas have been much more affected than others. Five indicators were used to differentiate between the various departments: treatments provided by the health and social system, the sale of Stériboxes®, the sale of Subutex®, arrests for heroin use, and lastly, overdose-related deaths. These indicators are based upon problem drug use (mainly opiate use).

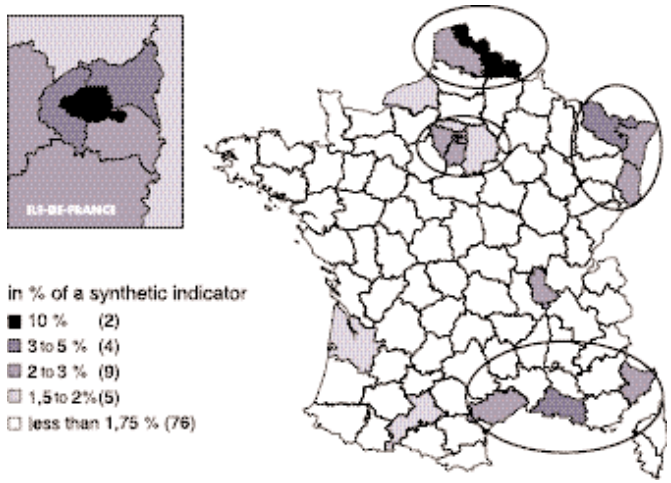
The global classification is based upon the simple average of the weight of each department for each indicator (see methodological references), which thus gives the same weight to each of the indicators.

The geographical representation thus obtained partly shows care and treatment available to drug users and the activity of police services. This does not represent the only geographical differences of drug use.

Global classification

This phenomenon remains geographically concentrated. Thirteen départements gather 50% of the phenomenon, and 28 of them gather 75%. Arrests do particularly aggregate, notably because 20% of those concerning heroin, cocaine and ecstasy users are made in the Nord département alone. Seventy-five percent of Subutex® and Stéribox® sales are made in just over one-fourth of the départements. Arrests for cannabis use do not form such a geographical cluster: 75% of the latter are made in 40 départements.

Geographical breakdown of drug use - Source : OFDT



Absolute classification

The geographical distribution of drug use is characterized by the existence of four regional poles : Paris and the surrounding region, the North, the North-East (Alsace and Lorraine), and the Mediterranean coast.

The common characteristics of these geographical poles are that they include the most inhabited départements, with a few exceptions. Outside of Paris and the surrounding region, they are situated on national borders.
An analysis of the 20 most affected départements first shows the four above-mentioned poles (Paris, Nord, Bouches-du-Rhône, Moselle, Bas and Haut-Rhin) and some highly inhabited border départements, then départements that contain a large city such as the Rhône, the Gironde, and the Haute-Garonne.

The ten most affected departments (1997 data)

Department	Global indicator	Treatment indicator (1)	Stéribox indicator (2)	Subutex® indicator (2)	Indicator - arrests for use of heroin, cocaine, and ecsatsy (3)	Overdose indicator (3)	Indicator- arrests for cannabis use (3)
Paris	10,95 %	9,73 %	10,58 %	9,53 %	8,19 %	16,74 %	3,5 %
Nord	10,15 %	9,40 %	4,27 %	5,44 %	19,29 %	12,33 %	7,9 %
Hauts-de-Seine	4,84 %	3,64 %	3,81 %	2,23 %	5,25 %	9,25 %	3,1 %
Bouches-du-Rhône	4,40 %	4,56 %	5,86 %	4,89 %	2,72 %	3,96 %	3,2 %
Seine-St-Denis	4,32 %	3,83 %	3,10 %	3,19 %	2,69 %	8,81 %	3,1 %
Moselle	3,04 %	3,09 %	3,10 %	2,81 %	4,90 %	1,32 %	1,8 %
Bas-Rhin	2,83 %	1,71 %	4,17 %	4,10 %	1,99 %	2,20 %	1,2 %
Val-de-Marne	2,83 %	2,17 %	2,97 %	2,40 %	2,19 %	4,41 %	2,1 %
Alpes-Maritimes	2,61 %	3,11 %	3,02 %	2,98 %	3,04 %	0,88 %	2,1 %
Haut-Rhin	2,38 %	1,60 %	2,47 %	3,19 %	1,55 %	3,08 %	1,5 %

Source : (1), SESI ; (2), SIAMOIS/RNSP ; (3,) OCRTIS

Lecture du tableau :
Paris représente 9,7 % des recours de la France entière, 10,6 % des ventes de stéribox®, etc.
Les chiffres de la colonne « global » sont calculés en effectuant la moyenne des chiffres en ligne (hors cannabis) pour chaque département.

Equal population classification

In order to take the differences in population of each department into account, the weight of a department is added to its weight in the general population for each of the preceding indicators. Thus, amongst the top ten départements, we find some that were amongst the top 20 in the last classification (with the exception of the Pyrénées-orientales). The position of the latter in this classification may be explained by the fact that it is a coastal department on a national border. The next ten départements are very different in the two classifications. There are some départements that border on the four above-mentioned poles (the Ardennes, Meurthe-and-Moselle, Val-de-Marne, and Vaucluse départements). The position of the Pyrénées-Atlantiques is once again linked to its location on a national border. Four départements are more atypical: the Charente-Maritime, (the only Western one in this classification), the Marne, the Aube and the Yonne.

After taking into account the size of the population, the classification obtained for cannabis is very different from that for the other substances. Only four départements, classified amongst the first 20 before, appear in the classification based solely upon arrests for cannabis use. Two lesser-inhabited départements (Hautes-Alpes and Ariège) are at the top of the classification followed by the Nord.

The twenty most affected departments with equal populations (1997 data)

Department	Global indicator	Treatment indicator (1)	Stéribox indicator (2)	Subutex® indicator (2)	Indicator - arrests for useof heroin, cocaine, and ecsatsy (3)	Overdose indicator (3)	Indicator- arrests for cannabis use (3)
Paris	2,45	2,18	2,37	2,13	1,83	3,75	0,78
Nord	2,25	2,08	0,95	1,21	4,27	2,73	1,74
Haut-Rhin	1,92	1,29	1,99	2,57	1,25	2,49	1,18
Pyrénées-Orientales	1,84	1,42	2,80	2,43	1,77	0,79	0,82
Hauts-de-Seine	1,78	1,34	1,40	0,82	1,94	3,41	1,13
Moselle	1,69	1,71	1,72	1,56	2,72	0,73	1,01
Alpes-Maritimes	1,68	2,00	1,94	1,92	1,96	0,57	1,36
Seine-Saint-Denis	1,58	1,40	1,13	1,16	0,98	3,21	1,13
Hérault	1,56	1,11	2,13	2,39	1,26	0,91	0,77
Bas-Rhin	1,52	0,92	2,24	2,20	1,07	1,18	0,66
Bouches-du-Rhône	1,45	1,51	1,94	1,62	0,90	1,31	1,07
Ardennes	1,34	0,98	1,18	1,43	2,21	0,92	1,01
Charente-Maritime	1,22	1,17	1,65	1,87	1,39	0,00	1,30
Marne	1,21	0,50	1,15	0,91	2,21	1,27	1,19
Pyrénées-Atlantiques	1,19	1,78	0,89	0,91	0,98	1,39	0,81
Val-de-Marne	1,19	0,91	1,25	1,01	0,92	1,85	0,89
Meurthe-et-Moselle	1,13	1,11	1,51	1,17	1,50	0,35	1,12
Yonne	1,06	0,53	1,22	1,47	2,11	0,00	0,96
Aube	1,06	1,73	0,80	0,91	1,87	0,00	0,87
Vaucluse	1,05	0,84	1,26	1,87	0,71	0,55	1,04

Source : (1,) SESI ; (2,) SIAMOIS/RNSP ; (3), OCRTIS

Lecture : les recours à Paris ont un poids dans l'ensemble des recours deux fois plus élevé que le poids de la population de Paris dans l'ensemble de la population française (métropole uniquement).

Characterisation of départements according to the indicators

The observation of the values shown in the preceding chart lead us to distinguish between three groups:

- Départements in which all the indicators (or nearly all) are situated at a high level.
In fact, Paris is the only département for which all five indicators, used to make a global classification, are situated at a high level. On the other hand, the number of arrests for cannabis use is relatively small compared to the size of the population.
In two other départements, all of the indicators (with the exception of overdoses) are situated at a high level: the Alpes-Maritimes and Moselle départements.

- Départements more characterised by high levels of Stéribox® and Subutex® sales.
By order of appearance in the global classification, this group includes: the Haut-Rhin, Pyrénées-Orientales, Hérault, Bas-Rhin, Bouches-du-Rhône, Charente Maritime départements, and further down the list, the Gard.

There is a strong correlation between levels of indicators for Stéribox® kits and Subutex®. However, there are some exceptions: the Hauts-de-Seine, with a very low indicator of sales of Subutex® compared to sales of Stéribox® kits, and the opposite case in the Vaucluse, with a high indicator for Subutex® and clearly lower indicator for Stéribox® kits.

- Départements characterized by a high level of arrests.

Amongst the départements characterised by a high level of arrests, are the following: the Nord, where indicators are high for arrests, treatment and overdose-related deaths; the Ardennes, Marne, Yonne and Aube départements.

There is very little correlation between the arrest indicator (equal population), the Subutex® and Stéribox® indicator, and the treatment indicator.

Lastly, we will note here that départements located in the regions surrounding Paris are particularly affected by overdose-related deaths.

Methodological References

Data used to establish the classification of departments came from the SIAMOIS/RNSP database for Stéribox® kits and Subutex®, from the 1997 SESI survey for treatment, and the OCRTIS for data on arrests and overdose-related deaths. For more precise information on these different types of data, refer to the sections concerned.

The first classification was established without taking into account relative sizes of populations in each department. Thus, there was a greater likelihood that the more inhabited departments are found at the top of the list. For each department, indicators were expressed as a percentage of the national total for the indicator being considered. If we take treatment as an example, 9.7% of all treatment was provided in Paris in 1997. The synthetic indicator is obtained by establishing the average of the percentages for the five indicators. Each indicator carries the same weight in the global one.

In the second classification, we eliminated the differences in population sizes by adding the percentages from the first classification to the percentage of the population of each department out of the entire French population. We limited ourselves to the 20-39-year-old age group, where the majority of users of hard drugs are found. In 1997, treatment in Paris represented nearly 10% of all provided, while the population of Paris represented just fewer than 5% of the population of metropolitan France. The share of treatment provided in Paris was nearly twice as high as its share of the total population. Thus, the capital city did not just mechanically appear at the top of the list because of the size of its population.

This indicator may be interpreted to be different from the average. Treatment per inhabitant was twice as high in Paris as it was on average throughout all of France. Departments whose value equalled, or was close to one, were in the average.

The typology of the most affected departments was empirically established and was not based upon the usual statistical techniques used. Unfinished work at the Health Watch Institute (ex-RNSP) using data from the SIAMOIS database will soon provide a typology based upon a complete statistical analysis of available data.

Illicit Drugs in the European Union

It is still difficult to make comparisons between the various European countries because of institutional differences and differences in methods of gathering data. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has begun work to coordinate the key indicators, but has not yet succeeded. We cannot go into detail here about the methodological problems raised by making comparisons between the different countries. It is important to remember that comparisons that are based upon the absolute levels of the indicators are always frail, and that comparing new developments is often more significant.

Recent developments in the use of substances throughout the countries of the European Union

Substance by substance, the following developments are currently occurring in Europe:

Cannabis: Use has stabilized in countries in which it has attained a high level; it is slightly increasing in other countries.

Synthetic drugs: The use of ecstasy is stabilising in countries where use is high, but is still on the increase in the others; ecstasy is used in different social milieus. The consumption of amphetamines has continually increased, and could become more significant than the use of ecstasy in the long run. The emergence of new substances has been observed in some countries.

Cocaine: Growth has been steady but limited; the number of users has remained low. The use of crack has remained stable, but has spread in some regions.

Heroin: Its use is growing amongst users of synthetic drugs, and amongst young people in some countries.
In addition, problematic development of drug use in small towns and rural areas has been detected in some countries.

The situation in France compared to the other countries

The use of cannabis and other drugs amongst the general population

Using information from general population surveys of drug use conducted in most of the European countries, it is possible to compare experimentation with drugs (lifetime prevalence) and the recent use of illicit substances (use during the year) in different countries.

Within the European Union, the most illicit drug commonly used is cannabis. According to the different countries, 5 to 30% of the population has already tried this substance, and up to 40% of young adults have done so. From 1 to 9% of the adults and up to 20% of young adults used this substance during the year. It is difficult to compare one country to the others since all countries did not provide information on prevalence, and different methods were used when conducting surveys. We can say that the prevalence of use over the last year amongst young adults seemed fairly close in France (8%), Germany (8%) and Denmark (7%) , and not too different in Spain (11%). Amongst 15-16-year-old lycéens, lifetime prevalence seemed particularly high in the United Kingdom, Ireland, and the Netherlands. According to the most recent

survey, prevalence in France would appear to be getting closer to these levels.

The use of amphetamines, which comes in second amongst illicit substances with which individuals have experimented in many countries of the European Union, is not less fraquently stated in surveys conducted in France. Ecstasy is used by 0.5 to 3% of the adult population in the countries of the European Union and by 1% of the adults in France.

In the EU, 1% to 3% of the adults have experimented with cocaine, and 0.2 to 0.3% have tried with heroin. France is not differentiated from the rest of the European Union for these substances. One percent of the French adults have experimented with cocaine, and 0.4% has experimented with heroin. In general population studies, the small gaps are not very significant or totally negligible.

Death and infectious diseases

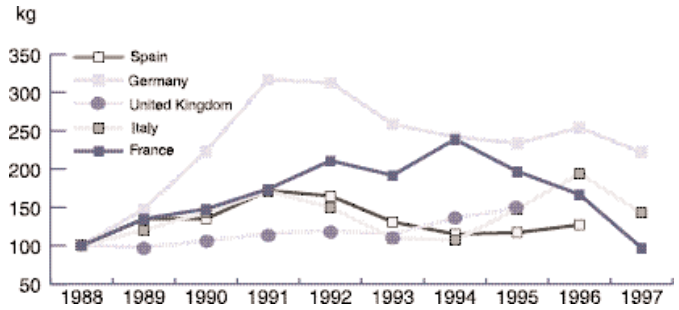
Absolute figures on drug use-related deaths may not be compared because of the different methodologies used to record them. On the other hand, it is possible to compare new developments.

The number of drug-related deaths strongly increased in almost all of the countries in the European Union at the end of the 1980s. It then began to drop in a certain number of countries (such as Germany, Spain, and Italy, then France, the United Kingdom), as well as countries that had recorded very few deaths before (such as Greece, Austria, and Portugal). This number peaked in France in 1994. Since then, the decrease has been fast and steady compared to Italy and Spain where deaths have begun to rise again. France is the only country today, in which the number of these deaths has returned to the level attained at the end of the 1980s. The only exception was in the Netherlands, where the level has remained fairly constant since 1985.

It is true that the restrictive definition used by France and the Netherlands to describe these deaths (which does not include overdose-related deaths or take into account accidents and suicides which may be attributed to drugs), tends to limit the amount of variation in these figures. One of the priorities of the EMCDDA is to coordinate figures on mortality.
Most of the countries have reported that HIV has either stabilized, or decreased.

Some countries seem to have been more affected than others. If we refer to the number of new AIDS cases declared[99] over the first half of the 1990s, this is the case in the southern European countries (Spain, Italy, Portugal) as well as France in a smaller measure. The Northern countries seem to be less affected.
Prevalence for hepatitis C viruses is high in all the countries, and there is no North/South division as observed for HIV.

Evolution in the number of deaths relating to drug use in the 5 most populous countries of the E.U.
Source : European Centre on Drugs and Drug Addiction (EMCDDA)



Requests for treatment and substitute treatments

The characteristics of the population of drug users who sought treatment from the health and social system are fairly similar throughout the European Union, and similar to those observed in France. In all of the countries, this mainly involved men (70 to 90% of the requests for treatment). The average age of these individuals is close to 30. However, a large percentage of young people in some countries such as Ireland, Great Britain, Portugal, Germany and Belgium, have also sought treatment. Heroin is the main substance used in 70 to 90% of the cases where treatment is sought, with the exception of the northern countries and Belgium where individuals may seek treatment for the use of amphetamines. Cocaine is at the origin of less than 5% of the requests for treatment in most of the countries (with the exception of the Netherlands, Flemish Belgium, and Luxembourg). As is the case in France, cannabis appears in 10% of the cases. On the other hand, the practice of injecting varies from country to country, but there is no information on this in many countries.

Substitute treatments are available in all of the countries of the European Union today. Some have maintained very strict criteria for gaining access to this type of treatment. Until 1998, methadone was the most commonly prescribed substance. France was differentiated because of its large number of buprenorphine prescriptions. Some countries are currently experimenting with LAAM[100].

Once again, it is difficult to provide a detailed breakdown of information on patients undergoing substitute treatment, and caution should be used when making comparisons between countries.

In terms of the declared number of patients undergoing substitute treatment relative to the total population, Spain, the Netherlands, and France top the list. Great Britain was differentiated because of the relatively low number of individuals undergoing substitute treatment. However, we do not currently know to what point these differences may be explained by the methods of counting and recording these numbers.

Arrests and seizures of drugs

- Arrests

The increased number of drug-related offences noted in France during the 1990s was not an isolated fact in Europe. Many countries experienced similar developments. In 1991, more arrests were made in Belgium, Greece, Austria, Spain, and Great Britain than in France until 1996. In Germany, the growth curve is similar to France. Some countries experienced atypical developments compared to the rest of the European Union: Italy, Denmark, and Sweden, where arrests remained at the same level as in 1991. At first, the number of arrests dropped in the Netherlands, but it began increasing again in 1994 (these arrests are only based upon trafficking).

On the other hand, it has been noticed that France is the country in which the most arrests for cannabis use were made in 1996 (79%), closely followed by Great Britain (77%). In Germany, cannabis is only at the origin of 43% of the arrests, 56% in Spain, and 65% in Belgium. In Italy and Portugal, heroin is the drug most often at the origin of arrest (respectively 45% and 58% of the arrests).
France is not the only country that mainly arrests users (79% in 1996). The percentage is higher in Great Britain (88%),

[99] *It is no longer possible to use this indicator to judge the seriousness of the HIV epidemic since the advent of tri-therapies in 1996-1997. New treatment possibilities do indeed help in lowering the number of AIDS cases with unchanged HIV prevalence.*
[100] *Levoalphaacetylmethadol : long-acting substance, prescribed only three tmes weekly instead of a daily dose of methadone.*

Sweden and Austria. On the other hand, users only represented 64% of the arrests in Germany. In Spain, the Netherlands, and Italy, users are not arrested as such.

- Seizures of drugs

In 1996, in the European Union countries, 659 tons of cannabis, 5.4 tons of heroin, 32 tons of cocaine, and 3.5 tons of amphetamines were seized. The biggest seizures of cannabis occurred in Spain, the Netherlands, the United Kingdom, France, and Belgium. A lower level of seizures differentiated Italy and Germany.

Larger quantities of heroin have been confiscated in Italy and Germany since the early 1990s, and since a more recent date in the United Kingdom. Lesser quantities have been seized in France, the Netherlands, and Spain.

Spain has reappeared as the country in which the most cocaine was seized, followed by the Netherlands and more recently Italy. The level of cocaine seized in France, the United Kingdom, and Germany is comparable.

Lastly, the United Kingdom seized the largest quantities of amphetamines, followed by Sweden, the Netherlands, and Germany. France just recently attained the level of this "historic " group. The United Kingdom has seized the largest quantities of ecstasy.

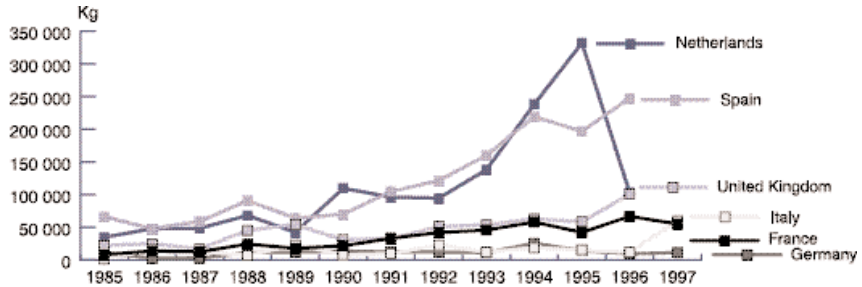
Quantities of cannabis seized throughout the European Union have increased the most. These quantities multiplied by 2,7 between 1990 and 1994. Quantities seized since then have decreased. Quantities of cocaine seized were stable until 1993, then experienced a strong increase. Quantities of heroin seized have fluctuated around 5 tons since 1992.

Developments in the seizure of cannabis and heroin are very similar in France and the United Kingdom with an intermediary position for the first substance when compared to the strong increases noted in Spain and the Netherlands, and the nearly stagnant situation in Italy and Germany.

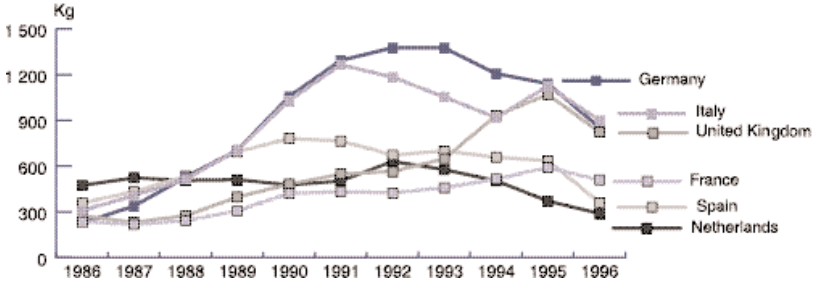
Concerning heroin, France and the United Kingdom differ from the profiles of Germany, Italy and Spain characterized by a faster increase in the number of these seizures at the end of the 1980s, and by a decrease which began in the early 1990s.

Similarities observed between different countries may be explained by situations in which markets are the same. Policies and priorities may also be similar from one country to the next.

Quantities of cannabis seized in some E.U. countries
Source : European Centre on Drugs and Drug Addiction (EMCDDA)



Quantities of heroin seized in some E.U. countries
Source : European Centre on Drugs and Drug Addiction (EMCDDA)



Methodological References

The main trends mentioned in this text came from the " Epidemiology " chapter in the EMCDDA report on the state of the drugs problem, published in October, 1996.

The analyses took into account national data concerning the different areas (arrests, incarcerations, treatment, general population surveys), furnished by the EMCDDA by its network of national focal points REITOX.

For More Information:

- *Annual report on the state of the drugs problem in Europe, 1998, EMCDDA.*

TRENDS

- Uses and Users
- Drug Trafficking
- Institutions and Public Policies

This section of the report deals only with illicit drugs. The authors of these texts were approached over one year before its publication. The observational field of the OFDT was broadened too late for us to begin a similar process for alcohol, tobacco and psychoactive medicine.

The OFDT requested the participation of authors whose research work was scientifically guaranteed. However, only the authors are bound by the contents of these contributions, which present the results of recent research or summarize information from reports.

The various texts presented here have been grouped into three categories: the first one approaches the issue of drug use and its consequences; the second one deals with trafficking; and the third one is based on institutions and public policies.

The first two texts approach illicit drug use over time. *Rodolphe Ingold* traces over developments in problem drug use since 1970, in terms of the substances used, consumption practices, and social and demographic characteristics of drug users. *Abdalla Toufik* looks into synthetic drugs, underscoring the existence of two cycles of use and the different phases of distribution of these drugs during the 1990s.

Sylvain Aquatias uses an ethnographic approach to cannabis use amongst young people living in suburban housing. Cannabis use is set within a context, which imposes a form of social control over use (groups of young people, neighbourly relations).

Drug use in prisons is one of the main issues facing the public authorities. There is too little data in this area. Over the last few years, *Michel Rotily* and *Claire Delorme* have conducted several surveys on drug use in prisons. Their main results are presented in this report. Their data is supplemented by the results of a recent national survey conducted by the Ministry of Employment and Solidarity amongst individuals entering prison.

The most important problem today, in terms of the consequences of drug use, is hepatitis C. Prevalence for HCV is very high, and until now harm reduction policies do not appear to have been successful lowering this rate. This is confirmed in a text contributed by *Claude Jacob*, using data based on drug users being treated in a specialised treatment centre in Metz.

The problem of drug trafficking is addressed in two different texts. *Alain Tarrius* investigated heroin trafficking in an area located between Barcelona and Perpignan. This activity is run by networks of individuals from different ethnic backgrounds, classic organized crime, and families who are well integrated in this region.

A text contributed by *Thierry Colombié* and *Nacer Lalam* investigates the trafficking of ecstasy. They describe how this trafficking has become more professional, and the growing integration between the classic organized crime milieu and the trafficking of "natural" drugs.

The third section includes several contributed texts that look into the various anti-drug plans that are a part of public action. This is either done to make a global assessment, or to better know the populations concerned by these programmes.

The first texts concern the health field. *France Lert* reviews current knowledge of substitute treatments with Subutex®, and the positive results of this type of treatment as well as problems that may arise. A collective text then analyzes a certain number of results derived from the analysis of the first 5,000 patients who received substitute treatment with methadone. In order to counterpoint medical substitute treatment, we found it interesting to present the results of a survey conducted by a group of researchers on Neocodion®, which is sometimes considered to be a form of self-substitution.

It is possible to describe the characteristics, behaviour in terms of risky practices, and treatment of drug users who frequent syringe exchange programmes, using the results of a survey conducted by *Julien Emmanuelli, Marta Valenciano and France Lert.*

Marc Bessin looks into the treatment of drug users in prisons since the 1994 reform that entrusted this treatment to the public hospital sector.

The following contributed texts, which are based upon mandatory treatment, stand at the interface between the health and law enforcement fields. *Michel Setbon* presents the main results of this research on the assessment of court-ordered rehabilitation treatment, showing that this measure truly only affects a very small number of arrested drug users. *Laurence Simmat-Durand* became interested in mandatory treatments pronounced within the framework of suspended sentences with probation. She shows that, depending on the courts of law, the same measure may be used very differently by .

Hélène Martineau conducted research on the actions of a police department concerning the repression of drug-related offences. She then used this research to create a typology of drug users arrested by the police, which differs from that which may be drawn from police statistics.

The last two texts deal with prevention. *Robert Ballion* conducted a statistical study on "social environment committees," which have since been renamed Committees for the Education of Health and Citizenship. In his text, he describes the effectiveness of setting up these preventive structures, their different existing methods of functioning, and their limitations and inadequacies.

Michel Joubert conducted much research on the issue of local policies in the field of fighting problem drugs. In his text, he goes back over the main stages that have led communities to invest in the prevention of drug use. He shows the importance and the role of new forms of local cooperation, particularly on the level of harm reduction actions in new local policies. Lastly, he establishes a typology of local policies.¤

USES AND USERS

A Retrospective Look at Drug Addiction Trends from 1970 to the Year 2000

Rodolphe INGOLD

Introduction

The study of "trends" means here the description of the characteristics of a given phenomenon and changes in it through time. Considerable difficulties are encountered when conducting studies in the field of drug addiction, which is badly defined with unclear boundaries. Our knowledge of most drug users is poor, and available studies provide sketchy information. There is considerable bias affecting available quantitative data. Indeed, these data mainly cover the medico-legal dimension of drug addiction (police, court, and treatment centre sources). They do not provide information on the use of identical substances in the general population, and do not directly reflect this use, with the exception of some surveys conducted in schools, or in the army, which nonetheless do so to a small degree.

In the following text, we will attempt to interpret the last 30 years with several elements that appear to be fairly disparate: epidemiological data, official and treatment institution reports, studies and research, and administrative and police data. The notion of trends may not only be applied to use, but also to users and their practices. We will limit our attempt to the most outstanding phenomena without approaching the issue of institutional changes that have occurred since the 1970s.

Opening Statement: Concepts and Sources

The notion of drug addiction refers to the interaction between drug users and the institutions that have been specifically created for them. A drug addict is an individual who has been voluntarily or involuntarily treated in these institutions at least once during his/her lifetime. Thus, drug addiction may be defined here as a particular type of social statute, and not as a behaviour in the psychological sense.

There are few available analyses, most of which tend to show that measuring this phenomenon is a perilous, random, and most likely vain exercise. We do not know how to measure the life of a drug addict, and it is probably better that way. However, some sources of information have gone largely unexplored. For example, the study of the mortality of drug addicts would most certainly benefit from a more favourable welcome from medico-legal institutes. Thus, these deficiencies lend significance to police data for information on mortality. The efforts of the OFDT, created in 1994, have been directed toward developing informational networks and new analytical methods. Most of the administrative data are from after 1980, and it is rare to find data from before 1974. Many archives have been destroyed.

The process of the development of drug use has not been identical in Paris, Provence, large cities, suburbs, and rural areas. Some regions, such as Metz, Marseille, Bordeaux and Biarritz, have experienced very similar developments to those in Paris. Others have experienced rather late developments of the epidemic of heroin use as seen in the Parisian region from 1977-1982. One of the effects of these differences, is regional variation in the current rate of HIV prevalence: around 20 to 30% in Paris and Marseille, less than 5% in Metz, Lille and Mulhouse. Three different time periods will be considered in this text: from 1970 to 1975, from 1975 to 1985 and from 1985 to 2000. During this most recent period of time, there has been an explosion in the use of stimulants such as cocaine and crack on one hand, and amphetamines and ecstasy on the other.
We have limited ourselves to the use of a small number of documents that may be classified as follows: administrative data (SESI, OCRTIS), research data (IREP, INSERM particularly), analyses and summaries (OFDT, official reports) and lastly,

* Scientific director of the IREP

institutional data (activity reports). We have also used our own recollections and have been actively and helpfully supported by our colleagues from the IREP network. An initial reading of these few documents enabled us to isolate some partial but significant data.

Descriptive elements

- Substances

The use of medicines and alcohol is extensive and very largely underestimated in the range of substances used by drug addicts. Over the last 20 years, the illicit substances more traditionally used in France have been dominated by cannabis and heroin (particularly in marginal milieus). Cocaine and other various substances such as LSD and all of the hallucinogenic substances follow these up. The use of amphetamines, especially barbiturates, at the end of the 1950s-1960s, preceded the development of heroin use at the end of the 1960s. The use of solvents, which came in waves, particularly in the early 1980s, should also be mentioned. The revival of amphetamines with ecstasy is currently the most significant phenomenon along with the arrival of crack and the increasing presence of cocaine. Lastly, LSD, one of the substances forgotten in the 1980s, has always been present on the market.

- Consumption practices

The practice of injection has existed in France for many years, going back to the 1920s (morphine and cocaine taken subcutaneously). It appears that intravenous injection only began around the time of the Second World War, when heroin took the place of opium. The first deadly overdose by intravenous injection was not listed until 1969 in the South of France. This method of use immediately became widespread amongst users of injectable drugs in France (heroin, cocaine). Amongst these individuals, the inhalation of drugs through the nasal passage, or sniffing, was mostly practised when they began using these drugs. Regular or addicted users often had to go on to injecting. The practice of "smoking" or "chasing the dragon" was fairly uncommon, appearing in the 1990s amongst prostitutes and the best supplied users. Crack, which was smoked and eventually injected, has played an important role in the development of oral forms of use. Other types of use, with the exception of smoking cannabis ("joints"), have remained marginal.

The last few years have been characterised by two important points: mixed practices (injection and "smoking") associated with heroin and crack, and oral practices associated with ecstasy ("popping" and "sniffing"). The act of "sniffing," which is classically associated with cocaine, is seen as a non-bleeding method of taking drugs. This does not exclude past or simultaneous use by injection. Instead, this act makes it easier to begin injecting the same substance. We are particularly concerned about amphetamines, cocaine and heroin, and fear such a development.

Injection practices have changed over time in connection with the arrival of AIDS and Hepatitis C. The practice of sharing syringes, which most drug users did before 1985, began to decrease that year, and even more so after the sale of syringes was liberalised in 1987. However, this favourable development was falsely reassuring. Indeed, injection materials were still being re-used, and this practice was strengthened. The latter most likely provides a partial explanation of the rapid development of a new epidemic with hepatitis C, identified as such in 1989.

- The Economy

The drug market has changed greatly in the last 20 years. An analysis of this market and how it has developed remains to be done. Indeed, we have not been able to come up with a satisfactory unit of measurement for substances that are available on the streets. The "gramme," the "grammes pesé (weight gramme)", the "demi (half)", the "paquet", the "bonbonne," and the "barrette" are French designations that have changed contents over time, without it being possible to measure the exact changes that have occurred. Thus, it is useless to want to establish a direct comparison of the price of different substances in function with periods in time, as these prices depend upon the announced quality of the substance and where it is obtained.

The packaging of substances has also been considerably modified. In the course of the 1970s, the usual way in which all powders were presented was the paper "cocotte" which consisted of a square piece of paper or aluminium carefully folded and shut. This type of packet contained from one to several grams of a substance. The unit used was the "grammme," but this corresponded to a lesser quantity. Heroin users could thus purchase a "gramme", a "half," or even a "quarter". The average price of a gram was around 400 francs in 1975. The price of cocaine, which has always been sold in quantities of at least one gram, sold at a similar, yet lower, price. Cannabis, in the form of hashish, was worth around ten to 15 francs per gram and was sold in the form of "barrettes" containing four to five grams for 100 francs apiece. In the 1980s, the trend went toward a decrease in the quantities available in a sales unit. For heroin mainly, packets were slowly replaced by "bonbonnes" which would contain varying quantities of these substances. On the streets, these units were equal to one injection. Then, small units of doses sold for 50 to 100 francs became available. The size of "barrettes" of hashish became smaller while the price remained the same. These could weigh from two to three grams or even much less. The price of weed, which became much more rare in the course of the 1980s, slowly increased as did all substances reputed to be of good quality. This is how the negotiated price of a gram of Afghan or Indian hashish ranged from 70 to 100 francs per gramme or more, depending upon the quantity. "White" heroin, of superior quality, easily sold for 1,000 to 1,200 francs per "gramme pesé". Cocaine was worth an average of 800 francs per gramme, but this price could be higher depending upon its quality and network.

The years 1976 to 1978 were an important turning point in regard to trafficking. Many cannabis dealers, whose activities were hampered by police and customs services, turned to selling heroin and often became users themselves. These same dealers later began distributing cocaine while integrating it into their own practices. In the past, small distributors who were in contact with many users, nearly always specialized in one type of substance. The new distributors of today have to offer diversified services and several substances. They, themselves, have had to adapt to the new forms of money circulation and must be somewhat competent in areas such as the Internet, the gold market, precious stones market, or even the weapons market. Thus, in them, their clients find many different easy ways of experimenting. The barrier that existed between the cannabis market and that of other drugs disappeared. An individual who smokes joints knows heroin or cocaine users because the same person supplies them. This development has not only occurred in France. In Holland, most dealers have "multi-menus" and offer "skunk", as well as ecstasy, cocaine or heroin.

New packaging has gone along with new forms of distribution and sales. The street market has adapted itself in that dealers have become more effective. Purchasing and sales operations are timed and quick, so that they have become less dangerous for buyers. The practice of home deliveries has developed, which is safer for the buyer, with the advantages of cellular phones. Lastly, networks of apartments and squats have played a considerable role in distribution.

Globally speaking, if we attempt to simultaneously take into account changes in packaging, unitary costs and inflation, we can suggest that the prices of all illicit substances noticeably dropped from the 1970s to the present. There may be an exception to this with cannabis for which prices changed the least during that period of time. This decreasing trend is even clearer amongst substances that more recently appeared on the market. Crack, which is available in the form of "cakes," sold for 400 francs in 1993. It is now sold for around 150 francs. Ecstasy, which sold for 300 francs per dose in 1985, now sells for around 100 francs. This development is also found amongst medicinal substances sold on the black market.

-Drug users and the request for treatment

Françoise Davidson, in a survey she conducted in 1971-1972 and published in 1977, made the first epidemiological description of drug addicts who sought treatment. *Françoise Facy* continued this description in 1986 with information from work conducted in specialized centres. SESI surveys began to be conducted and became available in 1974. Beginning in 1987, they were used to characterize individuals seeking treatment in hospitals and specialized centres.

By referring to the INSERM (1977) survey, it can be said that the 1,030 individuals seeking treatment in hospitals and specialized centres were very young (in 80% of the cases they were under age 24), mostly young men (65%), French (91%), unmarried, without children, and often lived with their parents. Many came from middle or upper class families (middle and upper management, merchants, liberal professions). The most commonly used substances were cannabis and

hallucinogens before heroin. Many were polydrug addicts, defined as individuals who simultaneously used more than three substances (77%). In the sub-group of addicted users (32% of the sample), heroin was the substance most used (77%), closely followed by opium (47%) and the other morphinics (33%). In the same group, many took barbiturates (43%) and amphetamines (38%). These characteristics of users at that time are corroborated by other data, particularly from reports made at the Marmottan Medical Centre during the same years. It was only around the period of 1974-1975 that heroin users began to represent the majority of individuals seeking treatment in drug addiction treatment centres.

By contrast, though not directly comparable, the sample we formed 1995-1996 (N=1 703) may be described as follows from a social point of view: most were men (72%), with an average age of 29 (from 16 to 53 years of age), French (89%), often wandering (39%), often having children (28%), often receiving income support (31%), unemployed, or having signed up for unemployment (41%), having been incarcerated at least once (53%), not having been medically treated when they have been infected with HIV or HCV (47%) and having resorted to sexual work at least on an occasional basis (2% of the men and 39% of the women). We verified that these characteristics were identical amongst individuals seeking treatment and users met on the streets.

SESI surveys, conducted in specialized and non-specialized health and social establishments every November from 1987 to 1995, confirm this data and these developments. It should be noted that the average age of drug addicts very progressively ranged from 25-29 years during this period of time, that the total number of users seen each year went from 25,000 to 65,000 and that the percentage of "polydrug addicts" is still quite high (55 to 61%).

It should be clarified that the age pyramid for drug users has considerably spread out amongst those " seeking treatment for the first time". Starting in the 1980s, in particular, many drug addicts obviously began using drugs either much earlier in life, or much later in their adult life.

What is important to remember from a strictly quantitative point of view is that this phenomenon has changed dimensions in a period of two decades. The examination of all data underscores this, beginning with figures relating to arrests and quantities of drugs seized at the borders. The number of arrests has gone from several hundreds to several tens of thousands. Quantities of seized drugs, which used to be measured in kilos, are now measured in hundreds of kilos of heroin, and tens of tons of cannabis. Today, there are an estimated 150,000 drug addicts in France. However, all of these estimates should be considered with caution. It is important to know that police data attest to a targeted activity and are not a complete account. The needs and social experiences of the users have also changed over time. These changes are not easy to approach: 1) The emergence of AIDS made it necessary to adapt treatment structures in a more medically-oriented direction at the end of the 1980s. The social impact of this disease, at the root of new prevention and treatment practices, has been considerable; 2) In the course of the 1980s, users appear to have begun directing themselves within the treatment networks in function with their original social milieu. This change may be seen in a compared analysis of certain clientele in treatment centres, on one hand, and the large development of hospitalization facilities for drug addicts in the private sector on the other. More drug addicts from wealthy backgrounds tend to go into such structures in France and abroad and are less present in public facilities.

- Health and Social Situations

We have few elements enabling us to characterize the social experiences of drug users, and we do not know the exact number of these users who are regularly receiving medical treatment. Information on the role of prisons, as well as the long-term outcome of drug users, is also poorly known. As an initial approximation we should, however, point out that the number of drug users who has been incarcerated, and the frequency of incarceration, have clearly increased since the beginning of the 1980s. Currently, around one of every two users has been to prison at least once.

The most striking point of the changes that have occurred in the social situation of this population is that it has become impoverished. An estimated 31% of these individuals receive income support, an indication of the severity of the existing deprivation they are experiencing.

Begging and turning to social aid organizations have become quite frequent, and a large percentage of the young women have resorted to sexual work. Many are excluded from the treatment system because they are too young or handicapped. The stigmatization of drug users, which has far from improved, seems to have got a second wind, despite the development of actions of proximity. Gaining access to hospitals is still a problem for the most marginalized and ill individuals. There is no solution to the situation for illegal aliens. It is clear that the state of abandonment of these individuals is worsening, though there is little information about this unexplored issue.

The health situation of users has also widely deteriorated over the last twenty years. New pathologies, particularly infectious, have emerged or developed: AIDS, hepatitis viruses and tuberculosis. Users are currently being helped by tri-therapies for AIDS, a vaccination against hepatitis B, and interferon for hepatitis C. They are waiting for bi-therapy treatment with ribavirine and interferon. Although mortality by overdose seems to have decreased over the last few years of the 1990s, many deaths are related to AIDS, suicide, killings and mental pathologies. We know little about the health complications linked to LSD, ecstasy and amphetamines.

Historical periods

- The Early 1970s

This period was characterized by the irruption of LSD on one hand, and the development of the heroin market on the other. Parisian drug addicts still went to Marseille to purchase "white" heroin sold by weight and mainly taken intravenously. Around 1974 a new variety of heroin appeared, of Asian origin, called "brown sugar" It was brown or beige and was less soluble in water, so these addicts began using lemons to dissolve it. In addition, many users took medicines such as Nembutal® and Mandrax®, and some, the "speed freaks," only took amphetamines sold in the form of powder or medicine. Lastly, the use of hashish from India, Afghanistan, and the Middle East became established and gradually developed. However, these years were dominated by the wide distribution of LSD that reached a peak around 1973. Many users from Paris and Amsterdam headed East toward Istanbul and the Orient. At this time, the first specialized institutions (i.e. Paris, Marseille, Bordeaux, Lyon...) experienced large inflows of drug users.

- 1975 to1985

This period was characterized by an unprecedented increase in heroin use that overshadowed the use of other substances. All of the available statistical data, with no exception, show a considerable increase in the number of users. Between 1977 and 1982 the number of arrests for heroin use went from 743 to 6,873; at the same time, the number of "cases handled", including all substances, went from 1,703 to 11,213. During this period, different varieties of heroin appeared, particularly "pink" heroin, of Asian origin, grey heroin most likely from the Middle East, and a white heroin of very pure quality that reappeared (if it had ever really disappeared). Claude Olievenstein was not wrong when he wrote the following in his official report in 1980:

"This may be shocking, but I would say that if the police, gendarmerie, and other services that have been mobilized to flush out smokers of hashish, had been mobilized on our borders to control the entry of hard drugs for even one day per month, we would perhaps not have had to face this absolute surge of heroin and cocaine that is characterizing the current situation."

The emergence of AIDS became evident through an epidemic of serious candidosis amongst drug users. However, LSD, which was still present, nearly disappeared as did Lebanese hashish, which was quickly replaced by resin from Morocco and weed from African countries and South America. Medicinal substances, particularly stimulants (Thymergix, Adiparthrol, Dinintel,...), became the rage. Cocaine use remained limited to a restrained group of users who were generally well integrated socially, but its shy emergence on the street market was detected as early as 1982 in Paris. One phenomenon had important consequences in the following years: users grouping together in squats (Belleville, Ilot Chalon). This would be at the basis of new sales techniques.

- From 1985 to 2000

While some regions experienced developments comparable to those occurring in the Parisian region (South and East of France), heroin use developed significantly in areas that had been relatively preserved until this time. This was the case in the North of France (region surrounding Lille) and suburbs. The rural areas could no longer be seen as having been spared from this epidemic. At the same time as this development, the practice of sniffing cocaine progressively and discreetly developed. Moreover, within the context of AIDS and better understanding of methods of use (the Netherlands, England), sniffing and smoking heroin began to develop (region surrounding Lille). However, in Paris, the arrival of crack brought by small groups coming from the West Indies was the big event. The market for this exploded around 1993 and grew from the squats of Stalingrad to all throughout the northeastern parts of Paris within the context of massive police intervention and the African underworld gaining control of the market. The use of crack remained discreet in the Parisian suburbs, and more or less anecdotal in Provence. However, the development of the use of crack in Paris evoked what happened in New York starting in June, 1998. Let us emphasise that the number of arrests for crack was close on the heels of the number of arrests for heroin, and that in 1998, more crack and cocaine users were arrested than heroin users. To this must be added the emergence of ecstasy use, which was confidential in the 1980s. In its wake, we must emphasize the insistent presence of other amphetamines sold in the form of powder and other various synthetic substances that were not clearly identified and had different names (speed, ketamine, DOB, ...). Lastly, cannabis remained the most widely demanded and distributed substance. The African source of weed, which was still quite active, seemed to have slowed down being relayed by sources from the Netherlands. Phenomena such as growing and producing for oneself experienced increasing and unprecedented success.

- Current Trends

A considerable event occurred with the advent of substitute treatment that began in 1993. The introduction of this new treatment (with methadone, buprenorphine and morphinics), resulted in a quickly growing number of individuals taking these substances. Integrating the sale of these substances in pharmacies was begun at the same time. Thus, new combinations amongst heroin users have begun to appear at the expense of this substance. This mainly involves associating opiates, alcohol, benzodiazepines (Rohypnol®) and crack. A significant share of crimes are committed under the influence of such mixes at times of mental confusion and total amnesia of what was done. These new combinations go along with changes in living and lifestyle. The number of individuals who have experienced social, family and economic degradation linked to the use of crack, in particular, has greatly increased. This has led many individuals to take on a down-and-out lifestyle dependent upon social services for survival. As a result of the consequences of these new uses of uppers (crack, ecstasy, amphetamines, ...), we must be ready for the arrival of a new generation of users in the field of drug addiction. These young individuals will have been initiated to drugs using these substances, and will use alcohol, opiates, and benzodiazepines when they are in need.

However, these trends have been seen through the development of use amongst populations that are already known to medico-legal institutions. We know much less about the same types of use amongst more discreet groups of individuals who are socially well integrated and thus unknown. This could become a prioritary area of research that would shed light on how this type of use is managed in more favourable social and economic environments. A certain idea of this type of use is given to us in some ethnographic studies, particularly those relating to cannabis and cocaine.

Conclusion

The social image of the drug addict has been changing for the last thirty years. While the drug addict of the 1970s appeared to be a flamboyant explorer and adventurer, he became more commonplace in the 1980s. He was inactive and disqualified, but had not yet been considered to be social waste, as he has tended to appear currently in the 1990s with phenomena of open scenes of "hunting dealers", and rejection in areas surrounding treatment structures. This transformation has serious implications concerning the development of prevention and communication actions directed toward users. We know, in particular, that a large share of the very rapid progression of the hepatitis C virus is linked to poor knowledge on the part of users concerning certain practices and risky acts such as "common preparations" and re-using syringes. This is even more striking since the number of individuals newly infected with the AIDS virus has been decreasing over time. Better knowledge of the lifestyles of drug users and how they portray health and social intervention should guide us in developing prevention and treatment activities.□

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Distribution of Synthetic Drugs in France

Abdalla Toufik

Over the last few years, public debate has been focused upon the dangers involved with ecstasy and the repression of techno parties that supposedly create a favourable environment in which this drug is used. This focus could well overshadow other problems that are equally as important in terms of public health. In this text, we will tackle two of these problems: the first, which relates to the distribution of different synthetic drugs[101] that arrived in the wake of ecstasy; the second concerns the interactions that may occur between these "new" and "old" drugs" (heroin, cocaine, medicines, etc.).

In order to do so, we will use the concepts of consumption cycle, on one hand, and distribution process on the other. By using the term "consumption cycle", we are referring to the "social life" of a substance: emergence, distribution, marginalization, and then disappearance. A consumption cycle begins when the substance is discovered/identified as a "drug" by a given social group, in a given geographical area, at a sociocultural moment in time. This does not begin when procedures and techniques for making the substance are discovered. Thus, the consumption cycle for LSD, which was discovered right at the beginning of the 1940s, only began in the second half of the 1960s. As for the distribution process, we are referring to a process of social selection. The result of this process is that groups of users "choose" to use a substance, and more or less promote it, thus leading to a geographical expansion and increase in use outside of the initial circle of "initiated" users. Thus, this distribution process is part of the "consumption cycle" of a substance without actually being identified with it.

This is how two distinct cycles of synthetic drug use began in France three decades apart (during the 1960s and 1990s). The symbolic substances of the 1960s were LSD and amphetamines in a lesser measure, and ecstasy in the 1990s. What particularly interests us here is the current distribution phase of this second cycle. Schematically, this distribution phase may be divided into four successive waves over a period of eight years (1990-1998).

The first of these four waves corresponds to the rapid phase of distribution of ecstasy that began in 1990. Two assumptions may be made to explain the speed of this distribution process. Both relate to the connection of this substance to the techno movement when it was first launched and the positive image it had because of this.

The emergence of ecstasy as a drugs, is closely tied to the emergence of techno as music. Therefore, the development of the two phenomena was synchronized and complementary. The techno movement served as a cultural foundation, playing a similar role to that of the hippy movement with cannabis in the 1960s. This is how ecstasy became integrated into the techno culture as one of its components right from the start. The historical precedent set by the distribution of cannabis via the hippy movement clearly shows us that the use of a particular substance at a given time during its "career" as a drug may overflow its original cultural foundation to include other categories of individuals who do not particularly identify with the sub-culture that favoured its emergence. Available data lead us to believe that ecstasy is currently in this "overflowing" phase of it distribution process. During this subsequent phase, the close ties it had with the techno movement, so essential at the time it was launched, tend to be less and less close and are even coming undone. Evidence of this may be seen in the diversification/multiplication of ecstasy use outside the festive techno framework (nightclubs, private parties, and even more and more solitary use).

Ecstasy is unlike heroin and cocaine, which are available in powder form. Technical knowledge and learning are required to prepare and administer these substances (intravenous, intranasal, or inhalation). Ecstasy looks more like medicine because of its galenical form (pills or capsules) and the fact that it is taken orally. On one hand this facilitates use, and on the other, it provides a "reassuring" social image for potential users (INSERM 1998). At the same time, the image of ecstasy has normalized the image of other drugs experimented with and used in the same festive framework (IREP 1997).

The second wave corresponds to the distribution of LSD and amphetamines that began in 1993. After having finished a first consumption cycle in the course of the 1960s and 1970s, these two substances began a second cycle. A recent study showed that 52% of the current users of amphetamines and 36% of the users of LSD began using these drugs between 1993 and 1997 (IREP 1998). From November 1993 to November 1996, the number of individuals receiving treatment for which LSD was the main substance used rose from 66 to 118, and the number of amphetamine users rose from 69 to 185 (SESI).

As for the distribution of these two substances, a large share of it is linked to fact that they are part of a high percentage of substances being sold under the name of "ecstasy" in France. Thus, an analysis of 73 samples of "ecstasy" revealed that around 30% contained only amphetamines or derivatives or were associated with other substances (Galliot-Guillet et al). When the substance taken as "ecstasy" is later identified as amphetamines and the effects prove to be "satisfactory", users tend to take it again.

The distribution of LSD has become increasingly coupled to that of ecstasy, and the two substances are frequently taken in a simultaneous, or sequential manner. This is done to strengthen, substitute, or intensify their effects.

Moreover, and independent of these factors, the demand for amphetamines (for their stimulating effect), and LSD (for its hallucinogenic effect alone), has been constantly on the increase. Between 1992 and 1997, the number of arrests for amphetamine use and use/dealing tripled from 50 to 151 and more than doubled for LSD, from 81 to 198 (OCRTIS).

The third wave of substances linked to the techno sub-culture, which began in 1996, concerns the distribution of Gamma OH and ketamine[102]. These substances, which appeared in the techno milieu within the last few years, seem to have "overflowed" the initial circle of initiated individuals around 1996. With the help of modest prices and easy availability, these substances have become increasingly widespread.

The fourth and final wave, also the most recent, corresponds to the distribution of new substances such as ice[103], and PCP[104] etc.There have only been sporadic reports of their presence in France, and little is known about the effects of taking them. At the present, use of these substances seems to be confined to a restrained group of "initiated" individuals, and thus distribution is still in its beginning phases.

In terms of public health, how could these four waves of distribution of synthetic drugs impact the general configuration of the use of psychoactive substances? In order to answer this question, one must first emphasize that it

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[101] *As a rule, the term «synthetic drug» refers to any substance produced in a laboratory with no natural origin, whether it is an upper, tranquillizer, hallucinogenic or other drug. Over the years, the term has been misused and has tended to be increasingly reserved for two classes of drugs: new or old uppers or tranquillizers which are more or less used in techno movement and for the most part generically sold as ecstasy.*

[102] *Two medicines used in anaesthesia. In small doses they produce hallucinogenic effects.*

[103] *Dextro-methamphetamine, also called crystal, is a smokable form of methamphetamine.*

[104] *Phencyclidine is a general anaesthetic whith hallucinogenic properties, used in veterinary medicine.*

is not possible to draw sufficiently reliable conclusions because of a lack of data from research or surveys of large representative samples and the fact that not enough time has gone by. However, the partial data available could be used to foresee the development of the following four trends:

1) The junction between old substances (heroin, cocaine, and medicines such as benzodiazepines) and new substances (synthetic drugs). This is how cocaine is probably used by a minority of individuals to intensify the stimulating effects of ecstasy, to be used in its absence or when there is not enough, or to combine its intrinsic properties. On the other hand, heroin, and medicine would be used more to manage "coming down" from a high (also a minority of individuals), in order to alleviate the negative or stressful effects. Of the 41 individuals surveyed by the IREP about this, 18 had had contact with heroin (of these 18, four are currently "drug addicts", 3 were former addicts; 3 had "sniffed" it for at least 8 months having since stopped; 6 had tried it from one to seven times; 2 still used it occasionally) (IREP 1997). Furthermore, of 163 users of ecstasy surveyed within the framework of another survey conducted by the same institution, it turned out that 32% had already used heroin and 72% had used cocaine at least once in their lifetime (IREP 1998). In a CEID survey conducted amongst a sample of 134 individuals, 55 (41%) took cocaine, and 25 (18.6%) took heroin as an associated substance. In the same sample, 18.6% had used cocaine, and 8.2% had used heroin when taking ecstasy.

2) Intravenous administration may also be favoured by the introduction of older substances, such as heroin, which are most often taken in this manner in France. It may also be favoured by the growing availability of some synthetic drugs that were originally medically prepared for injection (vials) or in a powder form which is easily soluble. Lastly, it may be favoured by the presence of a sub-group of individuals, amongst those who use ecstasy, who more or less often take drugs this way. Thus, in the above-mentioned CEID survey, we discovered that out of the 134 individuals surveyed, around 13% had already taken drugs intravenously. This relatively high percentage was probably due to the way in which the individuals surveyed were recruited (snowball method, used amongst individuals being treated in specialised treatment centres), which caused an over-representation of individual members of limited social networks. However, this figure should not be neglected in spite of its weaknesses, because the group of intravenous injectors (and ex-injectors) may play an initiatic part to this type of use, amongst other individuals.

3) The few elements we now have should incite caution. We can expect heroin use, which is currently clearly decreasing amongst "classical" heroin addicts, to be revived in time as the phenomenon we have observed opens access to a whole new group of potential users.

4) We have also seen a convergence and merger between networks dealing and trafficking "old" and "new" drugs. The preliminary results of surveys that are currently being conducted (Colombia and Lalam) have indeed shown that drug trafficking networks, which have been attracted by the profit margins offered by these substances, have integrated ecstasy and the other synthetic drugs into their traditional sales circuits for heroin, cocaine, and cannabis. This diversification could partly explain why ecstasy is being sold by young people from the "neighbourhoods," and why it is being dealt on the streets in certain areas (following the example of more classic drugs). Beyond the implications it has on the underground economy, the convergence of dealing could lead to a similar process on the level of the use of these two substances which have been separate until now.

Taking these data and trends into account involves the following: adapting current prevention strategies; researching new types of intervention; and developing a prevention message that corresponds to this new situation which is infinitely more complex than that of the beginning of this decade when ecstasy was first distributed.

Composition of samples sold as ecstasy.

Pills and capsules sold as ecstasy widely differ in their composition and their percentage of active elements. A team from the CEID in Bordeaux analyzed 8 samples sold as ecstasy. Of the 8, only 2 contained pure MDMA but in single to triple doses; 3 samples contained no MDMA but a neighbouring molecule (MBDB); 1 sample contained a mixture of MDMA and methamphetamines; and the last 2 contained caffeine and Lexomil®.

The Fernand-Vidal Laboratory of Toxicology analyzed 73 samples collected by the Médecins du Monde prevention team. The results of this analysis were the following: 16 samples(21.9%) contained MDMA. The contents varied widely from a few percent to 64% of the mass of the pill or powder; five samples also contained precursory substances (piperonyl derivatives); 3 samples of MDMA were cut with molecules that intensified its psychostimulant power; amphetamines and caffeine, or its action on visual sensations; chloroquine A total of 12 samples contained amphetamines only, or were associated with another substance, 2 were heavily associated with ketamine. Medicines were also sold as ecstasy. Amongst the samples analyzed by the above-mentioned laboratory, we found Nivaquine®, Fonzylane®, Triaminic®, Rinurel®, Cortancyl®, Vicks rub, and mixtures with vitamins.

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Drug Use in Prisons

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In the early 1990s the Ministry of Justice estimated that around 15% of the imprisoned individuals in France were drug addicts. In fact, this percentage widely varies per region, establishment, and particularly per given definition of drug addiction. The use of drugs in prison, a particularly controversial issue, has long been a taboo subject as has sexuality. Yet, the stakes are very high in terms of infection with the AIDS and Hepatitis viruses. Since 1994, we have tried to improve epidemiological knowledge about drug use in prisons through conducting research within the European network for the prevention of HIV and hepatitis viruses in prisons. We will successively tackle the following aspects: the percentage of incarcerated individuals stating they have used drugs during their imprisonment; the continuation of and initiation to drug use in prisons; other practices during which there is a risk of transmitting HIV or HCV[105] in prisons.

Estimate of the percentage of drug users, and intravenous drug users in the prison population

In a 1992 survey of 432 prisoners in Marseille, 20% of those surveyed stated that they had used intravenous drugs (mainly heroin) during their lifetime, and 51% had shared injection.
In 1996, a second survey was conducted amongst 574 prisoners in the same establishment as the preceding survey. 23% of those surveyed stated that they had already taken drugs intravenously. However, it is important to distinguish between those who stated they had injected drugs over the 12 months preceding incarceration, (13% of all of the surveyed prisoners, or 56% of the injectors) from those who stated they had not injected drugs during the same period in time. Amongst the active injectors, 37% stated they had shared their injecting materials at least once over the last three months.

Declaration of intravenous drug use by inmates

Intravenous drug use	1992 study	1996 study	1998 study
Lifetime	20 %	23 %	12 %
Within the last 12 months	ND*	13 %	9 %
Sharing of materials among active injectors within the last 12 months	51 %**	37 %	34 %

Source : Enquêtes réalisées par l'ORS PACA en milieu pénitentiaire de 1992 à 1998 [1,2,3,5]

** : ND = not available.*

*** : among all injectors (lifetime)*

In the 1997/1998 European survey, 43% of the 1,212 prisoners surveyed stated they had used (smoked, sniffed or swallowed) illicit substances over the 12 months preceding incarceration (i.e. cocaine, cannabis/hashish, benzodiazepines). Twelve percent of all the prisoners stated they had self-injected drugs intravenously in their lifetime, of which 9% had done so within the 12 months preceding incarceration; of the latter, 45% stated they had self-injected at least 10 times during the last 4 weeks before incarceration, and 34% had shared their equipment during the last injection.

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[105] Virus of viral hepatitis C.

The substances most often stated by these intravenous drug users were heroin (62%), cocaine (42%) and benzodiazepines (37%).

Estimate of the percentage of drug users who continued their practices, or were initiated to drug addiction, in prison.

The 1996 survey showed that 13% of the active injectors over the last 12 months preceding incarceration (9 cases out of 68) stated that they had self-injected drugs during the last three months of imprisonment (sharing materials in four out of nine of the cases).
Of all the individuals surveyed in the European survey that was conducted on four French sites, 32% stated that they had already used non-injectable illicit drugs in prison. Moreover, 35% of the intravenous drug uses state that they had already self-injected drugs in prison and 6% started self-injecting in prison. Amongst those intravenous drug users who were still active just before incarceration, 26% stated they had taken drugs intravenously during the last month of incarceration (of which 43% did so over 20 times), and one-half of them had used no bleach to disinfect their material.

Estimate of other practices at risk for transmitting HIV or Hepatitis viruses in prison (sexuality, tattoos), prevalence of these infections, and treatment.

The 1996 study had revealed that 3% of the intravenous drug users in prison stated they had sexual relations during the first three months of incarceration (mainly heterosexual relations in the visiting room, without a condom). Moreover, 16% stated they had gotten a tattoo during that period. The following chart provides the results of the European survey on statements about these practices in prison, and prevention possibilities for prisoners.
It has been noted that drug users more frequently state that they engage in risky practices in prison (outside of homosexual relations) than other prisoners. In addition, more of them have already had HIV or HCV tests, but the percentage of users and non-users that have been vaccinated for hepatitis B is fairly close, and proves to be highly insufficient. On the other hand, rates of prevalence for HIV and HCV, obtained from a voluntary saliva test, are higher than in the general population, and particularly alarming amongst drug users.

Conclusion

Risky practices and prevention of inmates according to drug use

	Non DU (57 %)	Non injectable DU (43 %)	IDU (12 %)	Active IDU (9 %)
Heterosexual relations without condom	4,7 %	11,6 %	15,3 %	13,6 %
Homosexual relations without condom	1,3 %	0,8 %	1,3 %	1 %
Tattooing	10 %	31 %	39 %	43 %
HIV test	59 %	78 %	76 %	76 %
HCV test	20 %	37 %	58 %	59 %
HBV vaccination	24 %	34 %	27 %	24 %
HIV prevalence	1,5 %	3,1 %	11,4 %	13,3 %
HCV prevalence	3,5 %	14,3 %	52,5 %	55,3 %

Source : Réseau européen de prévention du VIH et des hépatites en prison, Rapport 1998 [4]

These studies show the importance of risky practices as stated by prisoners (as much before as during incarceration), as well as the high rates of prevalence for HIV and hepatitis viruses. There is room for improvement in prevention, especially amongst drug users. Plans have been made for some prevention measures, but do not seem to have been generalized. A circular letter from the Ministry of Justice in 1996[106], made provision for free access to condoms for prisoners in the visiting rooms, outpatient care (UCSA) or prison medical departments. This circular letter also made provision for the distribution of bleach to prisoners from the prison administration. However this distribution was conceived within the general perspective of hygiene and was not specifically directed toward intravenous drug users 5.

In this circular letter provision was also made for the first prescription of substitute (methadone, Subutex®) but it appears that this has been fairly uneven in the French establishments. For the most part, these treatments are only prescribed if they were started before incarceration and generally stop when the individual enters prison.

Currently, an experiment called "specific treatment programme", is being conducted in an establishment from the 13,000 programme in Argentan, (Lower-Normandy region). The object of this programme, which is offered to prisoners on a voluntary basis, is to treat addiction (to alcohol, drugs and/or medicine) in order to achieve abstinence. It lasts three months, full-time, and is based upon a work group surrounded by specialized therapists. Similar experiments are being conducted in other countries. This type of action must be evaluated in France, in order to determine the interest of extending it into the prison system.

Switzerland, Spain, and Germany have already implemented syringe exchange programmes in prisons. This type of action should be tried in France within the framework of harm reduction policies.

Methodological References

All of these surveys are voluntary, respect anonymity, and attempts have been made to include the entire population and remain independent of the prison administration. This makes it possible to limit the phenomenon of sub-declarations.

In 1992, the ORS PACA, through the CIDAG and prison medical department, offered 432 individuals entering the prison in Marseille the possibility of filling out a self-administered questionnaire and to take a screening test. This survey was renewed in 1995.

In 1996, 574 individuals who had been incarcerated for three months in the Marseille prison agreed to fill out a questionnaire during the third, fifth and seventh month of incarceration. Each prisoner's questionnaire was linked by barcodes.

In 1997/1998, 1,212 prisoners that were present on a given day in four French prisons agreed to fill out a self-administered questionnaire and provide a saliva sample in a small container (in order to measure the anti-HIV and anti-HCV antibodies). The results of the test and the answers to the questionnaire were linked with bar-coded stickers (survey conducted with the same protocol in 22 prisons in seven European countries).

This methodology proved to be effective and will henceforth be used for surveys of prevalence conducted by the European Network for the Prevention of HIV and hepatitis in prisons.

[106] *Circulaire du 5 décembre 1996 relative à la lutte contre l'infection par le VIH en milieu pénitentiaire.*

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Survey of the health of individuals entering prison

The results presented in the preceding text may be usefully compared to the results of a recent study conducted by the Research, Studies, Evaluation and Statistical Department of the Ministry of Employment and Solidarity, using standard paperwork filled out by individuals entering prison. This survey, which dealt with the health of individuals entering prison, was conducted over a three-month period (May, June and July) in all of the prisons and prison quarters in penitentiaries. The length of the survey was adjusted according to the size of the establishment. There were 10,171 recorded entries during this period, of which surveys were filled out for 8,728 individuals (a coverage rate of 86%).

One in three of those entering prison stated that he/she used drugs on a regular and prolonged basis during the 12 months preceding incarceration. 25% mentioned regular and prolonged use of cannabis, 14% opiates, 9% cocaine or crack, 9% medicine used as drugs, and 3% other drugs (LSD, ecstasy, glue, solvents, etc.). Use of more than one substance was mentioned by 15% of the individuals entering prison. Intravenous drug use at least once in a lifetime appeared in 12% of the cases, and during the past year in 6% of the cases. Amongst those entering prison, 6% were undergoing treatment with Subutex® and less than 1% with methadone.

Regarding the other psychoactive substances, the survey showed that 33% of those entering prison stated that they excessively used some substance on a regular (more than or equal to 5 glasses per day) and/or intermittent (more than or equal to 5 consecutive glasses at least once per month) basis. A total of 10% drank excessively on a regular basis, and 6% associated regular and intermittent use. Nearly four out of five individuals arriving in prison smoked, and nearly one smoked over 20 cigarettes per day. Nearly one out of fivr individuals entering prison said he/she was undergoing treatment with psychotropic medicine, mainly tranquillizers.

Lastly, the survey showed that 28% of these individuals used at least two of the above-mentioned substances (only retaining those who smoked over ten cigarettes per day for tobacco). Half of them combined alcohol and drugs, which was the most frequent form of polydrug use. Fourty-three percent of the hard drug users excessively drank alcohol, and 30% smoked over twenty cigarettes per day.

Women prisoners, who only represented 5% of those entering prisons in 1997, were found to use cannabis less than men (15.7% compared to 26%). However, they more often used heroin, morphine, or opium (16.7% compared to 14.3% of the men), and the percentage was about the same for cocaine and crack (8.6% compared to 9%). As many women as men had injected over the last 12 months before incarceration, but clearly practiced injection at least once more often than men 15.8% compared to 11.6%). More women were undergoing substitute treatment at the time of imprisonment.

Women tended to smoke a little less than men, drink much less alcohol, and clearly state more often that they were undergoing treatment with a psychotropic substance.
There were nearly as many minors who smoked cannabis as there were adult men (24%). Close to 5% stated that they used opiates. It may also be noted that amongst minors, there is a high percentage of individuals who smoke from six to 20 cigarettes per day (59%), and a high percentage of intermittent users of (11.7% stating they drank five consecutive glasses at least once per month).Four and a half percent of the minors stated they were undergoing treatment with a psychotropic substance. Minors represented a little fewer than 5% of those entering prison in 1997.

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Ethnographic Approach to Cannabis Use in the Parisian Suburbs

*Sylvain Aquatias

Smoking cannabis in a suburban development

At the end of any afternoon, there are always a few young people milling about in suburban developments. They talk and gesticulate in the hallways or stairwells of the buildings, under the trees or leaning up against a car. What those walking by, or those who live there see, gives the impression that their activities are out in the open, and they have nothing to hide. Dealers, with their dogs, sell their barrettes in public places without even appearing to hide either. Has cannabis become so commonplace that individuals may get away with selling and using it in public?

Yet what is important to know is what kind of public we are discussing here. The joints might disappear in a matter of seconds if some young individuals are smoking on the front steps of a building they live in and a neighbour from the same building shows up. Although one might continue to smoke unscrupulously in front of certain individuals, they wouldn't do so for the entire world in front of others.

Joints are rolled as discreetly as possible, very quickly, and in such a way that they look as much like a cigarette as possible. If it is to be shared, the individual who asks is given a bit of cannabis so that he can roll his own cigarette rather than share. This is where the occupants of these developments quickly give a bad reputation to those who are seen smoking cannabis. If there is one thing, however, that is important to young people, it is the image their parents have of them. Rumours spread quickly, and who knows what parents might learn from a neighbour? If they are afraid of police intervention, it is not so much because of the potential risks as it because they are afraid that the police might burst into the family home. Therefore, they hide from neighbours who could potentially talk with their families, and more readily smoke in public areas where there is less of a chance of running into someone they know.

In suburban developments, it is necessary to protect oneself from rumours that would refer to young individuals as "drug addicts". Perhaps parents are partially duped, but children can always deny use as long as there is no proof.

Moreover, how could parents even want to hear the political-media speeches confirmed in which they are referred to as bad parents who have given up and are incapable of raising their children? And how could children not be tempted to hide any deviant behaviour from their parents knowing how important their upbringing is too them? It is thus impossible to communicate. This alone widens the gap between generations, without brotherly or parental love drying up and going away.

Yet rumours and reputations constantly run through the streets of the suburban developments, rightfully or wrongly accusing families for shortcomings in raising their children. As families are condemned by the media, politicians, and everyday speeches, each tries to differentiate themselves from the others. By accusing others of not taking care of their children as they should, these parents are mostly trying to show they are different, by maintaining that they take good care of their children. In this manner a type of social control is formed. They all watch the others' children, at the same time as their own, from the windows of their apartments. This is why the young people navigate from one building to another, more or less openly smoking according to whether or not they know someone may be watching them.

But couldn't these young individuals just simply conform to the wishes of their parents? Some do, of course. However, for many, to reconcile their parents' ideal with the reality they are living, is simply impossible. Their parents lived in a society where work was everything. Even those who became unemployed are so much affected by social disqualification that their children are very familiar with the value of work - even when they have never seen their parents work.
But they also know the reality of no jobs, academic failure, racism, and being controlled because of their looks. These young individuals smoke their first joint amongst friends, at school or in a hallway of one of the buildings, but this use

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often remains occasional. If they are already having trouble at school, perhaps the juvenile hospitality and euphoria of smoking joints speed up this process. However, sooner or later they quit school. They then enter into a long period during which they have no social status, or even any revenue that would enable them to acquire a status-enhancing appearance. They hang about in the early afternoon, bored, discussing the same old worn out subjects or keeping obstinately quiet. They often stay in the development, idle, having lost any perspective of the future. This is the point at which real cannabis use begins. Those who only occasionally smoked begin smoking on a daily basis. Some begin selling cannabis before smoking, and only smoke it because they have it at their disposal.

Excessive situations

Most of these young people try to save face even when they use and abuse cannabis. The social control family's hold over each other in the developments is relayed amongst each other. Thus, there is not only the question of hiding when rolling or smoking, but also of not exhibiting behaviour showing one has smoked too much. If one of these individual's eyes are too red, or his behaviour is too exuberant, he gets scolded by his friends.

Yet this control does not prevent excessive situations, whether they are collective or individual. Collective situations may be born out of boredom or a party atmosphere. In the first case, these idle young individuals meet at the end of the afternoon and smoke non-stop. This excessive behaviour is even easier because it is collective, and they are all in the same condition.

In the second case, these individuals meet in the evening. There is often no sign that this will be an excessive evening. Either some have got good cannabis - some "bomb" - and the others indulge, a friend stops by that they haven't seen for a long time, or they are all simply in a good mood for one reason or another. The evening is thus spent smoking joints in a joyful atmosphere.

In both cases these situations of excessive collective behaviour occur in closed-in areas, such as cellars, abandoned premises, or sometimes in apartments (although this was occurred more rarely). They also let themselves indulge because they have escaped the watchful eye of the development. However, sometimes situations evolving from boredom are so strong that even the most elementary caution is not taken.

Lastly, these excessive situations are sometimes individual. They may be simply occasional, linked to a particular event. Someone who has had a problem is going to smoke excessively to try to not think about it anymore, or to simply try to relax. However, sometimes life's situations become unbearable. This is what may happen when the reputation of a particular young individual has become so bad that there is no longer any reason to hide this behaviour. Social disqualification becomes so strong that excessive practices become common and rooted in daily life. Moreover, these practices may involve more than cannabis.

Cannabis use and social situations

Although the situations described here involve young, idle, individuals with no perspective for the future, intensive, or even daily cannabis use also involves young people who work and are relatively well integrated into society.

Some of these individuals use cannabis as much as their idle friends. Their use is often adapted to their schedule of activities. They only smoke in the evening after work. However, they can smoke a lot. Moreover, they often have access to stronger cannabis. As they are relatively mobile, they keep up on the places where they can find what fits their needs. In fact, on average, the active degree of the resin they use is twice that used by the idle young people. The latter remain within the local cannabis market, no getting around much. It is within their best interest to keep integrated in the cycle of services and exchanges that occur within the development.

Thus, it is becoming necessary to question why cannabis use is high amongst people from totally different social backgrounds.

According to our observations, individuals who have a stable professional and a family life, but have high levels of use, experience strong tension in these areas. Thus, there are young individuals who find themselves in unstable professional situations with a family to feed, and superiors who doubt they are capable of working, etc. In the same way, those in an unstable social situation in suburban developments, with high and prolonged levels of use, are subject to strong social tension, whether it be problems with their reputation, legal problems, or family problems.
Cannabis use never appears to be irreversible. Use increases or decreases, is regulated or abusive, or sometimes completely stops. The issue here, which is more important than problems with upbringing or parents giving up, is the place these smokers have in society (or more precisely their feeling of not having any place). This is one of the elements that are helpful in understanding the intensity of some uses. However, professional integration is not always enough to reduce high levels of use, as it may lead to high levels of tension. The different levels of cannabis use follow the twists and turns of personal experiences, social integration or disintegration. This was the case even though long periods of social stagnation were born from a precise socio-economic context that favoured high levels of use amongst the young people we met.

Methodological References

In order to carry out this type of ethnographic research we integrated with groups of young users of cannabis in the Seine-Saint-Denis département.

Our work was conducted in approximately ten suburban developments, but we focused upon two of these developments more than the others. Although we were able to meet around 40 young individuals in those two developments, we occasionally crossed paths with around 100 of them. Most of the individuals we met were 20 to 30-year-old men. For the most part, these developments presented all of the characteristics of urban segregation (removed from the inner-city and community facilities, deteriorating buildings, and a high level of poverty and social stigmatization, etc.).

We stayed with these young people during many long evenings, listening, talking, and watching. This is how we were able to collect information on patterns of use, transactions and the cannabis market, local social control, and more generally, the context and living of these young people. Observations were mainly made in the entryways to buildings, sometimes on the premises, in cellars or apartments. They were supplemented by interviews whenever that was possible. Lastly, we gathered a certain number of samples that were weighed and analyzed. Using these analyses, we were better able to understand the relationship between quality, quantity, and social relations in the cannabis market in the suburbs. The sample were analysed by Professor Gilbert Fournier in the drug analysis laboratory of the University of Chatenay-Malabry.

Research was conducted from October, 1994 to February, 1997. We were present in the developments approximately two evenings per week during this whole period. The field survey was conducted with Hamed Khedim.

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Prevalence and Incidence of HCV Amongst Drug Users Seen in the Drug Addiction Treatment Department of the CHS in Jury-les-Metz (Moselle)

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Hepatitis C is an illness still not well known, particularly amongst drug users. It has been much less visible than AIDS, which until recently was clearly seen to be as deadly. The risks involved with hepatitis C have been poorly assessed and thus inevitably poorly understood. Hepatitis C causes and will continue to cause death. However, it is not presently possible to estimate how many as there is no system for gathering data.

This faulty representation, and the fact that this illness has not been visible, may be combined with other factors to explain why there is such a high rate of prevalence amongst drug users (particularly amongst intravenous drug users). From 1991 to 1997, the percentage of HCV seropositive drug users seen in the drug addiction treatment department of the Jury-les-Metz CHS, Moselle (counted from the results), was around 70%. There have been few variations from year to year since 1991. During this same period, the percentage of HIV positive drug users went from 13 to 2%.

We were able to assess the incidence of seroconversion amongst 108 initially seronegative drug users for whom we were able to draw blood twice[107]. The average age of these drug users was 24, and 50% had intravenously injected drugs for an average of 5 years. Calculated on an annual basis, 18.6% of the initially seronegative drug users showed positive in the second test. This average rate includes change in serological status for 33% of the intravenous drug users compared to 7.2% of the non-injectors. Thus, over a one-year period, an intravenous drug user has a one in three chance of being infected with HCV, while the risk of being contaminated with HIV is very small for the same population. According to our data, the risk is also much higher amongst women (28.8%) than men (13.5%).

The high level of prevalence and incidence, that has been biologically noted, contrasts with prevalence as stated by drug users seen in our department. Of 670 patients seen between 1991 and 1997, 28% stated that they were HCV positive, and 25% stated that they were not sure of their serological status. The longer an individual had been using drugs the better he/she knew his/her serological status, leading to an increase in the number of individuals stating they were seropositive. Amongst those who had used drugs for a period of 0 to 6 years, 13.4% stated they were seropositive compared to 46% amongst those who had a "career" of 12 years. In the case of AIDS, stated seropositivity was on the contrary in accordance with biological tests. Drug users, and most particularly those who recently began using drugs, think they are much less HCV seropositive than they truly are. Perhaps this observation may be helpful in providing an additional element in explaining the continuity of the HCV epidemic. A population that underestimates is seropositivity is more likely to engage in behaviour that favours contamination.

Nevertheless, there is still need for an explanation of how this infection is spread, since HIV contamination has strongly decreased amongst the same population. The drop in the number of intravenous drug users infected with HIV may be explained by a decline in the shared use of syringes that has been encouraged by harm reduction policies. What is difficult to understand is why the same factors do not have the same effects for the two viruses. The explanation may be found in that users re-use their own syringes, and the HCV virus is stronger and more resistant. It may be transmitted through exchanging or putting together materials needed for injection. A seropositive user is likely to contaminate the water and other injection material used by another user. The latter might then become infected even though he/she only uses new syringes once.

* *Psychiatric doctor, department head, hospital practitioner, (intersecteur de Jury-les-Metz)*

[107] *An article was being written about this study at the time this report was being published.*

Successive surveys conducted by the IREP show that 75% of the users re-use their syringes, no matter how many new syringes might be available. Moreover, it seems that precautions are slackening as the danger of AIDS appears to be less present (particularly amongst new users).

Conclusion

Harm reduction policies have lead to a drop in the transmission of HIV amongst drug users, but not the transmission of HCV. We have been able to see the different factors that may be used to explain the development of the HCV epidemic using the observation of data from our own department. We have mentioned the strength and resistance of HCV, the re-use of syringes and sharing of injection materials, the high level of prevalence that has already been reached, the lack of knowledge and underestimation of seropositivity on the part of drug users, and their lack of knowledge of this illness.
The public authorities and the medical profession have not reacted as strongly as necessary to face the gravity of the problem. Doctors tend to abandon drug addicts to themselves, judging them incapable of conforming to the protocol of the treatment. Public health officials are less worried about HCV than AIDS, which could affect the entire population. In their eyes, the dangers of HCV seem to be contained to intravenous drug users.

It is sure that this population has had a hard time making its voice heard. However, it should not be abandoned to what many consider to be its fate (including some of the drug users). It is an urgent matter to intensify harm reduction policies and to adapt prevention messages for intravenous drug users. They must not simply focus upon the use of sterile syringes, but all injection materials (i.e. water, syringes, cottons, lemons, spoons).Protective practices should be simple and usable by drug users. The best carriers of prevention messages are the users themselves.

As concerns treatment, it is important to research and test the effectiveness of new protocols in prescribing less restricting antiviral medicines that are more easily observable. Particular effort should be made to create a hepatitis treatment network for drug users. Information must be able to be centralised within the network to improve the testing and treatment of patients. Each specialized centre should have a hepatology department to refer to. The means must be found to ensure the treatment of drug users during their hospitalisation, and to clinically train specialised drug addiction personnel in treating hepatitis.

The mobilization around HCV is also a way of continuing the efforts made to reduce the HIV epidemic, a trend that would challenge the increase of risky behaviour amongst the youngest users. By protecting themselves from hepatitis C, drug users would also be protecting themselves from AIDS.

Methodological References

Data presented in this article came from the medical files of patients who sought treatment in the drug addiction department of the Moselle region (drug addiction treatment department at the CHS de Jury in Metz, Baudelaire Metz centre and Baudelaire Thionville centre) between 1991 and 1997 (N=670). Annual seroprevalence measurements are carried out on the basis of biological tests.

The study of incidence, which was retrospective in manner, was conducted on the population of individuals hospitalized for detoxification in two centres in Lille and Metz between 1991 and 1997. Each hospitalization gave rise to a systematic biological assessment. Of the 1,002 patients hospitalized, it was possible to identify 108 who were initially seronegative, who had been hospitalised more than once, and for whom two biological assessments were available.

DRUG TRAFFICKING

Cross-Border Heroin Trafficking From Barcelona to Perpignan

**Lamia Missaoui, **Alain Tarrius*

This research attests to the trafficking of heroin, cocaine, and other psychotropic substances associated with this trade in the French-Spanish border region of Catalonia. The cities of Perpignan, and its département, Gerona, Barcelona, Lerida and Tarragona, as well as the Costa Brava, supported investigations designed to recognize developments in the production and distribution of these drugs.

Initial research conducted in 1996 and 1997 enabled us to establish the role of gypsy, Moroccan, and Senegalese populations in this cross-border trafficking in this area. By keeping some of the heroin from the large flow that moves between Barcelona and Perpignan (generally arriving from sub-Saharan Africa), Catalonian gypsies feed the local market for personal use. Andalousian gypsies (whom the Catalonian gypsies still referred to as "Spanish") are able to supply larger regional or international markets, frequently being helped by Moroccans from the last post-Fordist migration. There were, of course, non-ethnic distribution channels as well that mobilized individuals who had clearly been identified as delinquent. These individuals were found to resell heroin in well-known areas of the above-mentioned cities.

Our research particularly focused upon a little perceptible emerging phenomenon in the forms of semi-open trafficking we have just mentioned. We looked deeper into this recent phenomenon (two to three years) and assessed it. It was revealed by individuals who were arrested and convicted, on both sides of the border, by young individuals from highly legitimate, stable families in the local societies. These were children of farmers, merchants, government employees from different levels, self-employed individuals, and workers, who had been in these local areas for many years guarding and replicating their norms and values. We identified and met 79 young heroin traffickers for interviews or went with them as they moved around. They ranged in age from 19 to 27. Of these, 16 were unsuspected and 41 had already been warned or arrested. After observing them and listening to what they had to say, we established that there were around 250 of them, of whom 170 were unsuspected. There were 100 in France (Perpignan and its département, Narbonne, Béziers, Montpellier and Toulouse), and 150 in Spanish Catalonia. Their strong "invisibility" compared to traditional heroin traffickers was not only due to the fact that they did not use psychotropic drugs and did not expose themselves to the milieus that were usually known, but mostly because nearly all of them came from families that were socially highly cohesive. Revenue from these activities, which was often quite high when drugs had been trafficked across several borders, was invested in order to facilitate the professional success of these families that could not produce as they had been able to do in the past.

This approach to new populations of traffickers enabled us to identify with near certainty that there has been a change in the transformation and commercialization of heroin. Recently, and in correlation with the appearance of traffickers from "honourable local families", Barcelona, which was the centre for trafficking drugs in that area, has decentralized its activities toward the three average sized cities surrounding it: Gerona, Lerida (Lleida in Catalan) and Tarragona. Not only have sales been transferred, but production as well. Small units transform morphine in each of these cities. This is also where there is a concentration of all sorts of substances developed in the suburbs of Barcelona (ecstasy, amphetamines, and Viagra more recently).

Thus, the appearance and multiplication of these new traffickers not only marks a normalization of drug use because of the accreditation given by these very normal local families, but also the generalization and diversification of supply within a social fabric that is becoming more and more microscopic and diffuse.

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*** Professor as the University of Perpignan*

Police and legal authorities that are still almost exclusively mobilized by the "classic" trafficking networks have been relatively caught off guard by these new forms. Families "take back" their children as soon as they have been arrested, by offering incontestable moral, social, and economic guarantees that they will be reintegrated into society. A considerable number of these young people refuse to return to the family bosom after being arrested, creating groups of long distance smugglers who lead an original, semi-community style of living (Grenada / Malaga).

Thus the phenomenon studied does not appear to be random, but indicative of the emergence of new and formidable forms of close contact with psychotropic drugs.

Methodological References

The methods used were those of documentary (press and legal files, information from doctors, interviews, and immersion). On the other hand, two individuals who were notorious dealers (Senegalese and Andalousian gypsy), who had already been contacted in the first research conducted, enabled us to make progress in our study (classic ethnological methodology).

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The Evolution of Drug Rings Supplying Ecstasy in France During the 1990s: From Direct Supply to Intervention in Criminal Milieus.

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The introduction of ecstasy in France, through the techno movement that mainly occurred in the 1990s is a remarkable example of the development of an illicit drug market and how quickly it becomes complex. Two main characteristics were underscored in the study[108]: a growing interpenetration with the natural drug market (mainly cannabis, cocaine and heroin) and the growing position of "organized" crime in organising the supplying and providing of substances on a local or international level..

The "techno" music movement was the main support for the rapid development of the ecstasy market and its distribution in underground "techno" parties or those organized by specialized establishments (bars, discotheques) and places of entertainment linked to partying, sports, or sex. Use of this substance is associated with other more traditional substances that produce psychotropic effects such as cannabis and alcohol, but also LSD, cocaine, ketamine, and various medicines.

The interpenetration of the ecstasy market with other drug markets, immediately occurred within the very midst of these festive areas. It progressively, but rapidly, took effect from the rapid development of short cross-border networks, then from the opportunities provided by small and large national and trans-national criminal organizations.

Direct trans-border networks

The direct trans-border network is supported by the existence of easily accessible extra-territorial supply sources, known by buyers and the police, and a policy of bulk purchasing (several purchases together). Going back up the chain, these networks are controlled by producers of ecstasy that are represented by traditional groups of Dutch smugglers, then by criminal organizations that traffic drugs that have been converted into the production of synthetic substances. The latter mainly come from the Netherlands, then Belgium and Spain. They are increasingly becoming associated with laboratories and criminal groups from Eastern European countries. The example of the Netherlands shows that these small structures (in size), are able to make considerable profit. The lowest assessment of turnover for one organisation alone that was brought down by the Dutch authorities had nearly reached 270 million francs[109].

From the top to the bottom, and beginning with the producer, this network was made up of wholesale dealers who sold from 1,000 to 5,000 pills per week in France (who were in contact with the producers, were able to finance, had transporters, and a wholesale distribution network); semi-wholesalers (500 to 1,000 pills per week) who had a network of retailers; and lastly dealers (around one-hundred pills per week) who worked directly in parties.

Right from the start, those involved in the "techno" movement (party organizers, DJs or Travellers[110]) showed up at each level of this direct network. Some organisers even had a monopoly on the sale of ecstasy at their own parties (frequently the case for L.S.D.).
At the end of the 1980s, ecstasy was distributed at "techno" parties by some of these individuals, initially with use (use-dealing). Most of this supply came from small transactions conducted abroad (particularly in the Netherlands) using two

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[108] *COLOMBIÉ (T.), LALAM (N.) et SCHIRAY (M.), Etude des filières produits psychotropes à partir des soirées techno, OFDT, 1999.*
[109] *According to the synthetic drugs unit, islands and cocoa production were financed with these profits.*
[110] *Travellers from the «techno» movment are nomads. They live in buses or trucks on the roads of Europe attempting to maintain autonomy.*

risky methods: payment in cash for bulk purchases, and transporting the merchandise across borders. Thus, using the direct trans-border network had three main obstacles: a quantitative limit, the initial financial investment would not be too large due to the fact that the smuggler could be arrested at the border; time limits, the small stock didn't make medium and long term profits possible; and lastly the geographical and qualitative (amateurism) limits of these individuals. As early as the mid 1990s, the insufficient professionalization of these new middlemen trafficking ecstasy strongly contributed in making their trans-border excursions visible to the police.

There were two main effects from the growing demand for ecstasy in France, and the paralleled strengthening of surveillance on the borders between France and the Benelux countries[111]. The professionalisation of those involved in the direct trans-border network, and the integration of synthetic drugs into networks controlled by organised crime. Using capital accumulated during the first bulk purchases, dealers in this network developed strategies to escape repression, particularly along the borders (smuggler, spying on the police). This enabled them to maintain a regular supply. Consequently, becoming involved in a logic of criminal profit, some became important "multi-menu" middlemen (ecstasy, then cocaine and cannabis) who could fill the orders of the members of their network(s). By adding these new substances, this new generation of drug traffickers came into contact with suppliers and middlemen set up within France, who trafficked natural drugs. Most of the latter come from small or large criminal organisations (the "milieus") that dominate networks of organised crime in France.

The penetration of criminal networks into the synthetic drug market

In the South of France, this market alliance was favoured by the infiltration of important members of the local "milieus" into structures that organized "techno" parties (associations, producers), and by organized criminals in France who became involved in drug trafficking from Spain and the South East of France. There were two main consequences of the integration of these synthetic drugs into the wholesale trade (cocaine, heroin and cannabis resin): the creation of new networks within "techno" circles (festivals, parties) from the main instigators of the direct trans-border network; then the integration of new dealers, particularly from areas in large cities[112].

Moreover, these young individuals tried to be supplied by trans-national ethnic networks (Central Africa, the Mediterranean area, Asia), in Dutch and German cities.

Those involved in the last part of the distribution process are supplied by both of these networks. Information from field observations and the study of court files (1998) indicates that a growing number of these individuals are abandoning the direct trans-border network to work with the criminal network. Indeed, criminal suppliers offer two determinant advantages: "home" delivery, and advances paid in drugs. Once these have been delivered, most of the French dealers are unable to reimburse their debt(s). This financial mechanism appears to be the driving force behind the integration of "organized" crime into the ecstasy market, which seems to abide by a "shared portion" of the narcotics market in the South of France.

[111] *This strenghthening is due to adesire on the part of the French authorities ti limit «narcotourism» amongst young French people in the Benelux countries, particularly in the Netherlands, when the Schegen area was created.*

[112] *Within a technival (underground gathering) market share (ecstasy, LSD, hashisch, cocaine) is often marked by violent confrontation between «young individuals from the neighbourhood» and the organizers.*

Methodological References

This study, financed by the OFDT (forthcoming report), was conducted with help from the Maison des sciences de l'homme by researchers from the CIRED/CNRS.

The surveys were based upon "techno music parties". Researchers surveyed three types of individuals: those involved in the illicit drug market (users, dealers), through partially controlled immersion; associations linked to the "techno" movement; police gendarmerie and customs agents and individuals from the legal system (Departmental magistrate's courts).

Researchers participated in approximately 40 "techno" parties that were broken into two categories: underground and official. Information was gathered through guided interviews and from two questionnaires. The survey was mostly conducted in the Midi-Pyrénées and Languedoc-Roussillon regions.

INSTITUTIONS AND PUBLIC POLICIES

Treatment

Substitute Treatment with Subutex® in France[113]

France Lert

In February, 1996 French health authorities increased the availability of substitute treatment by authorizing the Schering-Plough laboratory to introduce Subutex®, onto the market (strong doses of buprenorphine in pill form, to be dissolved under the tongue). This product quickly became more popular than methadone, for which prescription rules are much stricter[114].

These new measures provided an official framework for the old practice of prescribing and using Temgésic®, (doses of buprenorphine for analgesic treatment). In France, as was the case in most countries where this medicine had been in circulation since the end of the 1970s, it was misused by users who lacked the means to purchase drugs, or to replace street heroin of poor quality. However, the average dose taken was still much smaller than doses proposed for substitute treatment.

The future of patients: strong retention one year after treatment was begun.

There is no systematic method of gathering data on individuals undergoing substitute treatment. However, some studies have been conducted, or are under way, to describe what becomes of these patients. SPESUB[115] , the largest of these studies, was conducted by the EVAL society upon a request made by Schering-Plough laboratory. Individuals undergoing treatment showed the classic characteristics of heroin-addicted users: 45% were over the age of 30, and around three-fourths of them were men. It was difficult to compare the characteristics of their lifestyle to those of individuals undergoing treatment in specialized centres because the methods of gathering information differed. Although the social situation of these individuals was marked by a low level of academic studies (only 51% had completed primary education), a low rate of professional activity (49% were inactive), and a noticeable share had shaky housing conditions (15%), it appeared that the social situation of individuals treated by regular doctors was slightly better than that of individuals within the population being treated in specialized centres.

The objective of global treatment for addicted users was to quit or reduce the use of licit or illicit psychoactive substances, to improve or at least stabilize their social situation, and to increase access to treatment for their somatic or psychiatric problems. However, the criteria of keeping individuals in treatment remained the main evaluation criteria used in the studies.

One year after being included in the study, 69% of the individuals were still being treated by the same practitioner (of which 9 out of 10 were still taking buprenorphine), 8% were being treated elsewhere, 6% were no longer being treated (for diverse reasons) and contact had been lost with 17%.
Amongst the patients being monitored, heroin use had dropped from 43% in the beginning to 14% during the month preceding their last appointment, and cocaine use had dropped from 19 to 5%. Twenty-two percent had continued injecting. Some improvement in housing conditions was observed, and there was particular improvement for professional activity (from 55 to 65%).

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[113] *This text was largely inspired by the report written by an INSERM work group : Evaluer la mise à disposition du Subutex® pour la prise en charge des usagers de drogues. Synthèse rapide de la littérature et des données disponibles et propositions pour un programme de recherche, juin 1998.*
** Research Directorl NSERM U-88*
[114] *Concerning the legal framework for prescribing buprenorphine and methadone please refer to the section on developments in the anti-drug addiction policy. For questions relating to the number of individuals undergoing substitute treatment, please refer to «Use nand substitution» in the indicators section.*
[115] *See Methodological references for a description of the study.*

Over time, the length of prescription grew for these patients. Medicine was issued by pharmacies for the longest periods of time. The average dose did not change, but was spread out over a longer period of time.

The results of the SUBTARES survey were similar. Amongst patients who began treatment in February and October of 1996, 72.3% were still being treated after one year (excluding individuals who had not been seen after the first prescription, or with whom contact had been lost during the first month). The use of benzodiazepines dropped during treatment.

Risks and misuse

The wide availability of Subutex® has had a certain number of negative effects and risks. A detailed evaluation would be necessary in order to understand the global impact in terms of public health.

Subutex®-related mortality and death
Twenty deaths have been reported by one legal medical laboratory alone amongst individuals who had taken Subutex® in the hours preceding death (use determined by doses found in various tissues or blood). According to those who wrote these reports, concentrations of buprenorphine and norbuprenorphine, were found to be on a treatment or supra-treatment level. In 18 of the 20 cases, high doses of benzodiazepines were found. Buprenorphine is known to have a slowing effect on respiration that might be increased by the concomitant use of benzodiazepines. Insofar as these in-depth post mortem investigations are not systematically performed, it is not possible to gain an understanding of the scope of these observations. However, it is important to remember that in countries in which substitute medicine is widely distributed, there is a high percentage of related overdose cases (within or without the framework of treatment). The association of other substances with benzodiazepines is also quite frequent; this type of use is both an aggravating factor in the physiological process and an indicator of risk (polydrug users are, as a rule, the most seriously addicted and non-integrated individuals). Thus, it is indispensable to systematically monitor and analyze these deaths today.

The observation of deaths relating to substitute substances must nevertheless be compared to the global impact on mortality.

There is currently no cohort study that could be used to measure mortality (annual death rate) amongst a population of individuals taking Subutex®, or even Methadone. The only data available today concern overdose-related deaths as collected by the OCRTIS from legal procedures. These numbers strongly decreased after peaking out in 1994, dropping 60% between that date and 1997. This drop indicates that the global risk of death is smaller, and may correspond to the implementation of harm-reduction actions (the massive distribution of Subutex® in particular). However, this parallel does not make it possible to identify the direct interaction between different public health measures and the reduction in the number of known deaths.

The injection of Subutex®
As was the case for Temgésic® in the past, a noticeable percentage of users inject Subutex®. This percentage varies from 12% in the SPESUB study to 20% in the SUBTARES study. Since the scope of this phenomenon was underestimated right from the start, these studies were not designed to measure the frequency of this type of use (systematic IV administration or alternating between types of administration, changes during treatment, etc.). Nevertheless, those working in the field indicate that it is frequent. Not all of the substances that make up the excipient of pills that dissolve under the tongue are soluble. This may be the origin of the abscesses observed amongst individuals who inject. During the months following the implementation of Subutex®
on the market, vein problems were also reported but this did not continue. The continuing use of injection is often attributed to an addiction to the gesture. It may also be interpreted as a mode of socialization amongst the group of users, or even dissatisfaction with the substance itself because of its pharmacological properties or because the dose is too small. Prescribed doses do appear to be fairly small (7.6 to 7.8 mg in the SPESUB survey). A more in-depth look should be taken at this question to better understand how Subutex® is used and the impact in terms of risks of viral infection.

Subutex® as a substance of transition
Individuals working in the field have observed the use of Subutex® amongst subjects who are not heroin users, and wonder about the role of this product as an addictive substance, or even one that leads to heavier use of opiates. Scattered observations show that these individuals are often users of alcohol, medicine or cannabis. The high volume of substances implemented on the market lends to these types of use of which little is known of their scope, and which may only correspond to a very small share of the medicine which is in circulation.

Resale of Subutex®
The preceding phenomenon is being fed by the unauthorized sale of Subutex® and possible multiple prescriptions. Those who purchase from this parallel market may do so because of discontinuity in medical treatment, problems in going through the steps necessary to obtain social security coverage and begin receiving treatment, or even because of a lack of preparation for steady treatment. These individuals could most likely benefit from threshold services. There is a particular lack of data about possible multiple prescriptions for the same individual. However, in areas where this has been established by the Social security funds (particularly in Alsace), the phenomenon appears to be limited. This issue is being discussed by some committees that are trying to persuade prescribers and patients of its importance, or to propose particular systems that associate the patient, doctor and Social security funds.

Many unknowns in optimizing substitute treatment.

The continued high demand for Subutex®, its large distribution throughout France, and the implication of a great number of doctors are testimony to the benefits felt by both users and professionals. Looking back over more than 30 months, one could believe that this is not simply a brief craze. A very close evaluation of the benefits and risks of this substance from a clinical point of view, as well as a public health point of view, still needs to be made.

This is indeed true as treatment testing was conducted amongst addicted individuals not suffering from serious somatic (hepatopathies, AIDS, diabetes, etc.) or psychiatric illnesses. Women were not supposed to be pregnant during testing. These pathologies (or pregnancies) are very frequent amongst drug users. The importance of substitute treatment during pregnancy has been clearly established: the woman may acknowledge her pregnancy earlier and receive better prenatal care. The treatment would prevent the foetus from experiencing repetitive withdrawal that is inevitable when the mother is using street heroin. However, little is known about adapting doses during pregnancy, the risks of the associated use of benzodiazepines, the effects on the progress of the pregnancy, birth, and particularly the withdrawal syndrome for the newborn and breast feeding (particularly in comparison with methadone).

Providing substitute treatment may lead to treatment for HIV and hepatitis C. However, this co-morbity, which is quite frequent, raises many issues relating to the interaction between medicines. The hepatotoxicity of this substance may be modified by the existence of an HCV infection. In the same way, alcohol use, which is quite common amongst this population, may worsen under substitute treatment and even weigh upon the prognosis of the HCV infection. Thus, a detailed evaluation of optimal treatment strategies is necessary.
Under the complex relationship between drug use, drug addiction and psychiatric problems there are still many diverse and poorly understood processes. If psychological suffering can be relieved by treatment with both psychological support and substitution and by improving living conditions, more severe psychiatric problems may need to be treated with psychiatric intervention and medicine. Treating such co-morbidity remains difficult on an organizational level, as well as in finding the best-adapted strategies and methods to use. This is another area in which the interaction between medicines has not been explored.

[116] *See Methodological references for a description of the study.*

Conclusion: continuation of a treatment adapted to the users' diversity and their living conditions

The provision of substitute treatment came late to France because of resistance from those supporting a treatment model based upon a psychoanalytical approach. France has followed the example of many countries now accepting and recognizing the prescription of opiates as a condition for a number of different types of treatment (social and educational support, psychotherapy, etc.).
Subutex® has enabled a transition to be made in the organization of treatment for drug addicts. It has offered new options and broadened the occupation of those in the health and social sectors that are involved in it. The heavy use of heroin, cocaine, alcohol and misused medicines is still a chronic condition, and even in cases where treatment has been successful individuals are vulnerable to relapse.

The fact that individuals may feel better and relations with professionals have improved, should not get in the way of constant research to find optimal solutions to improve the individualization of treatment, reduce risks of toxicity (overdose, interaction between medicines, hepatotoxicity etc.) and favour adapted treatment of the various co-morbidities. Adapting the treatment provided, searching for new solutions, and adopting strategies that have been tested in other countries (threshold services, heroin substitution, IV substitution) are still very current issues.

Pharmocological and treatment properties.

Buprenorphine stimulates the opiate μ receptors, blocks the κ1 receptors and δ2 receptors in a smaller measure. The effect on the opiate ? receptors is that of a partial agonist. Buprenorphine presents an exceptional affinity for the opiate ? Receptors and dissociates from them very slowly. However, these effects, which have been observed in animals, could be noticeably different in man where it is nearly impossible to show the partial agonist effect. This is why pre-clinical data do not make it possible to affirm innocuousness in man for any dose (as has often been believed). In clinical pharmacology, the effects (subjective effects - experienced as positive, euphoric, sedated, and objective effects - myosis, respiratory frequency, oxygen saturation in arterial blood), are proportional to doses up to 16-32 mg. For some effects, there is a plateau at 4 mg. The intensity of the effects obtained is globally identical to that of 60 mg of methadone.
Treatment tests, using buprenorphine for detoxification or maintenance, have been conducted in the United States for 20 years. Using the classical criteria for retention in treatment, it appears that for maintenance with buprenorphine, a dose of eight mg yields results along the same order as 30 to 60 mg of methadone, (closer to 60 mg). However, in the most recent study conducted on a large number of patients in centres throughout the United States, a daily dose of 16 mg gives better results than eight mg. This is in a galenic form (30% alcohol solution used in all the American tests) whose bioavailability is higher than that found in the tablets are sold in France and to be dissolved under the tongue.

Methodological References

➥ SPESUB study
Based on 1,000 patients treated by 105 general practitioners affiliated with drug addiction networks. The general practitioners were included in the survey because of their known involvement in treating drug addiction. Each doctor included the first ten patients over a given three-month period from May to June, 1996. These subjects have been treated for two years; the one-year results are currently being published[117]. Data was gathered at fixed intervals (1, 3, 6 and 12 months following being included in the study).
The study was conducted by the EVAL society and financed by the Schering-Plough laboratory.

➥ SUBTARES study
Retrospective survey conducted amongst four networks of doctors grouping together a total of 71 general practitioners in various regions (Paris, Strasbourg, Nice, Bordeaux). Names were drawn from lists of doctors in these networks. Doctors who agreed to participate in the study were included by alphabetic order until 75 usable cases had been found with a maximum five patients per doctor.

Criteria for including patients: high-dosage treatment with buprenorphine for major opiate addiction between the 12th of February and the 31st of October, 1996.

Data were gathered during the first visit, when the prescription for stabilization was given, and during the last prescription included in the survey period.

The study was financed by the Schering-Plough laboratory.

For More Information :

■ *Évaluer la mise à disposition du Subutex® pour la prise en charge des usagers de drogues, Synthèse rapide de la littérature et des données disponibles et propositions pour un programme de recherche, Rapport réalisé sous l'égide de l'INSERM par un groupe de travail dans le cadre d'une convention avec le secrétaire d'État à la Santé, Direction générale de la santé et le laboratoire Schering-Plough. Rapporteur France Lert.*

[117] *BLIN (P.), NOUVEAU DIBURCQ (A.), CHARPAK (Y.), MARTIN (M-P.), One year follow up of heroïn users treated by high dosage buprenorphine : The french experience. European Harm Reduction Conference, Utrecht, juin 1998.*

Monitoring of Drug Users to whom methadone is Being Prescribed

Work Group: Commission nationale des traitements de substitution
Gérard Cagni, Jean Dugarin, Françoise Facy, Xavier Legall, Jean-Luc Vigneule.

According to the circular letter DGS/SP3/95 from March 31, 1995, any centre prescribing methadone is obligated to provide information to be used in its evaluation. Unit 302 of the INSERM (F. Facy) was given the responsibility of analysing these data.

General Assessment

As of March 31, 1998, 5,360 individual files had been recorded at the INSERM (entry sheets).

For 1,418 of the 5,360 individuals, the latest available information was more than 18 months old (retained definition of maximum acceptable time). Either the structure had lost contact with these patients or the structures had not sent information about these individuals to the INSERM. We would also like to note 6 cases without precise details.

As of March 31, 1998, there were 3,936 cases that were being monitored. These 3,936 cases may be broken down into 1,319 individuals who had left the centres, 87 reported deaths and 2,530 individuals who had received treatment within the last 18 months.

Subjects treated (from entry information)

The results presented here refer to the 3,936 for whom information is up-to-date. Thus, this group is heterogeneous regarding the length of treatment, since the latest information may have resulted from notification of death, leaving a centre or any other type of monitoring.

Of these individuals, 79% were heroin users (main substance taken), 9% indicated they took Temgesic® or Subutex®, 2% Methadone®, 2% Skénan®, and 3% Moscontin®. A total of 91% of them used intravenous injection. Associated substances were mainly cocaine (35%), codeine (18%), alcohol (16%) and benzodiazepines (14%). The average age at which use began was 17 years. Thirty percent had already been included in an authorized substitution programme.

Thirty percent of the individuals monitored were women. The average age of admission was 32 years. The average academic level of these individuals was less than secondary school for 56% of them. Six percent had no health coverage.

Amongst patients who knew their serological status, 24% were HIV positive, 62% were positive for hepatitis C and 42% for hepatitis B.

Changes in the profile of subjects treated between the period preceding 1996 and after 1996 (from entry information)

A comparison of entry assessments for subjects treated before and after 1996 (out of the whole initial sample) shows that those treated after 1996 were more likely to have no resources or activity and engaged in less intravenous use at the time they began the programme. Patients included in the methadone programme after 1996 have made fewer attempts to detoxify. Thus, their length of intoxication is shorter than the length of their addiction. Lastly, the period of time between the first time they used the main substance and their first interview was shorter. Their average age is lower (33 compared to 35.6 before 1996).

The seriousness of the addiction manifested by heroin use, intravenous use, the length of addiction, relapses after withdrawal or substitution, is on average not as serious for the most recent patients. This is a reflection of easier access to treatment and more diversified practices in treatment centres, more of which are prescribing methadone.

Changes in subjects treated (from the monitoring sheets)

The general evaluation of patients may be seen in a transversal manner through time as compared to the cohort (assessment of all patients on a given date) or in function with the length of treatment (assessment of patients monitored over a period of one or two years). With the first method it is possible to monitor changes in practices. The second indicates changes in the patients.

- According to the information available to the INSERM on March 31, 1998, of the 3,936 subjects monitored, 2% died and 64% were undergoing treatment (accepting a delay of up to 18 months). A total of 34% had left the centre, 2% had changed centres and 11% had been sent to see a regular doctor (thus more than one-third of those who left continued treatment). The length of treatment with methadone in terms of months was less than one year for 57% of the subjects, and from 12 to 18 months for 14% of them.

  For this sample, the average dose of methadone was 61 mg, 43% of the subjects had received psychotherapeutic treatment, and 44% had received socio-educational monitoring. Associated treatments included anti-depressants (28%), neuroleptics (18%), and other psychotropics (44%).

- Amongst the subjects monitored for length of treatment, a sample of 690 cases corresponded to a length of 12 to 18 months. Amongst them, 83 left the centres and 10 died (Dec. 1998).

  Concerning declared use the habitual use of cocaine and opiates by heroin addicts strongly decreased (by two-thirds and one-half respectively). On the other hand, more than one-half of the individuals were concerned by an increase in the use of alcohol and benzodiazepines. Opposite changes were observed amongst one-fifth to one-third of the subjects. However, there was frequently a lack of response.

  A clinical understanding of the psychological difficulties and attitudes toward risk, on validated visual scales, show changes that are globally favourable:
  - Risks of blood contamination dropped in 42% of the cases, increasing in 7% of the cases. Risks of sexual contamination decreased in 36% of the cases, increasing in 10% of the cases.
  - Trouble with depression decreased in 37% of the cases, increasing in 12% of the cases. The seriousness of anxiety problems decreased in 42% of the cases, increasing in 15% of the cases. Psychotic problems decreased in 11% of the cases, increasing in 8% of the cases.

According to the retained criteria, a general improvement was established as early as the first year of treatment. Even though some situations failed to change, or even worsened, this corresponds to clinical observations of transitory states in the experience of drug addicts.

To understand the effectiveness of this treatment one must take into account the length of it, which is often recommended over a period of several years.
Improvements that have been recorded on a health and social level are similar to those found in the different international

surveys that evaluate treatment with methadone. The large amount of co-morbidity (psychiatric, infectious) makes it difficult to change behaviour in a quick, global and stable manner. Past experiences, which are often synonymous with the seriousness of drug addiction, are not usually factors of compliance in treatment. On the contrary, some elements of selection of the cases (individual characteristics of integration and family and social environment) are relatively favourable when compared to other populations of drug-addicted individuals.

Methodological References

This study is longitudinal, thus making it possible to monitor the patients treated (from a health and social standpoint), the activity of the services, and the orientation of patients. Provision was also made to research particular groups of patients. Epidemiological monitoring is done by the first centre at which medicine is prescribed, until there is a possible change to a regular doctor. Including patients in this monitoring process began before 1993. An initial assessment sheet is filled out, and files are updated every six months. In cases where the individual leaves, an exit form must be filled out, and information is provided in cases where death occurs.

The authorisation of the CNIL has been recorded to organise the computer processing of data. The INSERM assures that the individual data and results from the centres remain confidential.

Starting in 1993, the National French Commission opted to use a specific tool which took into account the experience of the first programmes from the 1970s that needed to be statistically validated.

For More Information :

- *Rapport DGS-INSERM, Étude épidémiologique des toxicomanes bénéficiant de prescriptions de méthadone, septembre 1998, 74 p.*
- *FACY (F.), Toxicomane et prescription de méthadone, éd.Krieff, 1999, 127 p.*
- *Epidemiological study on the follow up of patients on Methadone prescriptions in France, European Addict Research, 1999 (in press).*

Observation of the Use of Néocodion® by Pharmacies

**** F. Allaert, P. Beauverie, G. Fournier, J.-L. Garcia- Macé, D. Touzeau***

The use of codeine does not only involve Néocodion®, but this substance covers more of the needs of individuals who are addicted to opiates and sensitive to its effects. Codeine, which falls somewhere between a toxic substance and a palliative medicine, has a troubled image in the eyes of health professionals. Codeine sales have steadily decreased over the last three years (-5% in 1996, -18% in 1997, -14% in 1998). At the same time, the prescription of Subutex® has increased (+27%) in 1998. Different evaluations should be undertaken in order to better understand how codeine is used, and more particularly Néocodion®. This should be done using different observational perspectives (pharmacies, users, doctors or counselling areas) before attempting to determine the benefits and risks involved in the use of this substance, and, if necessary, to present adapted directive and treatment methods.

An initial survey conducted in 1997, in an area south of Paris, showed that nearly all pharmacies provided Néocodion® to drug addicts (an average of 15 boxes per week). In 13% of these pharmacies, Néocodion® users also purchased syringes at that time. In 2% of the cases they also purchased a substitute medicine.

A survey of Néocodion® users was conducted in 1998, with help from the pilot research committee** at the Bouchara laboratory. The key results of this survey are presented here.

Results

Of the 120 investigational centres approached, 48 agreed to participate in the survey. Thus, the rate of participation was 40%. Of the 193 individuals requested by investigators, 76.6% agreed to answer questions. Some of these individuals had been previously recruited in another investigational centre. The inter-centre re-capture rate was 2.1%. Thus, 144 questionnaires were analyzed.

Of these 144 individuals, 41 stated that they used Néocodion® (adult pills and syrup) as anti-cough medicine (or 28.5% of the clientele that had been willing to answer the questionnaire). The average age of these individuals was 42, and men and women were fairly evenly represented (46 and 53% respectively).

Use and users of Néocodion®

One hundred and three individuals declared, or were suspected of not using Néocodion® as an anti-cough medicine (adult pills) (71% of the population questioned). Their average age was 32 (20% women and 80% men). Of these, 73% stated that they worked. Average use was 36 pills per day, taken an average of 2.1 times per day, or 220 pills per week for an average of 59 months (min: 2/day-max:220 months). The substance was used on a daily basis (continual for over at least 7 days) by 64% of the individuals questioned (repeated: 14%, sporadic: 12%, occasional: 10%). Use had remained constant or decreased (for at least one month) in 49% and 41.8% of the cases respectively (increased in 9,2% of the cases). Of the individuals, 22.2% had a particular mode of preparation (washing the pills: 18,1%) mainly in cases for which Néocodion® use was recent. This was done to increase its speed of action.

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Associated uses

As concerns the use of psychoactive substances along with Néocodion®, 97% of the individuals agreed to answer questions. A total of 83% used tobacco, 48% alcohol, 42% cannabis, 23% strong agonist opiates, 8% weak or partial agonistic opiates, 1% other codeine substances, 13% psychostimulants, 18% minor tranquillizers. Lastly, 2% of the users of Néocodion® stated that they used no other psychoactive substance. Amongst all of the individuals who used Néocodion® outside of its indicated use, 46% considered that this use helped them to manage the use of other substances. Amongst those who only took drug intravenously, or 19% of those questioned, 86.7% considered that Néocodion® helped them manage their drug use. In 86% of the cases, heroin was the substance injected followed by opiate medicines then cocaine (in decreasing order of cited substances).

Addiction to Néocodion

For 80% of those surveyed, their primary addiction to opiates was attributed to strong agonistic opiates. In most cases the substance was heroin, but in 20% of the cases initiation was attributed to codeine. Amongst those who showed primary addiction to a substance other than codeine, 73% stated that they took no opiates other than Néocodion®. Previously, 76.5% of these individuals had tried to stop using it on their own and 24% had tried medical treatment. 58% of the individuals considered substitute treatment (Subutex®: 67% of the pharmacotherapeutic substitutes) and 54% considered detoxification. Only 33% of the individuals surveyed were able to benefit by having psychotherapy (either associated with drug therapy or not). Eight out of ten individuals stated that they wished to stop using associated substances (opiates 32%, cannabis 24%, alcohol 16%...). Previously, 78.2% had tried to stop using these substances on their own and 36.5% had tried medical treatment. Once again, only 36% of the individuals benefited from psychotherapy.

After a guided interview, 44% of the individuals accepted the pharmacies' proposal for orientation toward medical help, and 37% accepted a proposal to be directed toward a specialized structure. However, when asked what they would truly like, 38.7% wanted help, someone to listen or psychological support; 30% wanted non-specialized medical help; and 8.6% wanted specialised medical help.

Perception of pharmacies

The medicinal team indicated that 56.5% of the individuals surveyed were faithful customers in their pharmacy. In 19.4% of the cases of individuals who used Néocodion®, they also purchased medicine or medical paraphernalia (related to drug use, or not) at the same time (harm reduction kits, syringes, medicine with codeine, anti-retroviral tri-therapies...). Globally speaking, the teams working in pharmacies sensed that 76.3% of these clients used the issued products for self-medication within the framework of self-substitution or to correct withdrawal symptoms due to physical addiction (palliative). The relationship of these clients and professionals was satisfactory, good, or very good in 67.2% of the cases. The presence of such users was not considered to be bothersome in 87.9% of the cases, and 41.9% of the pharmacies considered that the situation of these individuals was either autonomous or one that enabled them to ensure autonomy for their family, or that they were in the process of being socially and professionally re-integrated (14%).

Discussion

The breakdown of Néocodion® users between officially recognized use (25%) and misuse (75%) leads us to believe that 97% of the production Néocodion® (adult pills) is misused. This is considering the differences in dosages and rhythms at which it is administered. Although the risk of inducing addiction cannot be measured due to the small sample studied in the "anti-cough" group of users, it appears that 20% of those who misuse Néocodion® have a primary addiction to codeine, even if some of them justify this consumption by indicating they used it before alcohol, cannabis or psychostimulants. The gender ratio and average age of individuals measured in this survey were similar to those stated in other national surveys conducted amongst drug users. However, we found that most of those surveyed stated that they had a professional activity, which does not confirm information from national surveys conducted during medical appointments: 73 and 24% respectively). It may be possible to explain that there is a difference because of a recruiting bias; the most marginalized individuals more easily seek help from medical services within the perspective of social help.

However, it is just as possible that the individuals surveyed idealized their situation. This is even more believable since those working in the pharmacies considered that only 41.9% of those surveyed were able to ensure their own autonomy or that of their family. Admitted use appeared to be stable and maintained over time, and use was mainly private. The response rate for associated use was high (97% of those who agreed to answer the questionnaire on misuse), which showed that there was a good relationship between the investigator and the client. However, associated use, and more particularly intravenous heroin use, appeared to be low (16% to 17%) for a drug addiction professional that sees individuals who are strongly addicted to heroin. However, while 68.7% of the users of Néocodion® initiated their opiate use with a strong, weak, or partial agonist, only 27% of these individuals continued the associated use with Néocodion®. Thus, in the sub-population, Néocodion® appears to be helpful in managing their use of strong or partial agonist opiates.

More unexpectedly, users brought up other circumstances during which this substance was used. These mainly included managing coming down from a cocaine or ecstasy high, but also more frequently managing the use of alcohol or cannabis. Néocodion® didn't prove to be more effective in these situations than in those involving addiction to opiates. However, although use within the framework of opiate addiction may be explained from a pharmacologic point of view, these unexpected uses may confirm the existence of alternate dependency or co-dependency. Even if there are validated therapeutic modes whose effectiveness is often limited (alcohol and tobacco addiction), we must admit that we are not able to propose detailed alternative solutions other than Néocodion® in cases of addiction to cannabis or correcting distress signals during cocaine attacks .

Conclusion

Users of Néocodion® who are seen in pharmacies are generally young, professionally integrated men. They justify their consumption of this substance in order to correct withdrawal symptoms and stop addiction to opiates, or as a means of maintaining substitution. Beyond this cliché, the results obtained make it possible to relativize data from medical offices relating to the social status of individuals and to discover other uses that are much more diverse and less marginalizing than those previously described. It is possible that this diversification comes from the process of an increase in polydrug addiction, but is also likely that new uses of Néocodion®, within the framework of self-treatment, are appearing. Thus, additional surveys on this use would enable us to better understand what use results from polydrug addiction, or co-dependency, alternate dependency or palliative treatment.

Misuse of Néocodion® has existed for many years, and in spite of a decrease in the secondary demand for the development of substitute medical treatment for opiate addiction, this phenomenon is still current. Although users gladly accept medical advice, few of them actually seek it out. Within this context, it is important that the pharmacist take advantage of these times to propose and repeat advice without breaking the trusting relationship that seems to already exist (while waiting for medical studies on the benefits and risks of this use).

Although the results obtained were fragmented, they underscored two points: the necessity of relying on a network of pharmacies to better understand the diversity of expectations of addicted individuals to better meet their needs and develop additional modes of observation.

Methodological References

This survey was conducted over a four-month period. It was proposed to 120 pharmacies throughout Paris and the surrounding region. After undergoing training at the Faculté de Pharmacie, survey conductors (students in their 6th year of studying pharmacy, dispensary option) joined teams in pharmacies, working full-time. The survey was based upon a questionnaire that enabled the surveyor to guide an interview with any client purchasing any form or dose of Néocodion®. The questionnaire viewed Néocodion® as an anti-cough medicine and a medicine that could be misused. In the first case scenario, some items made it possible to link use, as described by the client, to possible misuse. In the second case scenario, admitted misuse made it possible to get an idea of the characteristics of the population, the typology of its use, and the nature of its previous relation or expectations of the health system. Lastly, the questionnaire included a section designed to measure the pharmacy team's opinion of the surveyed client.

After the survey, the results were validated and the questionnaires were coded (in the presence of the pilot committee (*) and some of the survey conductors) before being entered into the computer. The processing and descriptive analysis was also done by the department of bio statistics and medical information at the CHU du Bocage in Dijon.

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Key Results of a Survey Conducted Amongst Drug Users who Use Syringe Exchange Programmes During a Given Week (30/04/98-05/05/98)

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Various studies that have been conducted in France and other countries show that practices of sharing syringes have continued. This may be due to problems in gaining access to them, or may be related to the situation that occurs when the drug is injected (injection in public areas, participation of several individuals, injection with a sexual partner or close friend, common preparation of the substance to be injected, etc.). Moreover, though data on the prevalence of HIV infection amongst drug users may lead one to believe that the incidence of new contamination is on the decrease, the transmission of HCV is still worrisome due to a high level of prevalence, precocity of contamination in the experience of the users, and a higher infectiousness of the virus (water, bowl and filter being potential vectors).

Syringe exchange programmes are front-line services within the framework of the harm reduction strategy. Information from a survey conducted amongst users who frequent syringe exchange programmes, which will have to be repeated at regular intervals, provides a description of the clientele that uses these structures. It gathers information about their risky practices and identifies their determining factors. This information should make it possible to adjust and complete strategies for prevention and access to care.

The results presented here only concern users who inject drugs who frequent syringe exchange programmes (bus, boutiques, fixed premises, or street work). These prevention structures, which only supply 10% of the syringes (mainly supplied by pharmacies), are very unequally spread throughout the territory. Similarities have been observed between data on socio-demographics and declared HIV, HBV and HCV prevalence amongst individuals in this population, and data from other surveys[118]. However, it is possible that those who use syringe exchange programmes differ from other intravenous drug users concerning other characteristics such as psychological problems or substances used.

Characteristics of subjects and substances used

The average age of subjects was 30 years. On average, they had been taking drugs for 11 years, and 74% were of the masculine gender. A total of 37% of the individuals were homeless (hotels, institutions, street), 19% had jobs, and 45% received the RMI (income support). A little over one-half had used the syringe exchange programme for over one year. Furthermore, 62% stated that they had at some time been incarcerated. Nineteen percent of these individuals stated they had injected drugs during their imprisonment.

Of the individuals, 73% stated they had used Subutex® during the month preceding the survey (one-half of these individuals had injected it on a daily basis). Fifty percent of the subjects stated that they had used heroin, 47% cocaine, 47% benzodiazepines, 24% morphine sulphate derivatives, 20% other medicines, 16% crack and 14% methadone. A

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[118] *Multi-centric study of the attitudes and behaviours of drug addicts faced with the risk of HIV and hepatitis virus infection (IREP, 1996), survey of HIV and HCV infection and mortality amongst residents of inpatient CSST centres (CESES, 2nd semester 1996), November survey (SESI-DREES, 1996).*

total of 29% of the drug users who participated in the survey reported no other illicit drug use during this period (other than cannabis which was used by 84% of those who answered the survey).

Profile of users

A system of classification, based on a factorial analysis of the relation between the variable of use (substances taken, context of use) made it possible to individualize five user profiles and to identify the characteristics associated with these profiles:

- the group of individuals who preferred to use Subutex® (37% of the participants), also characterized by a more recent addiction to drugs, little use of other substances, a lower frequency of injection, a less degraded social situation, and more often HIV and HBV seronegative;

- the group of individuals who mainly used cocaine and heroin (20%) ; no other characteristic was associated with this second group;

- the group of individuals who more often used benzodiazepines and other medication (19%), more often homeless;

- the group of individuals who used morphine sulphate derivatives (18%) used few other drugs, characterised by a longer period of drug addiction, less likely to know their serological status, and seeking treatment less frequently during the six months preceding the survey;

- the group of individuals who simultaneously used heroin, cocaine, (6%) also characterized by a high frequency of daily injection and often homeless.

Although these five groups are different in terms of risky behaviour, we have observed that they are neither distinguishable by gender, having children, nor their HCV status.

Risky practices

Amongst those individuals who had engaged in sexual activity over the last six months, 60% did not systematically use a condom during that period of time.
As for injection practices, 18% of the participants declared that they had shared their syringe and 71% the rest of the injection materials (water, cotton, spoon) in the month preceding the survey. These risky practices, linked to drug use, were not associated with the number of daily injections, social situation, or serological status for HIV, HBV, or HCV. On the other hand, they were associated with the type of substance used: those who used heroin or cocaine shared syringes and the other materials significantly more that those who used other substances. These risky practices are even more frequent now that the number of illicit substances has increased. They are also more common amongst users under the age of 26 than older users (21% compared to 14% for sharing a syringe, 76% compared to 69% for sharing the other injection materials).

Seeking treatment

Three-fourths of the users (76%) had sought treatment for their addiction to drugs (medically prescribed substitute treatment, post cure housing, or host family, medical or hospital detoxification) in the six months preceding the survey. Moreover, 49.4% had attempted to "get off drugs" alone during the same period with or without contact with the treatment system. A bivariate analysis of these data makes it possible to more clearly distinguish between three categories of users:

- users undergoing substitute treatment, either having had contact with other types of services (68% of the participants), characterized by a better social status with the exception of having been incarcerated in the past (having their own resources and housing, less frequent prostitution), taking fewer risks with drugs and sexual relationships, having a better knowledge of their HIV, HBV or HCV status, and use of more medicines than illicit drugs.
- users not undergoing substitute treatment having had contact with other types of services (8%), characterized by a vulnerable social status, a greater propensity to share syringes, most often unaware of their serological status for HIV, HBV and HCV, and more often users of illicit drugs.
- users not undergoing substitute treatment, reporting no contact with other types of services (24%), with similar characteristics to the second group with the exception of the use of a condom (more frequent), and past imprisonment (less frequent).

Lastly, there appeared to be quite a contrast between local situations for use, treatment, or risky practices.

Conclusion :

In spite of the limits linked to the possible specificity of the population that frequents syringe exchange programmes, one may nevertheless draw some conclusions:

- importance of intravenous use of Subutex®;
- a maintained level of unprotected sexual relations;
- continued practice of occasionally sharing syringes;
- continued sharing of injection materials other than syringes (water, cotton, spoon);
- more frequent risky practices amongst the youngest individuals;
- the health and social situation of the population using substitute substances is better than the other users (without our knowing if this situation was from before, or a result of the treatment.)

Methodological References

In 1998, the INSERM and the RNSP conducted a transversal survey amongst 60 of the 76 Syringe Exchange Programmes (PES) that distributed 94% of the 1.5 million syringes provided annually by the PESs in France. Drug users who asked for syringes for personal use during the week from 30/03/98 to 05/04/98 made up the population of the study. The questionnaire used for this survey was based upon the socio-demographic characteristics of the drug users, how long they had been using drugs, the use of substances, risky behaviour linked to intravenous drug use and sexual relations over the last month, and contact with the treatment system for their addiction within the six previous months. Eligible users who agreed to participate in the study had to fill out a self-administered questionnaire or fill one out with the help of a member of the team. The data was analyzed with EPI-INFO and SPAD software. Two categories of risky practices, linked to injection, were identified: the sharing of syringes (both sharing and borrowing) and sharing the other injection materials (water, cotton, spoon) within the last month. Sexual risk corresponded with a systematic lack of using a condom during sexual relations within the previous six months. Each PES kept a journal of passages during the week. The rate of participation equalled 50% (1,004 questionnaires).

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Treatment Policies and Practices in Prison

Marc Bessin

We are currently conducting an ethnographic survey relating to treatment in prisons and the relationship between prisoners, guards and health professionals. The latter have not been dependent upon the prison administration since the implementation of the law of 1994. This is the framework within which we encountered problems involving the treatment of incarcerated drug users. In this section we shall describe the concrete functioning of health-related treatment in the sites where we were able to conduct our observations, and more particularly the policies and practices related to treatment for drug addiction.

The reform of 1994, that related to health in the prison milieu (refer to the box) lengthened a process of decompartementalizing prisons and making them open their doors to new partners. It was implemented in a more general context of rapidly changing treatment practices in regard to drug addicts. In this section we will mainly emphasize the concrete changes that occurred in the fields we studied.

In the beginning the arrival of nursing personnel in prisons lead to a crystallization of the principles of all involved. Each of the various players became entrenched behind the official definition of his/her functions that generated tension, at times very high, particularly amongst the guards. The latter were requested to withdraw from relations between the nursing personnel and prisoners. They often felt that they had been demoted to the strict task of guarding prisoners. This presented them with an additional problem regarding their mission of reintegrating prisoners as stated by the prison administration. However, in spite of this, compromises were worked out to make the system function. The nursing personnel tried to rise above the constraints of the prison milieu and provide an "adjusted" form of treatment that remained as appropriate as possible in regard to medical ethics. Defining the role of each individual, occasionally painful at the start, seems to have finally been accepted despite some persistent attitudes amongst individuals who completely relativised the idea of "medical privacy" in prisons. Although this independence regarding how prisons function may prevent the manipulation of treatment for security reasons, this separation occasionally presents a problem when medical appointments truly underscore the pathogenic effects of living conditions in prisons with no way of changing them (i.e. hygiene, food, violence, preserving privacy, isolation from family...). In the same way, treatment and continuous care, in prisons, are often challenged by the instability and permanent movements to which prisoners are subjected. As a result of a lack of information, nursing personnel are often found to be waiting for a prisoner that has been freed or transferred.

A profound rationalization of treatment, the introduction of new techniques, documentation, more equal treatment and a selection of treatment requests, have limited the arbitrary nature of conditions for gaining access to treatment. Counselling has become more "educational", which has resulted in prisoners taking more "responsibility" for their health. Distribution attests to this: the use of phials (molecules diluted in water) has been abandoned, treatment is generally prescribed, and from now on nurses directly provide medicine on a daily or weekly basis (according to the policies of the services provided and the substances distributed).

Within the framework of drug addiction intervention, which potentially concerns 15 to 20% of the individuals in prison (High Committee for Public Health), the reinforcement of the medico-psychological teams responsible for dealing with it coincided with the possibility of implementing a harm reduction policy. Prison drug addiction treatment units integrated the SMPRs, in which specialized individuals often intervened in structures found outside of the prison environment. This problem is not as important in prisons, but is quite significant in jails.

Each incomer is systematically seen in all the services, including the SMPR, which deals with the question of possible drug addiction. Psychological treatment, which is then offered, must meet a demand and remain a palliative measure for prison counsellors who do not see prison as an environment conducive to treating drug addicts. These counsellors often believe that truly effective work only begins after an individual leaves prison, so they are confronted with limitations to continuity in their actions and a desire on the part of many former prisoners to completely break any links related to prison.

Substitute treatment (mainly with Subutex®) seems to have changed the problem of withdrawal, when psychiatrists accept to use it (this was not the case on one of the sites observed). In one of the areas studied, acquired experience made it possible to get around the systematic practices at the beginning of the process. This consisted of providing substitute treatment to any prisoner who reported that he/she was addicted to drugs. As a result of the fact that this practice no longer necessarily corresponded to a treatment objective, distrust on the part of counsellors in regard to a pressing demand prompted them to no longer necessarily urgently respond. Thus, they often did not initiate substitute treatment in prison.

Ultimately, drug addicted prisoners frequently end up using the different means necessary to escape being forced to experience withdrawal (from trafficking to requesting medicine). In the absence of a commonly defined policy between the UCSA and the SMPR, these "resourceful" practices, based upon a lack of cooperation and the different conceptions and experiences of the services involved, slow down collaboration in some establishments. These practices also rekindle differences in ideas with prison personnel who, for example, do not understand the lack of interest on the part of the nursing personnel in regard to the problem of trafficking. Thus, we see that an act such as distributing Subutex® meets several objectives (security, treatment, relief...) that create a source of conflict, but also one of adjustment. A guard could have very ambivalent feelings about substitution, denouncing the risk of trafficking while at the same time lamenting the disorderly conduct induced by a drug addict experiencing withdrawal. Refusal on the part of a nurse to see a patient complaining about teeth problems, who in reality wants medicine to calm withdrawal, may also be poorly interpreted by both the prisoner and the guard ("he/she is refusing to provide treatment"). Moreover, the guard no longer has the benefit of using medical treatment to maintain order by distancing the prisoner that is causing problems.

The last example shows the limits of rigidly compartmentalizing the various functions within a prison, where each individual can only fulfil his/her mission by adjusting and maintaining a tight interdependent relationship with the other categories of personnel..

In the law of January 1994, provision was made for transferring prison treatment services to public hospitals and social protection for any incarcerated individual. Mental health treatment, already the responsibility of specialized hospital centres (where there was a regional medico-psychological department - SMPR), was reinforced by the opening of new departments and planning for hospital beds in some prisons. A general hospital, close to all of the establishments, was made responsible for organizing and implementing somatic treatment within an outpatient treatment unit (UCSA). Thus, all prisons that were not a part of the 13000 programme (private concessions) generally made an agreement with two public hospitals.

Methodological References

This ethnographic survey, financed by the GIP "Law and Justice" Research Mission, is currently being conducted on two sites (a prison and a remand prison). It is being carried out through immersion in the establishments studied, and consists of observing activities in the medical departments and conducting semi-guided interviews with the main individuals involved in health treatment in prison (prisoners; nurses, psychologists and doctors in the UCSAs and SMPRs; social, guardian and management personnel in prisons; hospital administration; hospital departments; inspecting doctors). An initial research study was published following the conducting of a preliminary report.

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Law Enforcement

Evaluation of Court-Ordered Treatment

Michel Setbon

Court-ordered treatment, which was written into the Law Of 1970 (incriminating illicit drug use), represents the legal measure that makes it possible for health treatment to be given to drug users that are arrested by the various police services. Even if this measure is only a possibility, available to state prosecutors who decide whether to delay legal proceedings in exchange for acceptance on the part of a drug user to be directed by the Department of Management for Health and Social Action (DDASS) to a health structure, court-ordered treatment has become the health justification for prohibiting drug use: it objectively defines the drug user as a delinquent, sick individual, for which the illness represent the cause and delinquency (use) the consequence.

After 25 years of chaotic existence, court-ordered treatment became confirmed as a true health programme within anti-drug policy (through various circular letters). This formal confirmation, often recognized as little or poorly used depending upon the courts, was never truly evaluated (despite several attempts to do so). The objective of our evaluative research, conducted between 1995 and 1997, was to fill this gap using a representative sample of 25 county courts selected throughout the metropolitan territory.

Results

The reference value retained to asess court-ordered treatment was effectiveness, or the capacity of each local structure to provide health (or social) treatment to drug users, for whom it had been designed, as needed and until the process was completed. Thus, the effectiveness of treatment in itself was not evaluated, but rather the reality of its accessibility via the structure organized by the law. It was noted that efficiency did not only involve state prosecutors, but was determined all throughout the process from the arrest of the drug user to the "end of court-ordered treatment". Each of the individuals involved, the police services, judges, DDASS, and treatment structure, plays a part in determining the efficiency of court-ordered treatment throughout an activity of selection of drug users and its capacity to reduce the phenomenon of loss during the multiple movements of these users from one institution to another. By following through these steps, from both a qualitative and quantitative perspective, it appears that the continual reduction of potential candidates for court-ordered treatment throughout the process has resulted in three successive definitions of court-ordered treatment. These definitions are quantitatively different from each other and separate from official statistics: treatment ordered following the arrest of a drug user, and resulting from the interaction between public safety services and the prosecuting attorneys; court-ordered treatment as notified by prosecutors; court-ordered treatment that has been completed, which are considered to be effective orders.

Thus, in 1994, a reference year, only 1,266 (or 33%) of the total 3,848 treatments ordered by the 25departmental magistrate's courts that made up our sample were effective. Compared to the total number of court-ordered treatments "decided" (4,472), only 28% were effective, and compared to "notified" orders this percentage goes up to 41%. Using our sample of courts, there were an estimated 2,500 effective court-ordered treatments out of the 7,581 that were officially declared, while 45,178 drug users had been arrested.
At the same time, 15 of our 25 courts were found to be in local contexts where anti-drug strategies did not greatly favour an effective distribution of court-order treatment: largely oriented toward repressing trafficking and researching affairs, but not too concerned about arresting drug users, or being content with giving a simple warning after receiving a complaint without being summoned by the prosecutor.

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On a qualitative level, court-ordered treatment is presented as a system for which the level of effectiveness is determined by multiple variables. This system is marked by a nearly complete lack of integration. By this one must understand that because of the multiplicity of individuals involved, the diversity of their objectives and the sequential organization of the process, police, legal and health services tend to know little about each other or even contradict each other rather than work together. The poor understanding each of these individuals has of the whole process and its effects, accentuated by a minimal circulation of information, encourages them to satisfy their own objectives and professional stakes rather than to contribute in making court-ordered treatment effective. It turns out that the health objective often neutralizes the legal objective. In other words, the purpose of arresting drug users is not to provide health and social help through court-ordered treatment (or only on a random basis). In this, there are many sources of breakdown: strong opposition to court-ordered treatment (rare and limited to a few prosecuting attorneys), lack of belief that it works (frequent), or organization that is poorly adapted to the complexity of the structure (frequent).

As for the health objective that is the purpose of treatment, it is not very clear, or explicit, and is too dependent upon treatment structures that are within the perimeter of the court: rarely preventive, often openly non-curing, and more often than not palliative. Mostly, the health objective is already set instead of being established from an individual diagnosis in function with the substance used, level of addiction, socio-economic conditions, etc.

Discussion

With one-third of the court-ordered treatment being effective (or 5% of the total number of drug users arrested), the current organized structure has little real effect on the public problem of drug use. The Law Of 1970 has been weakened since the inefficiency of court-ordered treatment to achieve it intended health purpose may be added to the fact that incrimination of use is being contested: the definition of a drug user as a delinquent-sick individual in the Law Of 1970 actually ends up challenging the idea that they are sick, either because they were first judged to be delinquent, or because they were considered to be neither delinquent, nor sick.

To that end, making court-ordered treatment effective appears to be the condition for keeping drug use banned (arresting users can only be the means of reaching the final health objective). However, if improving the system of court-ordered treatment appears to be necessary, the question could be asked if it is still possible and under which conditions. An analysis of the facts leads us to propose that modifying the system is essential (once the priority of the health objective has been recognized and it has been adapted in function with the diagnosis of the drug user). The introduction of the objective and health agent should be made as early in the process as possible, that is to say when the decision has been made to notify that the court has ordered treatment. Thus, making court-ordered treatment effective could occur if the decision-making hegemony of police and legal forces was called into question through a balanced distribution of power with health authorities, a condition for integrating the two objectives: legal and health-related. Without such a conceptual change, along with the consequential organizational modifications, it appears that the end of court-ordered treatment has been programmed. This would then mean that the Law Of 1970 would be unfounded because it would no longer have an objective.

Methodological References

The adopted methodology, both qualitative and quantitative, aimed at taking into account, 1) the great diversity of distribution of court-ordered treatment noted amongst the various courts; 2) our hypothesis that there was a relationship between local police anti-drug strategies and the propensity of state prosecutors to use court-ordered treatment.

Four categories of courts/DDASS coupled together, were created using two variables drawn from official departmental data. The first represented police activity relating to the repression of use, and the second represented the distribution of court-ordered treatment to arrested users. Category A included ten courts that were characterized by a high prevalence of arrested users and a low ration of court-ordered treatment. Category B, included six courts that were marked by a high prevalence of arrested users along with a high ratio of court-ordered treatment. Category C included six courts with a low prevalence of arrested users and a high ratio of court-ordered treatment. Category D included three courts with a low prevalence for arrested users and a low ratio of court-ordered treatment.

"Decided" court-ordered treatment: with the exception of cases that are systematically referred to the public prosecutor's office, this decision is generally made while the arrested user is still at the police department and results in a consultation between police services and the public prosecutor (most often over the phone).

"Notified" court-ordered treatment: once the decision has been made to sentence court-ordered treatment, police services give the user a summons to come to the court (at which time he/she will be notified of the order by an assistant public prosecutor).

"Declared" court-ordered treatment: this regards the number of cases for which the court ordered treatment. It is provided by each court to the statistical department of the Ministry of Justice.

"Effective" court-ordered treatment: once the user has been notified of the order, he/she must get in contact with either the DDASS services, or, in some cases, directly with a specialised drug addiction treatment centre. After the individual has received the order, he/she generally must undergo treatment for a variable length of time (from one appointment to one year). The court-ordered treatment is considered to be effective if full treatment has been received.

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Drug Users Being Monitored by Probation Committees

** Laurence Simmat-Durand*

Amongst the different common law[119] obligations for treatment, we became interested in the one expressed by the court within the framework of deferred sentence with probation. This is quite commonly used for use-related convictions, yet is much less known than court-ordered treatment. This obligation for treatment presents characteristics that clearly differentiate it from court-ordered treatment. First, it is imposed at the end of the legal process within the framework of a conviction for any type of offence. This is unlike court-ordered treatment that may only be sentenced in cases involving use. Next, it is implemented by probation and assistance committees for the freed individuals (CPAL) with no intervention on the part of the Department of Health and Social Affairs (DDASS) as is the case for court-ordered treatment.

In this section we will compare a group of users subjected to mandatory treatment in the Parisian region and in the provinces.

All of the drug users treated within the framework of mandatory obligation to treatment were convicted for either a drug-related offence (use, holding-purchasing, supplying-providing, or trafficking), or for any other offence (in practice, theft or fraud). On average, the probation committee monitored them for over two and one-half years.

Group subject to mandatory treatment in the Parisian region

In the group treated in the Parisian region, the average profiles were differentiated by the main offence committed: users convicted in cases involving theft, holding or trafficking, are generally younger (average age 24) than those convicted for use alone (28 years). On average the latter began taking drugs six years before their conviction, a period of time that most likely has been underestimated. Their modal age for beginning drug use is 20 years. Those who only use drugs were convicted at a later age than those in the first category because their cases were successively closed with no follow-up or because of treatment measures to which users are first subjected.

Individuals in both categories (simple users and users having committed other types of crimes) are in very vulnerable situations, and a deferred sentence with probation seems to be a last resort in terms of social treatment. Legal action is thus a way of "managing" populations.

In cases involving theft, 82% of those treated had no job, most were single and non-independent, and only 36% had personal housing. Their average resources were 3,200 francs, which mostly came from the RMI or unemployment benefits. The observation of their experience shows a succession of steps, unstable contracts, and periods of unemployment. At the end of the road, once their rights had been used up, the RMI kicked in.

The situations of those convicted for a drug-related offence were even more vulnerable; the only resources available to 27% of them were the RMI or the AAH[120]. The latter allocation is provided in cases for which one's state of health is very poor and there is no hope of reintegration. Of 100 individuals whose health file is complete, 42 showed a serious pathology including 24 VIH infections, seven hepatitis infections and seven who were addicted to alcohol or medicine. An assessment of this jurisdiction (Parisian region) shows that the measure of mandatory treatment goes along with the results of a social and/or medical situation that has little chance of improving.

Group subject to mandatory treatment in the provinces

The provincial group is quite different, even if its small size is cause to be careful when making an analysis. In nearly all of the cases these measures were not sentenced for use alone, but for trafficking or holding-purchasing drugs. These offences, which are more serious, bring us back to the preceding case of a younger, exclusively masculine population (on average 24 years of age). On the other hand, their social situations contrast with those in the Parisian group: 41% are married and 32% have children. Revenues come a salaried activity or unemployment benefits. The RMI is rare, and the AAH does not exist. The state of health of this population is clearly less deteriorated (but they are also younger), and we observed that there was less health treatment already being provided before they arrived in the department.

In this provincial jurisdiction, the conception of probation appears to be completely different than in the Parisian region: it seems to be aimed at prevention and applies to young and relatively well-integrated individuals. It is not a last resort, but rather appears to be a step.

In conclusion, the measure of mandatory treatment within the framework of probation may be analyzed as a double sentence for this jurisdiction: it may be added to a prison sentence for more than one-half of those on probation, although one-half of these individuals had a clean record before this conviction. The rareness of this measure being used is most likely the consequence of a lack of adequate treatment structures within the considered department.

Methodological References

The results shown here, came from a survey conducted in two jurisdictions. Three groups of users were subjected to mandatory treatment. In the Parisian region, this was for a drug-related offence (239 cases) or for another offence (87 cases). Twenty-two cases were studied in the provinces. All available data sources were simultaneously used: legal file, DDASS file, office of legal order, probation file, and criminal record. Data gathered made it possible to reconstruct satisfactory biographies on the length of probation, and partial biographies for the previous years.

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[119] *Article L.132-45 alinéa 3 du nouveau Code pénal (New penal code).*

[120] *Handicapped adult allocation : for recognized invalids, a little more than the RMI; it has no modality for returning to work.*

Classification of Illicit Drug Users from the Point of View of Police Law Enforcement Activity

Hélène Martineau

An examination of statistics from the Ministry of the Interior shows that use-related arrests, and more particularly those relating to cannabis use, make up the majority of all drug-related offences. However, when looking into police practices, it appears that the categories used by these statistics-users, users-dealers, users according to age or substance-are insufficient when trying to understand the strategies implemented within the framework of the repression of drug use. A new classification of users that is more pertinent from the point of view of police services may be added to classifications in terms of substance or age.
Five categories appear, but it is not possible to calculate the share each represents out of all repressive action taken by public safety services:

The user - informer
This individual is not arrested (therefore is not the object of legal proceedings) but provides the police with information on how, when, and where dealers operate. The individual provides the necessary information to launch a case. He/she is not a regular informer, but a user that may or may not already be known to the police, that has been approached during rounds in an "are known for drug sales". These are called "routine controls."

The user-delinquent (non-drug-related crime)
This individual is either arrested for another crime (car theft, burglary, etc.) and his/her activity is noticed later, or the user is targeted by the police intervention and the facts reveal he/she is also involved in other non-ILS crimes. Most often these crimes will become the object of an incidental proceeding.

The user-delinquent contributes to creating a feeling of insecurity in a neighbourhood that results in active intervention on the part of public security forces to fight this delinquency. Moreover, the existence of non-ILS crimes may be used as a means of negotiation to obtain information on trafficking.

More generally speaking, because of the supposed relationship between drug addiction and delinquency, the people we spoke with indicated that the repression of drug use would lead to a reduction in delinquency and would thus become a "normal" mission for a police station in terms of public safety.

The user-witness
During a widespread police intervention, which after days of investigation targets the apprehension of drug trafficking individuals, a certain number of users are arrested and questioned before the dealer. Their testimony is useful in identifying the dealer. Thus, the user, who is a main source of information on the networks and vendors, may become a witness and proof in a case of drug trafficking.

A user arrested in a "narcotics operation" is therefore the object of proceedings that mainly serve to prop up the trafficking offence. In this case the repression of use is not directly targeted as the objective was clearly to "stop the dealing."

There is no doubt that this is the category of users most frequently mentioned by the police agents. It is an integral part of the dominant anti-trafficking strategy. Even though the user is not that important, he/she is the mainspring of this strategy.

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** ILS: Drug-related offence.

The simple user
This user may be apprehended after a "complaint" is received from a private individual. The objective is thus to respond to the emotion of public opinion. Nevertheless, as these interventions are judged to be ineffective in terms of fighting drugs, they are avoided as much as possible.

Some users are arrested during a traffic stop. More frequently, the user is arrested after an identity check, which is a necessary act that may eventually help in discovering narcotic substances on the apprehended individual..

In this case, proceedings are undertaken but the user is not necessarily kept in custody. He/she is detained at the police station for the hearing (maximum of four hours). Even though the arrest was not made within the framework of a "narcotics operation", the police often try to obtain information on dealers at the time of the hearing.

The user-dealer
The category of user-dealer is very difficult to define By definition these are individuals who use, but also sell drugs. If the latter may not be proved guilty or dealing, it is quite common to check if they hold a quantity of substances that are reserved for their private use.

On one hand, the distinction between simple user and user-dealer is based upon fairly subjective criteria, and often this raises the issue of thresholds over which a user may no longer be considered as a "simple" user. On the other hand, this distinction may be made after negotiation in function with information that the user may provide.

So, is the individual more of a user or a dealer? This is certainly the most contentious category, and even more so since the stakes are high; in the legal follow-up, only the user may benefit from court-ordered treatment and thus escape any legal proceedings if he/she undergoes treatment.

What emerges at the end of this survey, is that the user who is arrested during a "narcotics operation" is the only one that gets all of the attention of the police. The simple user does not interest them at all because he/she is rarely the object of legal proceedings, and treatment reserved for him/her is open to criticism on the part of the police agents we met. Therefore, those who spoke to us turned out to disagree with certain supporters of penalizing use, for whom arrest enables them to get in contact with the health and social system.

Methodological References

This study fits into broader research conducted within the framework of a convention with the CNRS (Health and Society Programme), under the direction of Laurence Simmat-Durand.

The survey was conducted in 1997 in two police stations in the Hauts-de-Seine region and on the level of the departmental specialized security brigade. The character of the study is largely exploratory, because it is currently very difficult to say to what measure the possible specificities of field in which the survey was conducted may have influenced the results.

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Prevention

Social Environment Committees

**R. Ballion*

The system

The system of Social Environment Committees (CES) was implemented in 1990 in schools, in order to organize prevention actions for students. The help of all individuals within the educational community was sought: professionals, students, families and social agents who all dealt directly with students in their environment.

This system is an expression of a two-fold development in prevention policy within the educational system. Previously the prevention process was characterized by the implementation of "health clubs" (1973). The process became clearer with the development of "relay adults" in 1983, and "relay-teams" (two years later), centred upon health problems and mainly the fight against drug addiction. This approach was based upon the implication of competent professionals who took this responsibility, with national educational health personnel in the lead. After this conception, which placed great importance on the medical approach and involved specialists, came another orientation that opened up to the difficulties experienced by young individuals (medical, social, or academic), and to adults that were sought out for this prevention action.

The objectives of this system were broadened in 1993. Larger missions were added to that of preventing drug addiction and risky behaviour. These included: "monitoring students within and outside of school" and "searching for solutions to health problems within the framework of global treatment of the difficulties encountered by young people" (circular letter, February 25, 1993). This process was confirmed in 1998 (circular letter from July, 1998) by the transformation of Social Environment Committees into Committees for Education about Health and Citizenship. Local National Education directors were asked to use a "voluntarist strategy" to generalize this system of prevention, whose mission was to unite everything that is done in favour of young people.

Implementation

The CESes were set up in secondary establishments. Occasionally primary schools were integrated into the framework of a CES that was commonly used by several establishments. In 1996-1997, only 28% of the secondary public establishments had a CES. Colleges (middle schools) represented 63% of all of these establishments (1,498 colleges). Professional lycées represented 16.3% (387 establishments) and general educational and technical lycées 20.7% (491 establishments). A total of 85.7% of the establishments that were classified as " sensitive " had a CES and 43% of the ZEP establishments.

A certain number of the "existing" CES do not truly exists, except on paper, or are "temporarily" not being used. Only 70% are actively functioning.

Upon being set up, the CES was mostly judged to be an organizational innovation, in spite of certain shortcomings for which a remedy should be found.

An interesting organisation

A high degree of satisfaction on the part of those responsible for the system.
Of these individuals, 79% do believe that the effects generated by the CESs are, "most satisfactory" (18%) and/or at least

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"satisfactory" (61%). Above all, the positive effects generated by the functioning of the CESs are based upon three points: changes in mentalities, changes in adult-student relations, and the development of participatory and responsible behaviour amongst students.

A flexible system whose shape fluctuates between two models.
The first model is one of a small group of individuals, part of an internal commission within the establishment, that establishes relationships with outside partners for the different actions conducted (40% of the CES use this model). The second, takes the shape of a large assembly that more or less sporadically unites the representatives of one or several establishments with outside partners (58% of the establishments). The functioning of the CES is optimised when the two forms are worked together (a large assembly from which there comes a pilot group and work committees (47% of the establishments).

A field of action that is more or less open.
The functioning of the CESs reveals the different levels that have marked the broadening of their field of action; from the limitation of only taking risky behaviour into account, to a global educational approach.

Establishments prefer considering their CES as:

A device implemented to take into account the prevention of risky behaviours (drug addiction, violence, suicide, etc.).	34 %
A system initiated to take every health and social problems of young people into account	31 %
A structure set up for facilitating a global educational support of the student.	35 %

Colleges and lycées that are more or less exposed to risk, are split into three groups according to their understanding of the seriousness of the difficulties face:

The establishments:

Develop, thanks to the creation of the CES, a reactive strategy in order to palliate the difficulties they are confronted with	30 %
Aim at preventing the expansion of problems, which would appear in the preceding group, in the absence of any measures to suppress them	25 %
Are clearly adopting a prevention attitude without being really confronted with difficulties.	46 %

A wide range of objectives.
There are four main objectives for action: dealing with problems related to sexuality (AIDS, STDs, pregnancy), violence between students, illicit drug use and tobacco addiction. Along with the prevention of risky behaviour(s), there are problems relating to difficult social situations and those relating to school. Thus, 62% of the establishments indicate that they take into account, through CES activities, problems of hygiene and malnutrition, 58% school-related problems, and 56% the question of absenteeism.

Limits and Insufficiencies

A partnership that could be improved.
The establishments have a fairly balanced opinion of the relations they have with exterior partners. On the whole, they consider that when these relations exist they are satisfactory with the exception of a minority, and that they have not become worse over time. Nevertheless, a small number of establishments express reserve about the quality of these relations. Moreover, nearly one-half of those surveyed, who are in charge of a CES, have a perception of the partnership that could be qualified as purely instrumental.

The establishments reckon "completely true" and "rather true" that:

Some partners of the establishment reluctantly consider the setting up of the CES for they think the latter seems to overlap onto their field of intervention	14 %
Some of them do not readily admit that the Nation Education could operate the running of this structure	17 %
Some of them have motivations that do not respond to the students' needs but to their own	24 %
The partners of the establishments are merely providing resources (services, lectures, etc.).	46 %

The trend of affirming the school's hegemony upon its environment, which does not facilitate the establishment of true collaborative relations, is encountered when the following question is asked. Which needs correspond to the objective of opening schools to the exterior ?:

The establishments answer:

Drawing from outside what is necessary for the school	67 %
Helping the school to manage what is globally done for the youth.	66 %

Difficulties and shortcomings.
For those in charge, there are four difficult main issues relating to the functioning of the system: an excessive number of tasks, a lack of availability, time constraints and weak mobilization amongst the adults in the establishments.

One of the largest shortcomings that our analysis revealed, concerns the participation of students. The system is set up to meet their needs, and their implication in the structure is essential, yet 40% of the CESs function without students.

It should also be noted that there are shortcomings involving the system's internal "visibility," since it is known that in 32% of the establishments the teachers know nothing about the Social Environment committee or the actions it undertakes. The situation is even less brilliant amongst students, since only 8% of the establishments believe that the large majority of their students know about the CES. This is the case even if 56% believe that students are aware of the actions undertaken by the CES, without associating them with it.

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- *La lutte contre la drogue à l'école et dans la cité. Toulouse - Université d'Eté. 1994.*
- *KARSENTY (M..), Étude sur les Comités d'environnement social, Paris, INRP, 1995.*

Methodological References

This study was conducted in 1996-1997. It included the following methods:

A qualitative survey of interviews of heads of establishments, nurses, social workers, school doctors, technical counsellors and chief educational officers. The establishments were chosen in such a way as to include the three types of secondary establishments: colleges, professional lycées, and general educational and technological lycées, and to make up a contrasting sample in function with the geographical situation of the establishment (city, suburb, rural) and descriptors (characteristics of the student population, Z.E.P establishments, classified as "sensitive," test results) that make it possible to constitute a socio-cultural and academic typology of the establishments.

A documentary study that was conducted by going through documents on Social Environment Committees provided by establishments, academic pilot groups, and the central.

A questionnaire survey sent to establishments, conducted in nine academies. The latter were selected in such a way as to constitute a sample of geographic zones that were representative of the differentiated development of Social Environment Committees. Five hundred establishments were surveyed, 287 responded (n= 287). Thus the rate of response was 57.4%.

Thus, the elements of understanding the functioning of the CESs have mainly been derived from the perceptions of agents involved in this system.

Local Policies as regards to Drug-Related Problems

Michel Joubert

It is possible to get some idea of the role of drug-related problems in local policies using research and information from several studies conducted from 1996 to 1998.

Administrative and political framework: a mission entrusted to towns that are directly confronted with drug-related problems

As is the case with many health-related problems, those involving drug addiction do not fall under the responsibilities handed down to local communities in the laws of decentralization. However, this does not prevent them from undertaking related actions. The fact that this was optional, along with the long-held feeling that such questions were the responsibility of the State, considering the uneasiness involved in recognising local incidence on politics, contributed to the fact that municipal commitments were extremely rare until the middle of the 1980s. The Law Of 1970 placed focus upon a treatment system and repressive action, and this was considered sufficient to cover all needs.

Several steps may be singled out in the integration of drug addiction-related questions into local policies. We come across traces of these steps today, considering the differences in the development of municipal commitment to this issue:

- The implementation of policies concerning public health, and the prevention of delinquency: to begin with, some cities placed drug addiction within the framework of redefining their public health policy (city-health network, experiences of the health community, implementation of prevention policies, and the promotion of health) or within contracts for prevention action undertaken in the CCPD.

- The triggering role of AIDS: At the end of 1985, state involvement in fighting AIDS corresponded to a new step, with incentive measures that played a part in mobilizing some municipalities until the first half of the 1990s. Many cities that had done nothing with the issue of drug addiction began working with structures working on AIDS, even if it meant integrating experiences in the area of drug addiction.

- The methodological role played by city policy: During this same period, city policy constituted a framework for "opening up" reflection and developing partnerships concerning drug-related problems by facilitating the implementation of networks, think tanks (involving different partners), and links between the different components of "risky behaviour."

- A movement that shifts in 1992: The DGS circular letter from March, 1992, that came on the heels of a national evaluation of the activities of treatment centres, lead to a "redefinition" of "treatment" centres. Involvement in prevention would remain marginal, with financing sought from local communities. The two-speared movement of the Law Of 1970 (treat-repress) came back to the forefront and was completed by a section on prevention that was sent back to the local communities and schools.

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An experimental field: the development of public policy networks.

At the junction of these three components of entering drug-related problems into local policies, new forms of professional cooperation would be tried. These would often short-circuit authorized structures (treatment centres) in order to construct preventive coalitions with the goal of understanding the phenomenon from a new perspective (the effects of social vulnerability, parallel economy, territorial approach, changes in risky behaviour and lifestyles, actions targeting the reduction of risks linked to intravenous injection).

Interactions, negotiations, alliances, prevention and harm reduction: Cities played a fairly important role in anchoring and legitimising harm reduction policies (movement linked to AIDS prevention). Whether they initiated, facilitated, or became completely involved, a certain number of these cities (including the three studied in the Seine-Saint-Denis area) would become areas in which drug addiction-related referents and representations would be readjusted such as: the establishment of Steribox® kit distributors, the action of syringe exchange teams, the opening of low threshold "boutiques" that would enable users to find their role in the city and have contact with counsellors; but also the implementation of health-related actions conducted amongst young individuals in different neighbourhoods and "counselling areas" implemented to link the population and local agents. New alliances were created, and use (taking suffering, social problems, and different logical perspectives on life into account) and the health and social risks that are involved with use, were approached in a different manner.

Stakes involving territorial coordination: this phase of opening up to new agents, introduced a situation in which the links between those involved had to be readjusted, particularly for the specialized treatment centres who had to be repositioned in the field of treatment and harm reduction (linking substitution with integration policies and local work, working with the associations and communal agents). Problems with coordination then became central: sharing territory, searching for complementary actions, and graduation between the different levels of prevention. Along with the "official" networks, other networks of individuals from different structures and institutions began to exist. They created cooperation that was focused on the public, whether for taking into account the first commitments in harm reduction, flexible treatment structures for active users affected by HIV or working in the field. Problems of coordination and implication also occurred on a departmental level with the commitment of the Seine-Saint-Denis Departmental Concil (creation of a Departmental mission for drug addiction prevention) that would contribute in developing bases for exchange and training local agents.

The strategic role of working in the field: This point is central; local policies constituted support for the development of work to be conducted as "closely as possible" to local individuals concerned with drug problems (whether for prevention or harm reduction) (Korf, Riper, 1998). This was a new direction for front line field action that has always had to work to prove its legitimacy (in the eyes of local elected officials such as the DDASS, the police, and other field workers present in neighbourhoods - prevention clubs, social workers).

Great heterogeneity: the main types of local policies

This trend, which is identifiable in a department, varies greatly from one town to the next, and is not the same in other large French cities either. A study conducted by the RESSCOM (Joubert, Bertolotto, 1998) shows that there are several major directions:

- A position that focuses on primary prevention: These cities have not taken into account the situation created by the development of ADIS amongst intravenous drug users as much as others. This may be because the local presence of this problem is considered to be weak, or the towns think that this issue does not fall within their area of competency. Primary prevention actions (interventions in schools, general information) associated with support for treatment centres constitute the basis of local policy.

- Integration within a dynamic of public health: This targets integrating AIDS and drug addiction problems within a more global strategy of understanding risks in the health field. The approach to the use of licit and illicit substances that was chosen, often tries to articulate the coordination of agents (networks), treatment (support for treatment units), and training, with primary prevention actions centring upon health information. There is strong action around alcoholism, which is presented as a public health priority falling under the field of drug addiction. Linking this with city policy is stronger here than elsewhere. The networks give a lot of room to associations (AIDS, harm reduction, prevention). This policy is directed at the entire population, but also to the health and social professionals that have to be trained on the public health process. Over 80% of the cities state that they work to train agents and relay individuals for the prevention of drug addiction, as well as to develop links between the various agents and specialized professionals.

- Local harm reduction strategies: This approach comes from the explicit mobilization toward the most vulnerable individuals, both concerning AIDS and drug addiction. For a long time, the "injectors" were in the line of fire, as they are more particularly exposed to HIV and HCV infection. The approach remains oriented toward "public health," in the sense that there is question of implementing policy aimed at protecting this population from the particular health risks related to injection. The "hybrid AIDS-drug addiction" approach (Lovell, Féroni, 1998) presupposes that there is a minimal political framework and partners in the field, (associative type partners). It is based upon two main methods (Bach, 1994):

- The development of systems that make it possible to ensure the supply of sterile syringes to users (i.e. network of pharmacists that sell Stéribox® kits, syringe exchange programmes run by teams working on the street that use mobile structures, automatic distributors ensuing that used syringes are collected).

- The implementation of a policy of substitution that is aimed at ensuring the stabilization of the drug user's situation. This is done by transitioning to a substitute substance for heroin (centres or units in which methadone is prescribed, work with doctors for the prescription of Subutex®) that may result in stopping the use of injection and preventing marginalization (individuals recover their capacity to take steps, quite illicit activities).

These systems, which are a matter of state commitment through the DDASS, could only be implemented in a coherent and efficient manner when the city networks of those working in the field (associations, networks that integrated neighbourhood doctors, treatment centres) were willing and enthusiastic participants.

- Emphasis placed upon social cohesion and security: This direction comes back to making the choice of addressing these issues on the level of already existing prevention and treatment structures. Social cohesion is understood as the capacity of agents from the cities to act in all areas: education, prevention of delinquency, general and health-related information. It meets some resistance to a direction that might be too much on the side of harm reduction, even if support for this may sometimes be implemented. Phenomena are considered to be the symptom of global dysfunction that comes to destabilize local equilibrium. The legitimacy of intervention thus fits into a field that is broader than just the health field, which integrates a social aspect (solidarity, social treatment for marginalized drug users) and a security aspect (link established with the prevention of delinquency).

-Community type orientation: This type of orientation presupposes that the emphasis be mainly placed upon the mobilisation and participation of the inhabitants, the training and commitment of "relay" individuals, the necessity of helping the population (rights, access to treatment, harm reduction) and the existence of local resources (competent health agents, associations, treatment centres that wish to be partners). This combines several actions: work at providing information to at-risk populations through field work (prevention relay individuals working in the neighbourhoods, counselling areas initiated by inhabitants), and creating strong mobilisation around treatment for individuals with AIDS (access to treatment, networks, help for families, integration). Although we find all the levels of prevention, the common point that is stated is the community process with a desire to achieve development of local solidarity toward affected individuals.

Methodological References

Research conducted for the Minister of Research (M. Joubert and Villes et toxicomanies, 1998) was conducted over a three-year period in the Seine-Saint-Denis Departmental in the Parisian suburbs. The situation and evolution of territorial policies were analysed on a departmental level (strategies used on the level of the DDASS, specialised treatment services and the General Council) and a city level (three committed cities were the object of considerable research). Most of those involved were surveyed, data on activity was gathered, and changes in positions were monitored through time. The survey conducted for the city of Marseille (M. Joubert and "Les municipalités face au Sida et aux toxicomanies") was based upon a survey by questionnaire conducted in cities with over 50,000 inhabitants (54 respondents - nearly one-half) and a qualitative study undertaken in six cities.

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Annex

Abuse, Harmful Use and Addiction, Definitions (CIM10, DSMIV)

Abuse of a psychoactive substance (DSMIV)

A - Unsuitable mode of use of a substance that leads to a change in functioning or significant clinical suffering, characterized by the presence of at least one of the following symptoms over a period of 12 months:

1 - Repeated use of a substance, leading to incapacity to fulfil one's major obligations at work, school, or home (for example: repeated absences or poor performance at work due to the use of the substance, absences, temporary or definite suspension from school, neglect of children or household tasks).

2 - Repeated use of a substance in situations where that may be dangerous (for example: while driving an automobile or working with a machine while under the influence of the substance).

3 - Repeated legal problems linked to the use of a substance (for example: arrests for abnormal behaviour relating to the use of the substance).

4 - Use of the substance in spite of persistent or recurrent interpersonal or social problems, caused or exacerbated by the effects of the substance (for example: arguments with a spouse because of the effects of the substance, fights).

B - For this class of substances, the symptoms never reached the criteria of addiction to a substance.

Use that is harmful to health (CIM10)

Mode of use of a psychoactive substance that may be harmful to one's health. Complications may be physical or psychological.

Diagnosis is based upon clear proof of use of one or several substances that brought on psychological or physical problems. This type of use often gives rise to criticism and negative social consequences. However, the disapproval of others, or the cultural environment and the negative social consequences, are insufficient to make the diagnosis. This diagnosis is not made when the subject presents a syndrome of addiction and specific problems linked to the use of alcohol or other psychoactive substances..

The abuse of a psychoactive substance is characterized by use that gives rise to harm in the somatic, psychoaffective or social fields, but this definition does not refer to the licit or illicit character of the substances.

DSMIV Addiction (1994)

Inappropriate use of a substance, that causes distress or significant clinical malfunctioning. This may be shown in three (or more) of the following symptoms that could occur at any point in time during the same 12-month period:

1- Tolerance, defined by one or other of the following symptoms:
- a. need for a clearly superior quantity of the substance, to reach intoxication or obtain the desired effect;
- b. a clearly decreased effect for continued use of the same amount of the substance.

2 - Detoxification, as shown by one or another of the following substances:
- a. characteristic withdrawal symptoms for the substance;
- b. the same substance (or a related substance) is taken in order to calm or avoid withdrawal symptoms.

3 - Individual takes a superior quantity of a substance more often, or over a longer lapse of time than intended.

4 - Persistent desire or unfruitful attempts to reduce or control use of the substance.

5 - Considerable amount of time spent to procure, use or get the effects of the substance.

6 - Important social or occupational activities abandoned or reduced due to use of the substance.

7 - Continual use of a substance in spite of knowledge of the existence of a persistent or recurring physical or psychological problem determined or exacerbated by the substance.

Clarify:
With physical addiction: signs of tolerance or withdrawal (item 1 or 2 present).
Without physical addiction: no signs of tolerance or withdrawal (items 1 and 2 absent).¤

Summary of the Report by Professor PARQUET

In accordance with the terms and conditions of the scientific committee that is overseen by Professor Parquet, as established by Mrs. Élisabeth Hubert, Minister of Public Health and Health Insurance on October 5, 1995, Professor Parquet's report is a helpful tool for the benefit of decision makers and those working in the field. It provides a conceptual framework for the prevention of behaviour relating to the use of all psychoactive substances. Several factor justify this approach.

Basis for common reflection

For a long period of time, the organization of prevention was based upon a broad outline that associated classic behaviours for each substance (example: alcohol and alcoholism). Thus, there were specific messages for each of the substances. However, underscoring the fact that there are similarities in the neurobiological mechanisms and clinical characteristics of behaviour in the different situations involving addiction to the various psychoactive substances, led the scientific community to refocus the problem of addiction on substance use behaviour and not the substances themselves. This approach targets the individual and the harm of which he/she might be in danger, or to which he/she is subject. It provides internal consistency for prevention messages that then fit into a more global policy of promoting health. It provides the basis for common, trans-sectorial reflection since it "promotes the idea of observing, analyzing, and studying observable phenomena that are easy for the different professional bodies concerned to access and define".

The behavioural approach leads to a distinction between use, abuse, harmful use and addiction. These notions have already been introduced by international referential classifications: the DSM IV (1994) the CIM 10 (1992) of the World Health Organization. These definitions underscore the psychopathological and behavioural dimension of a break with the subject's usual behaviour. The DSM IV expresses the fact that addiction to psychoactive substances is not always determined by physical addiction: psychological addiction has also been observed. It accounts for the temporality of substance use behaviours amongst the subjects (of their development over time).

Professor Parquet's report includes a critical analysis of scientific knowledge and foundations developed by the French and international professional and scientific community. The main and secondary objectives of prevention are re-mentioned in the report, as well as the two types of theories underlying primary prevention measures: developmental theories (based on the development and functioning of the personality) and theories that are based upon the psychoaffective and social process. A certain number of recommendations may be drawn from this analysis.

Prevention strategies

Professor Henrion showed the necessity of linking specific prevention (or thematic) - to deal with the various types of use and populations facing the problem with their own determining factors, and general prevention- as it would be a good idea to consider that using psychoactive substances may be risky behaviour. However, it is important to avoid breaking up the diversity of prevention actions that are undertaken - which has been favoured by using the approach to substances, amongst others - in order to facilitate the integration and suitability of messages for individuals who are in highly vulnerable situations.
Thus, the primary prevention strategy would be to characterize prevention in terms of a programme. The idea is to establish diversified objectives that are adapted to the needs of specific populations, in order to have an influence on the processes and factors involved in health (protection, risks). Planning allows for these objectives to be expressed in an operational manner (which behaviour(s) or behavioural factors need to be modified?) and to explain the underlying theories and methods necessary to carry them out. Thus, specific objectives would be linked in order to fulfil the general objectives of the prevention process, or in other words:

- prevent the initialization of use;
- develop the individual's capacity to manage his/her use with the littlest risk possible;
- to prevent use from developing into addiction (physical or psychological).

There is insufficient information on risks alone, but this remains the first, essential step.
The specific condition necessary for implementing coherent policy is that there be parallel development of a regular and long-term financial framework for it, that rises to the level of (the objectives and) the stakes that have been brought forward.

The French health system must no longer be centred around the notion of illness, but on the notion of health and its related factors. This idea favours increasing prevention to a broader approach, promoting health and therefore health education. Professor Parquet even speaks of promoting human dignity, because integrating the education of citizenship seems to fit into this dynamic. Indeed, the "compliance of individuals to organize their lives in function with the rules and laws enacted by society favours the preventive character of the legal prohibition of using psychoactive substance". The convergence of initiatives and principles that have been adopted within the areas of health and social action seems to be necessary within this framework, because it harmonizes the principles of prevention with those underlying treatment and rehabilitation. It complies with the consistency of legislative and regulatory laws that favour an agonistic effect - which is non-contradictory at least - for measures pertaining to the fight against trafficking, supplying drugs, and actions aimed at reducing demand.

Moreover, any responses developed must make it possible to adapt the phenomenon of "drug" use, and the determinant factors and value systems of the various individuals involved, to the changing character of the phenomenon: administrative and political authorities, those working with drug addiction or prevention, society and communities. This makes it essential to evaluate any actions undertaken. Indeed, within the framework of an explicit, coherent health policy, evaluation makes it possible to identify pertinent public and private initiatives in relation to the phenomenon in given areas or moments in time. Evaluating actions makes it possible to strive toward finding complementarity in the efforts that are being made. The appropriateness of preventive responses to the reality of the "drug" phenomenon also makes it necessary for a critical analysis of the existing data and measures to be made, thanks to the studies following from the perennial sources of information (OFDT, INSERM, HCSP, CNRS, INSEE, etc.), and be distributed by the MILDT. On this basis, an annual report, endorsed by the government, should be available to those working in the area of prevention and drug addiction, to the media and general public. This report would provide these individuals with a referential document upon which they could found their choices of how to contribute to community health action.

It is necessary to develop a common culture that allows to initially harmonise terminologies (the terms of use, harmful use, abuse or addiction being recommended given their less stigmatizing character and the clear criteria to which they refer). This culture would also favour the appropriateness of any discourse concerning drugs as supported by the public authorities, specialists, the media, or the different social communities that use or do not use psychoactive substances, with the reality of the phenomenon.

Training for those working in the field of prevention

Prevention agents are those who, because of their professional job, their initial professional training or social character (such as the family), may be "confronted" with users or psychoactive substance use behaviour. However, being involved in prevention requires a certain amount of knowledge short of the legitimacy induced by the good will of the subjects or their status. The scope of activities of those working in the field of prevention first lies in their personal capacity to figure out the specificity of needs and problems, and to communicate adapted responses while encouraging subjects to

participate and take responsibility for their actions. It is essential that these agents know how to distance themselves from their own involvement, value systems and representations, in order to ensure their role in accordance with the ethical principles of respect and solidarity toward others. At the same time, certain knowledge (of how the problem might be expressed and potential responses) is also essential. This knowledge is based upon the characteristics of supply, the different types of use, the substances and psychosocial and epidemiological elements of the personality of drug users. Obviously, it is also necessary to have knowledge of the principles and methods of public health, or prevention methods.

Summary of the Report by Professor ROQUES

Objectives and Methods

Review the short and long-term effects of licit and illicit substances, particularly on the central nervous system. Current knowledge of the neurobiological bases have been analyzed, as well as work undertaken to look into any possible biological and genetic predispositions to compulsive behaviour and on a psychiatric level, the relationship with other pathologies of the same type. Individual and collective danger was examined with the use of statistical assessments of prevalence, morbidity, and the co morbidity of the substances.

Conclusions

The use of all drugs leads to the stimulation of the dopamenergic mesocortical llimbic path, which plays a major role in the system of reward. This is not specific to drugs, and there is no direct correlation between releasing dopamine into the limbic system and the risk of addiction, or even the intensity of the reward. It's the faculty of establishing a state of hypersensibility of the dopaminergic system that characterises "hard drugs". This hypothesis has not been perfectly established, and its molecular mechanism is still unknown.

A biochemical predisposition to abusive behaviour would be created during the initial contacts an individual may have with the drug. At this stage, two parameters would play an essential role: genetic inheritance and the socio-cultural and emotional context. This would explain why all individuals do not present the same degree of vulnerability and it is the unfavourable conjunction of these two parameters that would facilitate the "possible drift" toward addiction.

Repeated stress during the creation of networks of neurons and the constitution of the personality most certainly play an important role in vulnerability. This is why a conflictual family and socio-cultural environment during childhood is a particularly high factor in the risk of addiction.

Results of the comparative study on the dangers of drugs (see chart):

Psychological addiction, evaluated by the length of after-imagery, being "drawn" to a substance, and by the approximate evaluation of relapse, emerges with heroin, tobacco and alcohol. Social danger includes behaviours that may lead to very aggressive, uncontrolled actions induced by the substance. It may also include disorderly behaviour that is risky for the individual or others that occurs while trying to obtain the substance. Thus, heroine, cocaine, and alcohol are placed in a group that represents high danger. In order to evaluate general toxicity, the number of users must be taken into account. Heroin, alcohol, and tobacco are part of the group that represents a high level of general toxicity.
Therefore, none of these substances is without danger. All may cause a feeling of pleasure, though tobacco does so at a clearly smaller degree. All of these substances may cause psychological addiction. However, three groups may be defined if the goal is to compare levels of danger: the first includes heroin (and opiates), cocaine and alcohol; the second includes psychostimulants, hallocinogenics, tobacco, and benzodiazapines, and the third includes cannabis. These groupings are subject to modification if new results are discovered.

Recommandations

Recommendations relating to the Conclusions

Studies and research need to be developed in the following areas: genetics, neuroendocrinology, molecular biology, biochemistry and neuro-imagery. This must be done in order to understand the mechanisms of predisposition, factors of vulnerability, types of action, the mechanisms of long-term addiction and general related danger.

Evaluate the danger of ecstasy and its related derivatives.

Whenever a medicine acting in the central nervous system should be developed, conduct a preliminary study of its possible toxicomanogenic use.

General Recommendations

- Watch the development of potentially addictive substances and new drugs more closely, and centralise this information.
- Set up clinical studies of the drugs.
- Initiate specialized drug addiction teaching programmes.
- Extend substitute treatment.
- Improve the system that gathers statistical data on drug addiction.

Drugs dangerousness factors(refers to page 182 of Pr Roques report)

	Heroin (opiates)	Cocaine	MDMA	Psycho-stimulants	fstrong Alcohol strong	Benzodiaze pines	Cannabis	Tobacco
Physical addiction	very strong	weak	weak	weak	very strong	medium	weak	strong
Psychological addiction	very strong	strong but intermittent	?	medium	very strong	strong	weak	very strong
Neuro-toxicity	weak	strong	very strong (?)	strong	strong	0	0	0
General toxicity	strong a/	strong	possibly strong	strong	strong	weak	weak	very strong
Social danger	very strong	very strong	weak(?)	weak (possible exceptions)	strong	weak b/	weak	(cancer)
Existing substitute treatment / other	yes	yes	no	no	yes	not researched	not researched	0 yes

a/ no toxicity for the methadone and the morphine therapeutically used
b/ except for car driving and use while researche trials of «submission» and «auto-submission» when their harmfullness then becomes very high.

INSERM's Collective Expert's Report on Ecstasy

The INSERM took the initiative to conduct a collective expert's report on ecstasy. A multidisciplinary ad hoc group made up of researchers and clinicians in the fields of toxicology, pharmacology, neurology, psychiatry, epidemiology and sociology, was created in 1997.

The conclusions of this report were made public in June, 1998. The first section provides an analysis of international scientific, biological, and clinical data on ecstasy (MDMA). The second section is mainly devoted to analyzing the French contextual use of this substance.

The analysis of data from international scientific literature enabled the group of experts to shed light on three serious consequences of ecstasy use due to the pharmacological properties of the MDMA molecule that is the main compound of ecstasy:

The possible, although exceptional occurrence of a syndrome most often associating hypothermia the first time the substance is taken or after it has been taken several times. This could lead to death in spite of appropriate medical attention.

The appearance of psychiatric complications within a short or long period of time after taking ecstasy. In these cases it would be difficult to say whether they have been induced alone or appear because of the use of ecstasy.

The revelation of neurological lesions in primates that have been given doses of MDMA similar to those habitually taken. These may remain infra-clinical for a long period of time.

These pharmacological properties make MDMA a toxic substance independent of any abuse. The experts agree that it is extremely important to provide information on the toxicity of this substance. This is all the more important as some individuals believe that only the other compounds that may be present in the pills are toxic. For this reason, they propose that extemporaneous testing be conducted in areas where this substance is taken. Yet, this practice could create a false sense of security amongst users.

The group of experts used their analysis of international data and the French context for ecstasy use to formulate three series of recommendations relating to the distribution of information and prevention, to the creation of observational structures, and to the development of research.

INFORMATION ET PREVENTION

Inform the users of ecstasy about the intrinsic short and long-term dangers of MDMA and the aggravating factors linked to the conditions of its use;

Help those in the medical profession to recognise the somatic and psychiatric symptoms of MDMA intoxication;

Draw the attention of individuals involved in prevention to the specificity of the substance and how it is used.

CREATE OBSERVATIONAL STRUCTURES

- Set up a system to gather data on mortality and morbidity linked to the use of MDMA.
- Set up surveillance of chronic users to evaluate cognitive problems.
- Establish a structure for analyzing medical files to research the biological and genetic bases for individual susceptibility.

Broaden the systems that observe the use of new drugs such as ecstasy.

DEVELOP RESEARCH

- Promote studies on the degeneration of serotoninergics and its possible implication in the appearance of cognitive problems.
- Continue studies on the toxicomanogenic properties of MDMA in animals, in order to determine whether or not addiction to this substance exists;
- Standardize identification and dosage protocols for MDMA and its metabolites;
- Promote epidemiological studies to understand the scope of ecstasy use in France;
- Develop research in social sciences on use, trafficking, and public policy concerning synthetic drugs and the use of ecstasy in particular.

Repression of Drug-Related Offences in France

Repression - The Offences

MILDT-MILAD

Texts	Incrimination	Sanctions
Public health code L.628	- illicit drug use	- 1 year imprisonment - 25 000 francs fine
Public health code L.630	- provoking a crime provided for in article L.628 of the Public Health Code or an offense provided for in articles 222.34 to 222.39 of the penal code even if this provocation had no effects - showing these offenses in a more pronusing light - provoking (with or without effects) the use of substances shown as having the same effects as drugs	- 5 years imprisonment - 500 000 francs fine
New penal code Art 222-39 1st paragraph	- supplying or seeling for personal use	- 5 years imprisonment - 500 000 francs fine
Art 222-39 2nd paragraph	- supplying or selling to minors in schools or administration premises	- aggravating circumstances 10 years imprisonment
New penal code Art 227-18 1st paragraph	- inciting a minor to take drugs	- 5 years imprisonment - 700 000 francs fine
New penal code Art 227-18 2nd paragraph	- agravating circumstances : minors under 15 years old	- 7 years imprisomnent - 1 000 000 francs fine
New penal code Art 227-18-1 1st paragraph	- inciting a minor to traffick drugs (transporting, supplying, selling)	- 7 years imprisomnent - 1 000 000 francs fine
New penal code Art 222-18-1 2nd paragraph	- aggravating circumstances : minors under 15 years old	- 10 years imprisonment - 2 000 000 francs fine
New penal code Art 222-37 1st paragraph	- illicit drug transporting, holding, supplying, selling, purchasing, using	- 10 years imprisonment - 50 000 000 francs fine
Art 222-37 2nd paragraph	- facilitating drug use (false prescription, or complicity)	
Art 222-36 1st paragraph	- importing or exporting illicit drugs	
New penal code Art 222-39-1	- impossibility to justify one's ressources in relation with his way of living while being in touch with somebody trafficking or taking drugs	- 5 years imprisonment - 500 000 francs fine
Art 222-39-1 2nd paragraph	- aggravating circumstances : minors	- 10 years imprisonment - 50 000 francs fine
New penal code Art 324-1	- money laundering (whatever the offenses)	- 5 years imprisonment - 2 500 000 francs fine
New penal code Art 324-2	- laundering aggravated : 1- usually committed or committed in the exercice of his duties 2- committed by an organized group	- 10 years imprisonment - 5 0 000 francs fine
New penal code Art 222-38 1st paragraph	- money laundering from drugs trafficking (importation, purchasing, selling, transportation, supplying)	- 10 years imprisonment - 5 000 000 francs fine

NB. The attempt of offences provided for in articles 222-36 to 222-39 is punishable by the same sentences

Repression - The crimes

MILDT-MILAD

Texts	Incrimination	Sanctions
New penal code	- illicit drug production or fabrication	- 20 years imprisonment
Art 222-35 1st paragraph Art 222-35 2nd paragraph	- crimes committed by an organized group	- 50 000 000 francs fine - up to 30 years imprisonment
New penal group Art 222-36 2nd paragraph	- illicit drug importing or exporting by an organized group - running or organizing a group whose goal is illicit drug	- 30 years imprisonment - 50 000 000 francs fine
New penal code Art 222-34	production, fabrication, importation, exportation, transportation, holding, supplying, selling, purchasing or using	- life imprisonment - 50 000 000 francs fine
New penal code Art 222-38 2nd paragraph	- money laundering from crimes cited in the below mentioned article (222-34, 222-35, 222-36 2nd paragraph	- from 20 years to life imprisonment - 50 000 000 francs fine

Additional setences can be applied, such as denying access to specific places on the French territory, suspension of the convict's civic rights, etc..

ACRONYMS

AFLS: Association française de lutte contre le Sida (French Association for the Fight Against AIDS)
BEH: Bulletin épidémiologique hebdomadaire (Weekly Epidemiological Bulletin)
BEP: Brevet d'études professionnelles (Certificate of Professional Studies)
CAGE: Cut Annoyed Guilty Eyes-openner
CAP: Certificat d'aptitude professionnelle (Certificate of Professional Aptitude)
CESDIP: Centre de recherches sociales sur le droit et les institutions pénales (Centre for Social Research on Law and Legal Institutions)
CESES: Centre européen pour la surveillance épidémiologique du Sida (European Centre for the Epidemiological Monitoring of AIDS)
CFES: Comité français d'éducation pour la santé (French Centre for Health Education)
CHRS: Centre d'hébergement et de réadaptation sociale (Centre for Housing and Social Readjustment)
CIRED: Centre international de recherche sur l'environnement et le développement (International Research Centre on the Environment and Development)
CJN: Casier judiciaire national (National Police Record)
CRIPS: Centre régional d'information et de prévention du Sida (Regional Information and Prevention Centre for AIDS)
DACG: Direction des affaires criminelles et des grâces (Department of Criminal Affairs and Pardons)
DAS: Direction de l'action sociale (Department of Social Services)
DCSSA: Direction centrale du service de santé des armées (Central Management for the Military Health Department)
DDASS: Direction départementale de l'action sanitaire et sociale (Departmental Management for Health and Social Action)
DETA: Diminuer entourage trop alcool
DGLDT: Délégation générale à la lutte contre la drogue et la toxicomanie (General Delegation for the Fight Against Drugs and Drug Addiction)
DGS: Direction générale de la santé (General Health Department)
DIS: Drogues info services(service national d'informations téléphoniques) (National Telephone Helpline)
EVAL: Bureau d'études évaluation médicale, médico-sociale, santé publique (Office for Medical Evaluation, Medico-Social and Public Health Studies)
GAFI: Groupe d'action financière international (International Financial Action Group)
GDR PPS: Groupement de recherche " Psychotropes Politique et Sociétés " (Psychotropic Drugs, Policies, and Society Research Group)
GRASS: Groupe de recherche et d'analyse du social et de la sociabilité (Research and Analysis Group for Social Issues and Sociability)
IHE: Institut de l'hygiène et de l'épidémiologie (Hygiene and Epidemiology Institute)
ILS: Infraction à la législation sur les stupéfiants (Drug-related Offense)
INRA: Institut national de la recherche agronomique (National Institute for Agronomic Research)
INSEE: Institut national des statistiques et des études économiques (National Institute for Statistics and Economic Studies)
INSERM: Institut national de la santé et de la recherche médicale (National Institute for Health and Medical Research)
IREP: Institut de recherche en épidémiologie de la pharmacodépendance (Research Institute for Drug Addiction Epidemiology)
MILDT: Mission interministérielle de lutte contre la drogue et la toxicomanie (Interministerial Mission for the Fight Against Drugs and Drug Addiction)
OCRGDF: Office central de la répression de la grande délinquance financière (Central Office for the Repression of Grand Financial Delinquency)
OCRTIS: Office central pour la répression du trafic illicite de stupéfiants (Central Office for the Repression of Drug-related Offenses)
OFDT: Observatoire français des drogues et des toxicomanies (French Observatory of Drugs and Drug Addiction)
OMS: Organisation mondiale de la santé (World Health Organization)
ORS: Observatoire régional de la santé (Regional Health Observatory)
ORSIF: Observatoire régional de la santé d'Ile-de-France (Regional Health Observatory of Ile-de-France)
PACA: Provence-Alpes-Côte d'Azur
PNUCID: Programme des Nations unies pour le contrôle international des drogues (United Nations Programme for International Drug Control)
RMI: Revenu minimum d'insertion (minimum benefits paid to those with no other source of income)
RNSP: Réseau national de la santé publique (National Public Health Network)
SCERI (FND): Service de la communication, des études et des relations internationales (Fichier National des Détenus) (Division- Communications, Studies, and International Relations (National Prisoner Database)
SED: Sous-direction des la statistique, des études et de la documentation (Sub-division - Statistics, Studies and Documentation)
SEDAP: Société d'entraide et d'action psychologique (Society for Help and Psychological Action)
SESI: Service des statistiques, des études et des systèmes d'information (Department of Statistics, Studies and Information Systems)
SMPR: Service médico-psychologique régional (Regional Medico-Psychological Service)
SOFRES: Société française d'enquêtes par sondages (French Survey Company)
TRACFIN: Traitement du renseignement et action contre les circuits financiers clandestins (Processing of Information and Action Against Clandestine Financial Circuits)
UDVI: Usager de drogues par voie intraveineuse (Intravenous Drug User)
VHC: Virus de l'Hépatite C (Hepatitis C Virus, HCV)
VIH: Virus de l'Immuno déficience Humaine (Human immunodeficiency virus,HIV)

OBSERVATION SHEET

Your feedback on this report will help us to further develop this work..

Please fill out this sheet with any criticism, remarks, or suggestions and return it to us.

- Remark(s) on the topics covered, the basic report, or methodology used:

- Suggestion(s)

- Other observation(s)

To be returned to:

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