OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

2007 NATIONAL REPORT (2006 data) TO THE EMCDDA by the Reitox National Focal Point

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

ENGLISH VERSION

REITOX

Contributions to the report.

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CONTENTS.

SUMMARY

In France, the year 2006 saw the adoption of an Addiction Plan by the General Health Authority (Direction Générale de la Santé or "DGS") and the Directorate of Hospitals and Patient Care (Direction des Hôpitaux et d'Organisation des Soins or "DHOS"). Six major themes concerning the provision of health care for drug users were established for the period 2007-2011 (part 1). The previous government also adopted the law dated 5 March 2007 concerning the prevention of delinquency, one of the key points of which particularly concerned drug use[1]. The memorandum officially establishing "therapeutic communities" was published in October 2006. On 29 August 2007, a new president was appointed to head the Interministerial Mission for the Fight against Drugs and Drug Addiction (*Mission Interministérielle de Lutte contre les Drogues et la Toxicomanie or "MILDT"*).

No new results have been published concerning surveys carried out among the general population. The end of 2006 and the first half of 2007 were devoted to the processing of existing data on a regional basis (ESCAPAD 2005), the launch of ESPAD 2007 (for which the data analysis is currently underway) and the preparation of ESCAPAD 2008. The CAST (*CAnnabis Screening Test*) was the subject of a psychometric assessment, the results of which are expected during 2008. A presentation was provided of the Quanti-festif survey carried out by C. Reynaud-Maurupt in the "techno/party" environment, financed by the OFDT (please see part 2: "Specific groups")

In mid 2007, "Cannabis Données Essentielles" was published (*Cannabis: Key Data*), the first complete monograph exclusively devoted to the leading illegal substance consumed in France. In addition to usage levels, a diverse range of themes are examined including regular and problem use of this substance, THC concentration levels, estimated market data (clients, resellers, turnover, etc.) in addition to public perceptions and responses. The report can be downloaded at the following address:
http://www.ofdt.fr/BDD/publications/docs/cdecomp.pdf

Where prevention is concerned, the ReLION scheme has submitted its initial results (part 3). The analysis of the RECAP data concerning requests for treatment supplied its initial results in 2006. These were updated during the second half of 2007. This data further adds to the information obtained from the low threshold structures (part 4).

High dose buprenorphine accounts for 80% of all substitution treatments prescribed in France. This medicine is also the subject of misuse, an estimation of which is presented (part 5). Over and above the quantitative aspects, we should also note the appearance of a new type of trafficking, which appears to be better organised and focused on the countries of Northern and Eastern Europe.

For the first time ever, the Central Office for the Repression of Narcotics Trafficking (Office Central de Répression du Trafic Illicite de Stupéfiants or "OCRTIS") has not published detailed information concerning overdose deaths recorded in 2006. For its part, the DRAMES data has not been published at all. On the other hand, the CépiDc-INSERM has updated its data, which is reliable but available only up until 2005. A comparison of the three information sources is presented (part 6), which reveals two interesting aspects: the under-recording of overdoses by the OCRTIS and DRAMES, and the continued existence of a lower level of overdose deaths in France than those seen in neighbouring countries. Comorbidities related to drug use are once again covered by several information sources.

[1] http://www.drogues.gouv.fr/IMG/pdf/mise_en_page_5_web.pdf

The report includes a presentation of the results from the Coquelicot survey, the PRELUD survey in addition to RECAP data.

Sentences for narcotic offences are continuing their upward trend according to data supplied by the Ministry of Justice, with an increased number of sentences issued for drug use and drug consumption in 2005 (part 8). Further "upstream", the data supplied by the OCRTIS shows a slight reduction in the number of arrests for narcotics use and trafficking in 2006. Cannabis is by far the most prevalent substance.

Concerning the prevention of crimes related to drug use, the only new point is the announcement of future saliva tests to be applied to vehicle drivers. Trials are currently underway (part 9)

Overall, seizures of illegal psychoactive substances in 2006 were lower than those seen in previous years. However, this reduction hides a number of disparities including a reduction in cannabis and crack seizures, and an increase in cocaine and heroin seizures. The retail price of cocaine has nevertheless continued falling, reaching a historically low price in 2006 (part 10).

Summary of *Selected Issues*.

Public expenditure
Drug use entails a cost which goes beyond simply providing treatment for drugs users. This selected issue proposes a quantification of public expenditure committed by all French authorities including the Ministry of Health of course, but also the Ministries of Justice, the Interior, Education and Defence, etc. (direct link to the article).

Vulnerable groups of young people
This selected issue discusses the subject of vulnerability considered from three key angles: from the viewpoint of general population surveys (enhanced risks of use); from the perspective of users faced with psycho-social precariousness; and finally with regard to the provision of treatment for users (direct link to the article).

Drug-related research in Europe.
A summary of the current state of drugs research carried out in France, regarding the subjects covered but also the organisation of research and the various teams involved. This special issue also provides an insight into the structural strong points and weaknesses, including in particular the duality between the contribution made by the neurocognitive sciences (an advanced sector) and the fragmented nature of the contributions made by the social sciences (direct link to the article).

PART A: NEW DEVELOPMENTS AND TRENDS

1. National policy and background information

National policy: background information

The legal framework: The law dated 31 December 1970 constitutes the legal framework within which French policy in the fight against drugs is implemented. It lays down three key targets for public action:

- To severely curtail drug trafficking;
- To firmly establish the principle of a ban on narcotics use while at the same time proposing treatment alternatives to repression of use;
- To ensure that treatment remains free, while also protecting the anonymity of those users wishing to obtain such treatment.

The five-year public health law for 2004-2008 adopted in August 2004 has enshrined the harm reduction policy (Réduction des risques, RDR) for drug users as part of the public health code. The RDR is consequently the responsibility of the state.

The list of substances covered by the 1970 law (order dated 22 February, 1990 establishing the list of substances considered as narcotics) is constantly evolving and regularly includes the addition of new substances recognized as posing a danger by order of the Ministry of Health, following proposals from the general manager of the French Health Products Safety Agency (Agence française de sécurité sanitaire des produits de santé, AFSSAPS)[2].

The institutional framework: The Interministerial Mission for the Fight against Drugs and Drug Addiction (Mission Interministérielle de Lutte contre les Drogues et la Toxicomanie, MILDT) is the organisation given the task of laying the ground for the discussions to be held by the Permanent Interministerial Committee for the Fight against Drugs and Drug Addiction (Comité interministériel permanent de lutte contre la drogue et la toxicomanie) and of handling the coordination and implementation of the resulting decisions.

Didier Jayle, the former president of the MILDT who was appointed in October 2002, was the initiator of the five-year action plan against illegal drugs, tobacco and alcohol (2004-2008), adopted in July 2004 (Inpes et al. 2006; Ofdt 2004).

Budget and public expenditure: The main expenditure in the fight against drugs concerns the credits from the Ministry of Health and Social Protection and those from the MILDT. The costs for the specialised care centres for drug addicts are paid by the health insurance management companies.

The social and cultural context: The vast majority of the population supports the existing measures provided under the harm reduction policy (treatment by means of substitute products, the free distribution of syringes, etc.) and generally remains committed to prohibitive anti-drugs measures (opposing the

2 Appendices I and II of the list of products classified as narcotics correspond to tables I and IV of the 1961 Single Convention on Narcotic Drugs. Appendix III includes the substances from tables I and II and certain substances from tables III and IV of the 1971 convention on psychotropic substances. Appendix IV comprises psychoactive substances which are not classified internationally in addition to certain precursors.

authorisation for cannabis or heroin use under certain conditions, and opposed to the unrestricted sale of cannabis (Beck, F. et al. 2003c). When the use of illegal drugs is envisaged for therapeutic purposes and under medical control, half state that they would be favourable to the issuing of heroin and three-quarters agree to the medical prescription of cannabis on medical grounds for certain major illnesses.

In 2002, the number of people favourable to the unrestricted sale of cannabis was higher than in 1999, but this group still remains a minority (24% stated that they agreed with this suggestion compared to 17% in 1999).

1.1 The legal framework

Changes to the list of products classified as narcotics

The Iboga tree (*Tabernanthe Iboga*), a hallucinogen used during initiation and religious rites in West Africa, in addition to one of its components, ibogaine, and certain by-products, have been classified as narcotics by order of the Ministry of Health (published in the *Journal Officiel* of 25 March), "due to their hallucinogenic properties and their high level of toxicity." The *Agence Française de Sécurité Sanitaire* (AFSSAPS – French health products safety agency) launched an inquiry in 2005 following the death of a man in France who had consumed an iboga infusion.

A benchmark for risk reduction activities

The circular no. DGS/S6B/DSS/1A/DGAS/5C/2006/01 dated 2 January 2006 from the Ministry of Health and Solidarity (NOR SANP0630016C) officially confirmed the creation of the Reception and Risk Reduction Support Centres for Drug Users (Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues, CAARUD), grouping together the low threshold structures and transferring their financing to the health insurance system. On 23 November, the DGS/SD6B/DGAS/DSS/2006/493 circular was published concerning the budget for the year 2006 for those medical/social establishments and departments dealing with individuals facing specific difficulties (CAARUD, CT – Communautés Thérapeutiques/Therapeutic communities, CSST, CCAA etc.).

On 14 May 2007, Decree number 2007-877 was published, concerning the role of the Addictology Treatment, Support and Prevention Centres (Centres de soins, d'accompagnement et de prévention en addictologie or "CSAPA", NOR: SANP0721630D)[3]. The provisions of this decree include bringing together the specialised drug addiction treatment centres (Centres de Soins Spécialisés en Toxicomanie, CSST), the outpatient treatment centres for alcoholics (Centres de Cure Ambulatoire d'Alcoologie, CCAA) under the "addictology" banner, with them offering a common treatment programme for all types of patients. In theory, the CSST and CCAA are required to treat any person suffering from an addiction to a psychoactive substance. In practice, however, we should nevertheless expect continued differences in both specialisations and treatments.

Increased cooperation to fight drug trafficking

A communiqué from the Ministry of the Economy, Finance and the Budget dated 21 March 2007 concerning money laundering states that *"France strictly conforms to the recommendations made by the Financial Action Task Force (FATF) concerning money laundering. With this in mind, in 2006 it completed the introduction of the second anti-laundering directive from the European Union (…). The third anti-laundering directive, which*

3 http://www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=SANP0721630D

should be introduced by 15 December 2007, further updates the previous measures. Among other things, this directive further extends its scope with the inclusion of a requirement to declare any suspicions of transactions related to an infraction subject to a period of imprisonment in excess of one year. It makes it possible for professionals to adapt their procedures based on a risk assessment"[4].

1.2 The institutional framework, strategies and policies

The addiction plan

In November, the General Health Authority (Diretion Générale de la Santé, DGS) published a plan entitled "*Prise en charge des addictions 2007-2011*" (*Dealing with addiction: 2007-2011*) which sets out six main priorities: improving the way in which addictions are handled in health establishments, improving the way in which they are handled in medical/social establishments, improving the range of treatment provided by general physicians (GP) and the way in which these interface with the health and medical/social sectors, boosting prevention activities, improving training and improving research in the addictology field at hospitals. A budget of 77 million euros will be allocated on an annual basis over a five-year period.

Therapeutic communities.

The circular number DGS/MILDT/SB6B/2006/462 of 24 October 2006 (NOR SANP0630464C) concerning the establishment of therapeutic communities following the governmental programme addressing illicit drugs, tobacco and alcohol (2004-2008), details the terms and methods for the creation and authorisation of these therapeutic communities with the aim of offering a greater variety of care. These communities are defined as "*organisations aimed at dependant consumers of one or several psychoactive substances, with the aim of bringing about abstinence* [which differentiates them from low threshold structures], *the specific characteristic of which is the fact that they place the group at the very heart of the therapeutic and social integration project*".

The therapeutic communities are so-called experimental establishments which eventually (after a three-year period and following assessment) should be considered as medical/social establishments. Unlike the CSAPA, they propose long-term accommodation (up to two years) and therapeutic care including peer support.

The circular from the Ministry of the Interior dated 4 December 2006

A circular concerning the prevention of delinquency, the latest generation "local security contracts" (*contrats locaux de sécurité* or "CLS") (NOR TNTK0600110C), is aimed at overhauling the CLSPD (local security and delinquency prevention contracts, under the auspices of the Mayor) adopted in 2002. This is based on the circular from the Ministry of Employment, Social Cohesion and Housing dated 24 May 2006. The prevention policy must focus on tailored responses to be applied to any person or family in difficulty.

The CLS were established via the inter-ministerial circulars dated 27 October 1997 and 7 June 1999. The circular dated 4 December 2006 included a somewhat critical assessment of the way in which the CLS operate, including their operating resources and objectives which were set in an "unrealistic" manner, and requests a reassessment of requirements.

4 http://www.elysee.fr/elysee/elysee.fr/francais_archives/salle_de_presse/communiques_du_conseil_des_ministres/2007/mars/communique_du_conseil_des_ministres_du_21_03_2007.74515.html

The three main objectives continue to be rather general in nature, but it should be noted that the circular stipulates the application of so called victimation surveys which include a module focusing on the perceptions of drug use and trafficking.

The law dated 5 March 2007

The application decree number 2007-1388 of the law on the prevention of delinquency dated 5 March 2007 was published on 26 September 2007. This law increases the range of penal sanctions available concerning the use of, or incitation to use narcotic substances, through the introduction of awareness-building courses concerning the dangers of using cannabis and other illicit drugs. These courses, proposed by the public prosecutor, are financed by the recipient of the sentence and are intended to raise awareness of the risks related to drug use regarding both health and the penal and social consequences of such behaviour (reduction in consumption, reduction in problem drug use, etc.). People targeted by these educational courses are chiefly users whose addiction is very slight or who are yet addicted, and who therefore do not fall under the compulsory treatment scheme.

Changes at the MILDT

On 28 August 2007, the Council of Ministers confirmed the appointment of Etienne Apaire (a former investigating judge) as head of the MILDT to replace Dr. Didier Jayle. The new manager stated his wish to have the law of 5 March applied, cancelling/posponing? a revision to the law of December 1970; the interfacing with the five-year plan currently underway (2004-2008) and its assessment; and finally prevention. He focused strongly on the mediation role which the MILDT is required to play at an inter-ministerial level.

1.3 Budget and public expenditure

The organic law concerning financing laws dated 1 August 2001 (LOLF) profoundly reformed the way in which the State is managed. The overall budget is now divided into 34 separate missions, 133 programmes and almost 580 actions whereas previously it was set by ministry. There is now a "drugs and drug addiction" programme (which operates within the scope of the health mission), under the responsibility of the MILDT's president. The MILDT makes use of three key operators for the implementation of this programme and the relevant actions: the public bodies DATIS, OFDT and CIFAD (Centre interministériel de formation à la lutte anti-drogues - *Interministerial centre for training in the fight against drugs*). Up until 2005, the inter-ministerial activities for fighting drug addiction (the MILDT budget) continued to be financed via chapter 47-16. In 2005, the structure of the MILDT's budget was chiefly organised around the inter-ministerial coordination of the three different aspects (prevention, health treatment, the application of the law and the fight against trafficking). As a reminder, the MILDT budgets for the years 2003 to 2006 were respectively 37.51, 33.75 and 32.40 million euros.

Just like any other public sector budget, the financing for the MILDT is now covered by the "organic law concerning finance laws" (LOLF[5]) and has been since 1 January 2006. The MILDT's work is now focused on three main themes:

5 The LOLF reforms the order of 1959 and organises the state's budgetary procedures around two key principles: the notion of performance in public management and greater transparency concerning budgetary information in order to establish inspection by the parliament. Please visit the website of the Ministry of the Economy and Finance for a general presentation, for details of the budgets and for the main activity reports:
http://www.minefi.gouv.fr/themes/finances_etat/budget/index.htm
for the publication of the 2006 budget;
http://www.performance-publique.gouv.fr/cout_politique/depenses_etat/2007/TSDEPMSNFICHE_MSNSA.htm
for the health budget;
http://www.performance-publique.gouv.fr/performance/politique/pdf/2007/DBGPGMPGM136.pdf

Table 1.1. Specific credits related to inter-ministerial activities aimed at fighting drug addiction voted as part of the finance law and implemented (2006-2007).

Actions	2006	2007
1. Interministerial coordination of the preventive, health and repressive aspects	30.63	31.95
2. Experimentation with new partnership schemes	5.50	3.05
3. International cooperation	1.20	1.50
Total	**37.33**	**36.50**

In millions of euros. Sources: MILDT; Ministry of finance.

Although the total sum allocated poses no problem (with an increase in the budget between 2005 and 2006, followed by a slight fall between 2006 and 2007), it is impossible to draw a comparison between the various budgetary chapters. The estimates for the 2008 budget are not yet official.

1.4 The social and cultural context

Unlike the 2002 presidential elections, the issue of drugs was virtually absent from the 2007 election campaign. The monthly publication *Technikart* was the only one to have questioned the contenders concerning their opinions and plans in this field, in its March 2007 issue. As the *Le Monde* newspaper explained in its *Dossiers et Documents* supplement in June 2007, "*the presidential election campaign has focused very little on the problem of drug addiction*".

Despite this relative discretion where political debate is concerned, the newspapers have continued to regularly cover drug related issues.

Although during the autumn and winter the press was particularly interested in tobacco (and to a lesser degree, alcohol, with the organisation of the convention on alcohol), due to the announcement of a new decree concerning the ban on smoking in public places, illicit substances were certainly not overlooked.

As always, cannabis continues to be the product most frequently discussed in the press. From September 2006 onwards, several newspapers reported on rumours concerning the possible presence of glass microbeads in cannabis circulating in France (*Libération*, 23 September 2006). This subject was covered on an occasional basis up until March 2007, when the Ministry of Health and Solidarity issued a memo concerning the "*health risks related to the consumption of cannabis cut with glass microbeads*". On 12 March 2007, *Le Figaro* published an article entitled *"Intoxication by glass microbeads in cannabis"*.

The issue of the treatment of young cannabis consumers also aroused the interest of the press. This was widely discussed as the front-page article in the *Nouvel Observateur* on 26 October 2006: *"Parents et ados: les pièges du cannabis"* (Parents and teenagers: the cannabis trap"). For their part, *Le Monde* and *Le Figaro* discussed this subject in the issues dated 27 October, when they reported on the initial feedback from the "outpatient cannabis abuse clinics" set up in 2005.

However, it was particularly during the early summer of 2007 that cannabis began to receive intensive media coverage. The weekly publication *Courrier International* devoted a cover page to cannabis on 21 June entitled: *"Cannabis. Pourquoi les pro rejoignent les anti et*

for the specific budget allocated for the field of drugs and drug addiction.

sonnent l'alarme." (Cannabis: when the pros and antis unite). Shortly afterwards, the publication of a summary document by the OFDT (*Cannabis, données essentielles/Cannabis: key data)* provided an opportunity for a number of newspapers to discuss the presence of this drug in France. *"Cannabis: une addiction française" (cannabis: a French addiction)* was the headline in the *Le Monde* newspaper on 11 July which, in addition to offering a general overview, also focused on the level of THC. For its part, Agence France Presse, devoted a feature to the boom in home growing (10 July).

On 11 July, *Le Figaro* explained that "*cannabis addicts are increasingly numerous.*" *Libération* covered the subject on 7 August, following the publication of two new studies focusing on cannabis-related risks in *The Lancet* and *Thorax* magazines, with the front-page headline "Cannabis is harmful too!"

Over the same period, other themes were also covered by the press.

The disclosure of the annual report from the Central Office for the Repression of Narcotics Trafficking (Office Central de Répression du Trafic Illicite de Stupéfiants or "OCRTIS") in October 2006 provided an opportunity to report on the fall in cannabis seizures and the rise in those for cocaine (*Le Monde*, 13 October, *Libération*, 19 October). Generally speaking, the increasing circulation of this substance has attracted the attention of the media. As an example, we should mention the *Coke au féminin* feature with real-life accounts in the women's magazine *Marie-Claire* in October 2007 or *Cocaïne l'alerte* in the magazine *Choc* on 19 July 2007.

In addition to discussing issues related to insecurity, in March a number of newspapers including *Libération* and *Le Parisien* reported on the death of two homeless people living in tents set up in Paris alongside the Saint-Martin canal, from overdoses possibly related to misuse of methadone. On 17 March, *Libération's* headline was *"Death tents at the Saint-Martin canal."* The subsequent deaths of other homeless people, in Strasbourg and later in Nice under similar circumstances were also reported by the press.

Still on the subject of substitute treatments, the problem of Subutex® trafficking was covered several times by the press (*le Parisien* on 31 March 2007, *Libération* and *le Figaro* on 2 April 2007) following the dismantling of a drugs network and several arrests. On 26 May 2007, the weekly publication *Marianne* devoted an article to this theme: *"Comment la planète se shoote au Subutex français"* (The world is hooked on French Subutex). On 16 June, *le Parisien* reminded its readers that fraud is running at a high level. Finally, on 1 and 2 July 2007, *Le journal du dimanche* followed by *Le Figaro* discussed new measures aimed at combating trafficking and fraud.

Among the rarer substances, methamphetamine received far less attention than last year. On the other hand, iboga (a plant finally classified as a narcotic in March 2007) was the subject of various articles over this period. The press namely discussed the numerous concerns raised about the misuse of this hallucinogenic plant which caused a death in France during the summer of 2006. Following a dispatch from Agence France Presse in January, *Le Monde,* among others, took an interest in this substance in its article published on 27 February 2007. The same month, the magazine *Choc Hebdo* devoted a multi-page report from Gabon to the subject, accompanied by photos, under the title "*L'iboga, plante tueuse?*" (Iboga: a killer herb?). In March, AFP reported on the classification of this substance as a narcotic.

Finally, during 2007, a number of publications reported on the bloody gang warfare raging in the working class districts of Paris and Grenoble, which was being fought in particular for control of the heroin and cocaine trafficking business. In early June, *Marianne* wrote, "*Five dead in three months. The estates echo to the sound of gunfire in Grenoble.*" *Le Parisien* (on

11 and 24 June 2007) reported on the deaths in Stains, a town in Seine Saint Denis. This theme was taken up by *Le Figaro magazine* which carried an article on 16 June entitled "*Seine Saint Denis: the dealers battle it out on a 'no-go' estate".*

Cannabis: Key Data.

Published in July 2007, "*Cannabis Données Essentielles*" (*Cannabis: Key Data* or "CDE") is the first national monograph devoted exclusively to cannabis. Its media impact has been considerable (please see part I).

The law dated 31 December 1970 forbidding the trafficking, sale, purchase and use of cannabis remains the benchmark legislation in this field. Cannabis is treated no differently from any other narcotic and its purchase and use can result in legal action. However, over several years we have witnessed a reduction in the number of cases resulting in legal action and an increase in so called alternative methods (which in no way represents the abandonment or suspension of the cases concerned). These alternative measures include cautions, court-ordered treatment programmes and health guidance measures.

Cannabis is the leading illegal substance mentioned and consumed in France. Some 31% of 15-64 year olds state that they have tried it at least once in their lifetime and 9% have used it during the last year. Cannabis use is a predominantly male trend, where both experimentation and regular consumption is concerned, consumption being something which tends to reduce with age and in particular with the arrival of adulthood. Cannabis use is more common among secondary schoolchildren and students and rarer among the non-working population, (particularly pensioners). Three groups stand out in particular: farmers are below-average users, in contrast to individuals belonging to socio-professional groups such as workers, shopkeepers, craftsmen or company managers. Executives and the intermediate professions are close to the average.

Along with the Czech Republic, Spain, the United Kingdom and Cyprus, France has some of the highest cannabis use levels seen in Europe, both among adults and among schoolchildren between 16 and 17 years of age.

The cannabis consumed in France is chiefly Moroccan in origin. It is imported directly or travels via Spain, which is ideally located geographically. A new trend is emerging however - the growth in "home growing", including in urban environments, with the so called "cupboard" method. It is estimated that approximately 200,000 people aged between 15 and 64 have made use of this technique. The total turnover for cannabis sales is approximately 832 million euros. That for "home growing" (subject to this being sold at the observed market prices) is around 83 million.

Despite certain popular misconceptions, the concentration of THC in cannabis in France has not undergone any significant change since 1993, the year in which a reliable tracking method was introduced. Rather than the measured levels, it is instead the wide variability of rates noted between the regions which are of interest, these being higher in the north due to the proximity of the Netherlands and lower in the south (the highest recorded levels are the ones which have changed).

The relationship between the regular and problem use of cannabis and various somatic and mental problems has now been proven: for example, cannabis increases the risk of schizophrenia among those persons with a vulnerability to this illness. A number of public initiatives have been implemented as possible solutions:

- Prevention, particularly in educational environments and via “travelling” drug prevention schemes.
- Awareness-building campaigns aimed at teenagers and young adults, for example, the campaigns based on the results of the *“Stupéfiants, Alcool et Mortalité”* project (SAM – Narcotics, Alcohol and Mortality); please see the *Selected Issue* on this subject, 2006 Report).
- Provision of access to information and treatment by the social services telephone help desk (DATIS – please see part III).
- Treatment in specialised centres (CSST) and the launch of the "outpatient cannabis abuse clinics".

2. Drug use

Drug use: general context

Four different levels are generally used when describing the scale of drug consumption. These levels have been drawn up based on internationally used indicators:

- Experimentation: the use of a drug at least once during a person's lifetime;
- Occasional use: drugs consumed at least once a year;
- Regular use: drugs consumed at least 10 times during the last 30 days;
- Daily use: drugs consumed every day.

In certain cases, the term "recent use" is also used (referring to consumption of a drug at least once during the last 30 days).

Drug use among the general population: France runs several surveys in order to identify the scale of this use:

- For the adult population: the "Baromètre Santé" (run by the INPES - the national institute for prevention and health education. This is a five-yearly survey). The survey of representations, opinions and perceptions of psychotropic drugs (EROPP), carried out every three years by the OFDT [Epidemiological table number 1].

- For the school age population: the European School survey Project on Alcohol and other Drugs (ESPAD), carried out every four years (INSERM-OFDT) [Epidemiological table number 2].

- For young people: survey of health and consumption on the occasion of the call to preparation for defence (ESCAPAD - Enquête annuelle sur la santé et les comportements lors de la journée d'appel et de préparation à la défense) carried out by the OFDT among young people aged between 17 and 19. This survey makes it possible among other things to interview young people who left the educational system early. [Epidemiological table number 30].

In France, cannabis is the most frequently used illegal substance and its consumption has significantly increased over the last 10 years. In 2005, 3 adults out of 10 in the 15-64 age group had already experimented with cannabis, while fewer than one in 10 use this substance on an occasional or regular basis (Beck, F. et al. 2003c). Cannabis use generally involves all social groups, even if a number of trends can be identified. Cannabis use levels are slightly higher among pupils and students (Beck, F. et al. 2005), single people (Beck, F. et al. 2002), the unemployed and, in the working population, among the intermediate professions, and are significantly lower among workers (Peretti-Watel, P. et al. 2004). However, the differences between the various social-professional groups are globally quite slight.

Those who declared that they experimented with illicit drugs other than cannabis were very much in the minority. As an example, an estimated 12.4 million people experiment with cannabis, compared to 1.1 million for cocaine, 900,000 for ecstasy or 360,000 for heroin. However, the slight increase in experimentation levels in the 18-44 age group for cocaine (3.3% vs. 3.8%), hallucinogens (3.0% vs. 3.6%) and ecstasy between 2002 and 2005 demonstrate the increasing circulation of these products. Experimentation levels for heroin have remained stable over the last 10 years (Beck, F. et al. 2003b).

Regardless of the product in question, males living in large urban complexes have a higher propensity to experiment with drugs (Beck, F. et al. 2002). Those experimenting with illicit drugs are frequently unemployed or have a low income, with the notable exception of individuals experimenting with cannabis, who tend to be better integrated socially.

At the age of 17, after tobacco, alcohol, cannabis (53.2% among boys and 45.6% among girls) and psychotropic medicines, the substances most frequently experimented with are: poppers (5.5 %), hallucinogenic mushrooms (3.7 %), inhaled products and ecstasy (3.5 %) and, to a lesser extent, cocaine (2.5 %), amphetamines (2.2 %) and LSD (1.1 %) (according to ESCAPAD 2005 (Beck, F. et al. 2003a).

Drug use among specific groups: the most recent investigations carried out among prostitutes (male, female and transgender) have shown that the recent use of illicit drugs, with the exception of cannabis, concerns only a minority (Cagliero et al. 2004; Da Silva et al. 2004). However, this was more frequent among men and transsexuals (recent use of poppers: 13%, ecstasy: 11%, cocaine: 7% and heroin: 2%) than among women (recent use of heroin: 5%).

Among the homeless population, the data is fragmented. We know however that all types of substances are available and used. Users living on the street "display intoxication practices significantly different from drug addicts better integrated into society. Whether due to a lack of money or planning, they tend to consume whatever they come across on a day-to-day basis […]" (Solal et al. 1996). The estimated prevalence of illegal drug use during recent months varies from 10% to 21% or even 30% according to the age, income level and cause of homelessness of the person concerned, and the support structures visited (Amosse et al. 2001; Kovess et al. 1997; Observatoire Du Samu Social De Paris 1999). The drugs most frequently used apart from alcohol and tobacco are cannabis and cocaine.

A recent survey into alcohol consumption among the homeless population offers an insight into the alcohol consumption levels of the various categories of persons who turn to accommodation services or hot food distribution centres. It has made it possible to highlight the diversity of consumption practices among this population group, according to the type of accommodation and resources, and the age, sex and nationality of the respondents. The huge diversity of social situations encountered is matched by the wide variety of behaviour patterns vis-à-vis alcohol (Beck, F. et al. 2006b).

Although epidemiological knowledge of drug addiction in professional environments is hindered by numerous obstacles (of an ethical, technical, financial, temporal, regulatory, cultural or practical nature), a few means of assessment are available. In 1995, a survey involving anonymous urine samples from 1,976 employees in the Nord-Pas-de-Calais region revealed that 17.5% of the employees consumed at least one psychoactive substance including up to 40% of those holding safety/security posts (Fontaine 2006). For most users well integrated in a professional environment, this consumption is hidden from their professional entourage, with the drugs being taken outside working hours whenever possible. (Fontaine 2006).

A qualitative survey published in 2006 also focused on the users of hallucinogenic plants and mushrooms (Reynaud-Maurupt 2006).

Attitudes to drugs and drug users: The tool used to assess the attitudes of the French to drugs and drug users is the EROPP survey. This survey makes it possible to measure the perceived level of information concerning drugs, the substances known and recognized as being drugs, and the estimated level of danger presented by the substances concerned. The survey also studies public opinion as regards the way in which drug addicts are perceived.

In 2002, 61% of French people declared that they felt they were well informed about drugs, this being slightly higher than in 1999. In response to the question: "what are the main drugs of which you are aware, if only by name?", the French respondents mentioned an average of 3.8 products. The product most often mentioned was cannabis (82%), followed by cocaine (60%), heroin (48%) and ecstasy (37%) (Beck, F. et al. 2003c).

The substance considered to be the most dangerous by the French respondents was heroin, followed far behind by ecstasy and cocaine, alcohol and tobacco, and finally cannabis (only 2% of those interviewed considered cannabis to be the most dangerous substance). This ranking varies little between age, sex or socio-professional groups. The perceived level of danger posed by cannabis varies according to the age and sex of the individual, and particularly to his proximity to this substance. (Beck, F. et al. 2003c).

2.1 Drug use among the general population

No new information available.

2.2 Drug use among young people and the school age population.

No new information available.

2.3 Drug use among specific groups

Please see the *Selected Issue* on "Vulnerable Young People", and in particular, the second part.

The "techno/party" environment

In the "techno/party" environment, a quantitative survey (known as the "TREND *Musique électronique*") involving an ethnographically representative sample of 1496 individuals was carried out in 2004 and 2005 on five French sites. This made it possible to measure the prevalence of drug use among four sub-populations in the "techno/party" environment but also to study the practices and representations among this population (Reynaud-Maurupt et al. 2007).

The survey highlighted the frequency of cocaine use (35% during the last 30 days) and ecstasy (32%) in addition to the daily use of cannabis (40%), in the four affinity groups considered.[6]. We should note the high prevalence of the regular use of stimulants: cocaine or

6 The "Alternative" group (rave and free parties). Part of this group comprises counterculture enthusiasts; the Urban group (music bars) comprised of individuals who first and foremost define themselves by their fondness for music. Better integrated at a social level, this group includes a higher percentage of students; The "Clubbing" group (i.e. clubs playing electronic music). This group is chiefly comprised of hedonists, who devote a substantial budget to going out and to buying clothes. The *'gay friendly*" establishments investigated during the survey belong to this particular affinity group; the "Select" group (invitation-only/sponsored entry clubs or bars requiring "smart dress"). This is a "chic and trendy" sector of society with a living standard which is higher than that found among the other groups, whose members cultivate a "closed» attitude vis-à-vis outsiders - Reynaud-Maurupt, C.,

ecstasy is used more than once a week by 18% of those encountered in the “techno” environment and 26% in the “alternative” environment.

Table 2.1. Consumption on at least one occasion during the last 30 days of the main illegal psychoactive substances or those used other than for their normal purpose, (N = 1496).

	N	%
Cannabis	1,025	68.5
Hallucinogenic mushrooms	186	12.4
Crack or free base	91	6.1
Non-base cocaine	518	34.6
Ecstasy	484	32.4
Heroin	100	6.7
Ketamine	35	2.3
LSD	157	10.5
Amphetamines	200	13.4
Poppers	153	10.2
Opium and/or poppy heads	64	4.3
Benzodiazepines	27	1.8

Source: The “Quanti-festif” survey, OFDT/GVRS, 2004-2005 (Reynaud-Maurupt et al. 2007).

The number of people experimenting with heroin identified in the survey is higher than expected. Among the entire “techno/party” population surveyed, 23% have already experimented with heroin. This figure rises to 41% in the “alternative” environment. Indeed, we are witnessing heightened visibility of heroin use in the “techno/party” environment, chiefly at major events (free parties or technivals). When distributed, this is normally referred to as “*rabla*” and in this case is mistaken for a natural product such as opium. Heroin use in such circumstances tends to be seen as less of a stigma as it is generally sniffed or smoked. Its use is linked to that of stimulants, from which it helps the user to come down more easily, limiting the risk of addiction for users (TREND festive qualitative data (Cadet-Taïrou et al. 2007)).

Chaker, S., Claverie, O., Monzel, M., Moreau, C., Evrard, I.*, et al.* (2007). Pratiques et opinions liées aux usages des substances psychoactives dans l'espace festif "musiques électroniques". OFDT, St Denis, http://www.ofdt.fr/ofdtdev/live/publi/rapports/rap07/epfxcrn9.html.

Table 2.2. Consumption on at least one occasion during the last 30 days of the main illegal psychoactive substances or those used other than for their normal purpose, in the affinity groups.

	Alternative N=476 %	Urban N=398 %	Clubbing N=430 %	Select N=192 %	
Cannabis	88.2	73.6	50.2	50.0	***
Hallucinogenic mushrooms	24.8	13.8	2.1	2.1	***
Crack or free base	13.4	4.5	1.4	1.6	***
Non-base cocaine	50.0	27.1	27.9	27.1	***
Ecstasy	53.8	24.9	24.9	11.5	***
Heroin	15.5	3.5	2.3	1.0	***
Ketamine	6.5	0.8	0.2	0.0	***
LSD	23.5	8.0	2.8	0.5	***
Amphetamines	29.0	8.0	5.3	3.6	***
Poppers	9.0	7.3	17.2	3.6	***
Opium and/or poppy heads	8.6	4.3	0.9	1.0	***
Benzodiazepines	2.3	1.0	2.1	1.6	ns
Cocaine and/or ecstasy	70.8	37.7	37.2	30.2	***
All products * except alcohol and cannabis	81.3	46.7	43.2	34.4	***

* Hallucinogenic mushrooms and/or crack and/or cocaine and/or ecstasy and/or heroin and/or ketamine and/or LSD and/or amphetamines and/or poppers and/or opium and/or poppy heads and/or benzodiazepine taken at least once.

NS: non-significant. ***: p<0.0001, ns non-significant. Source: the "Quanti-festif" survey, OFDT/GVRS, 2004-2005 (Reynaud-Maurupt et al. 2007)

Combining products is a frequent practice (43% of those people associating with the "techno/party" environments during the last month), with the main substances concerned being alcohol (in 88% of cases), cannabis (82%), cocaine (57%) and MDMA (53%). The other substances feature less prominently (amphetamines 14%, synthetic hallucinogens 10%, natural hallucinogens 10%, heroin 9%, etc.).

Table 2.3. Combination of three products at least once during the same evening, including alcohol but not including tobacco, during the last 30 days, within affinity groups (N = 1489).

	Altern. N = 469 %	Urban N = 398 %	Clubbing N = 430 %	Select N = 192 %	
Yes, once or more	69.9	37.9	28.4	22.4	***
Average number of products combined	3.4	3.3	3.2	3.2	*

***: p<0.0001, *p<0.05. Source: the "Quanti-festif" survey, OFDT/GVRS, 2004-2005 (Reynaud-Maurupt et al. 2007)

Although injection remains marginal among this group (4.6% at least once during the individual's life and 0.5% at least once during the last month), the use of straws is an extremely widespread practice (66% at least once during the individual's life and 43% at least once during the last month). Among those having sniffed drugs, 53% shared a straw during the last month.

Table 2.4. The administration of psychoactive substances via nasal inhalation and by injection during the individual's lifetime and during the last 30 days, within the affinity groups.

	Alternative %	Urban %	*Clubbing* %	*Select* %	
Administration by nasal inhalation (n = 1493):					
Yes, at least once in my life	85.1	62.9	55.0	49.5	***
Yes, at least once during the last month	63.9	30.6	30.5	27.1	***
Administration by injection (n = 1487)					
Yes, at least once in my life	8.5	4.3	2.6	0.5	***
Yes, at least once during the last month	1.5	0.3	0.0	0.0	-

***: p<0.0001. Source: "Quanti-festif" survey, OFDT/GVRS, 2004-2005 (Reynaud-Maurupt et al. 2007)

The qualitative data from the TREND scheme reveal an increase in MDMA injection among marginalised young users in the festive environment. Several sites participating in the scheme mentioned the growth in the sniffing of ecstasy tablets in the commercial festive environment. A number of factors explain these changes: the quest for a "faster high", the "fashion" effect, with sniffing being seen as a "cooler" administration method, and finally the social aspect related to the sharing of lines of powder.

2.4 Attitudes to drugs and drug users

EROPP survey. No new information.

3. Prevention

General context

The legal framework:

Drug prevention is only partly dealt with by French legislation. It is mainly the laws governing the use, advertising or access conditions for alcohol and tobacco[7] which cover this subject. Since November 2006, the ban on smoking in areas intended for collective use (the Evin law) has been extended to areas welcoming the public (including workplaces)[8]. Very few laws cover the prevention of illicit drugs. The law which forms the cornerstone of the fight against drugs (law number 70-1320 dated 31 December 1970) does not mention it. In 2004, for the first time ever, a law stated that *"information should be provided concerning the consequences of drug use on health, especially regarding the neuropsychological and behavioural effects of cannabis, in schools (…)"*[9]. It also sets a minimal threshold *"of one annual session, in groups composed of people of the same age."* Finally, since 1990, the circulars from the Ministry of Education have laid down the main guidelines regarding drug prevention as part of the more general framework of preventing risk-generating behaviour.

Political coordination from a central down to a local level:

The MILDT has responsibility for the initiation and coordination of drug prevention policies. National guidelines are laid down by the government programme, of which it is the authorised depository. The *2004-2008 governmental programme addressing illicit drugs, tobacco and alcohol* and the 2003-2008 five-year prevention and education plan from the ministry of education[10] establish the principle of harmonising and extending prevention activities by scheduling these throughout pupils' academic life (from primary school onwards). Other action plans further contribute to these national guidelines in the drug prevention field. This is the case for example with the 2003-2008 national plan to combat cancer (which has given a welcome boost and led to a call for additional funds concerning anti-smoking activities) but also the 2007-2011 plan for addiction treatment and prevention from the ministry of health. This plan puts the accent firmly on early identification and on reception schemes for drug users (please see the "Selective Prevention" section).

Within each ministry concerned, a section (which is the key point of contact for the MILDT) coordinates the various drug prevention targets between the central and decentralised level. The implementation of national guidelines at a local level is therefore handled by the state's decentralised departments, and particularly by the Drug and Dependency Project Leaders (*chefs de projet "drogues et dépendances"* or CPDDs) appointed among the prefectorial staff.

7 The law no. 91-32 of 10 January 1991 concerning the fight against smoking and alcoholism, Journal Officiel (JO) dated 12 January 1991, p. 4148 (NOR: SPSX9000097L), the Law no.2003-715 making it illegal to sell tobacco to persons under the age of 16 (JO dated 3 August 2003). Decree no. 2006-1386 of 15 November 2006 defining the conditions for the application of the ban on smoking in areas intended for collective use, NOR:SANX0609703D.

8 Smoking areas meeting strict standards can be installed, except in education establishments, health establishments and areas receiving minors, which must be fully non-smoking. Only recreational and restaurant areas will continue to benefit from a waiver until February 2008 to give them time to meet the necessary standards.

9 The public health policy programming law no. 2004-806 of 9 August 2004, NOR: SANX0300055L.

10 Introduced by circular no. 2003-210- of 11 December 2003, NOR: MENE0302706C.

Under the coordination of the MILDT, the project leader defines and runs the département's drug prevention policy. To do so, he uses the credits assigned to dependency prevention activities and to the training of professionals, and consults with local institutions (state departments, judicial authorities, local authorities[11] and, wherever possible, associations) in order to coordinate the objectives of the public bodies and to determine the financing required.

At the same time, regional and trans-sectorial schemes concerning health or the fight against social exclusion (PRSP), security or urban policy (CLS, CEL)[12] also make it possible to distribute public credits. Furthermore, the identification of priority areas requiring assistance (ZUS or ZEP[13]) drawn up according to socio-economic indicators, housing or educational quality (i.e. levels of educational failure and pupils receiving grants) makes it possible to concentrate additional resources to target disadvantaged groups.

In the school environment, school principals annually draw up preventive measures to be carried out among pupils. Although they benefit from a certain amount of leeway in this area, they nevertheless receive recommendations from their regional authority (the Education Office), according to the ministerial guidelines laid down. Most secondary education establishments possess a Health and Citizenship Educational Committee (*Comité d'éducation à la santé et à la citoyenneté* or CESC), which includes the educational community and key players from outside the establishment (associations, institutions, etc.) to coordinate drug prevention within their establishment.

<u>The principles and characteristics of drug prevention:</u>

Since 1999, the fight against drugs has been extended to cover legal psychoactive substances such as alcohol, tobacco and psychotropic medicines. It is based on two key principles: early intervention vis-à-vis young people in order to delay the age at which they start using such substances and intervention methods aimed not only at preventing usage but also at limiting misuse.

Drug prevention has always been based on the notion of extending common rights and services guaranteed by the state or delegated to the associations, according to the notion of proximity (for the various decision-making levels and the local participants). Thus, most addiction prevention activities are covered by the notion of "universal prevention" and are carried out in a school environment where they largely involve the educational community in the coordination and implementation of the activities. "Selective" prevention or "indicated" prevention is chiefly the responsibility of specialised associations (we should note that the terms "universal", "selective" or "indicated" prevention are not commonly used in France).

Drug prevention is characterised by a low level of state intervention in its concrete forms. Nevertheless, in 2006, a practical intervention guide for school environments was circulated by the ministry of education and the MILDT (see the "universal prevention" section). Furthermore, thanks to the various initiatives aimed at "professionalizing" this particular field and harmonising the principles underlying drug prevention activities, a number of approaches have emerged - going beyond the simple provision of information concerning risks and the adoption of an interactive approach or the development of psychosocial skills,

11 Autonomous, decentralised administrations (organised on the level of the *département* or the region) possessing a specific remit, for example in the fields of health, youth / child welfare.

12 PRSP: Regional public health programmes which have replaced the Regional health programmes (PRS) and the access to prevention and care programmes for those in insecure circumstances (PRAPS); Local security contracts (CLS); Local education contracts (CEL).

13 ZUS: Sensitive urban areas; ZEP: Priority education areas.

etc. However, the *modus operandi* concerning psychosocial skills nevertheless remains somewhat vague for a number of key players.

Support measures for decision makers and professionals:

The role of the National Institute for Prevention and Heath Education (INPES) is to carry out assessments, to develop prevention practices and to implement national programmes, (particularly media campaigns).

The Centres for information and resources on drugs and dependence (*Centres d'information régionaux sur la drogue et les dépendances* or "CIRDDs") provide technical support to drug and dependency project leaders and to the authorities. They provide documentation, methodological advice to help with the drafting of projects and finally observation, particularly with regard to drug prevention.

The Drug Prevention Tools Approval Committee coordinated by the MILDT gives its opinion concerning the quality of the tools submitted to it, in order to encourage the reliability and coherence of the anti-drug message.

In order to be fully represented in public debates and to encourage dialogue among professionals, the specialised associations are organised into joint organisations (including the FNES, ANPAA, ANIT, FFA, CRIPS[14]). All of these associations organise training, series of conferences, think tanks or documentary networks related to the prevention of the use of psychoactive substances.

The monitoring of current drug prevention activities:

A scheme for the monitoring of local drug prevention activities was experimented with in 9 of the 26 French regions in 2007, thanks to the network of CIRDDs and at the MILDT's initiative. Coordinated by the OFDT, this system seeks to gather simple indicators in order to identify the main characteristics of local preventive activities related to alcohol, tobacco, psychotropic medicines, illicit drugs and doping products. It covers activities, (whether subsidised or not), aimed at avoiding initial experimentation or repeated use of harmful substances, addressing a final target audience, in a given location and for a given period of time. The survey covers the actions carried out during the previous complete calendar year or academic year. It excludes those actions carried out on an individual basis, in addition to awareness-building or training activities aimed at intermediate players. It also excludes actions relating to risk reduction, treatment or supply reduction. The organisations invited to participate have been selected based on their status, and not via subsidy channels, in order to involve "hidden players" overlooked by traditional financial or political networks. In 2007, for practical reasons, "only" schools (from primary education through to university), legal youth protection services and those involved in applying the law were systematically invited. From the next financial year onwards (2009), other organisations should be included in the survey including: socio-educative centres, socio-medical centres in the main French towns and cities and the main companies. All of these organisations are and will be identified by each CIRDD.

14 FNES: Fédération nationale des comités d'éducation pour la santé/National federation of health education committees (www.fnes.info); ANPAA: Association nationale de prévention en alcoologie et addictologie/National association for the prevention of alcoholism and addiction (founded in 1872, www.anpaa.asso.fr); ANIT: Association nationale des intervenants en toxicomanie/National association for drug addiction professionals, (www.anit.asso.fr); FFA: Fédération française d'addictologie/French addictology federation (www.addictologie.org); CRIPS: Centres régionaux d'information et de prévention du sida/Regional aids information and prevention centres, (www.lecrips.net/reseau.htm).

Data collection was carried out on a voluntary basis thanks to an online questionnaire with protected access (self-administered, with "closed" questions). Just like the surveys carried out among the general population, the data was processed anonymously by the OFDT.

The statistical results were presented in departmental, regional and national terms (i.e. for all "9 regions" altogether) thanks to standardised information sheets which can be downloaded via the Internet (*www.ofdt.fr/relion*). This data is commented upon by the CIRDD for local figures and by the OFDT for the nine regions altogether. A report on the activities carried out in school environments is also produced for each regional education authority *(académie)* involved (the "*académies*" are the regional administrative level of the national education system).

3.1 Universal prevention

In France, universal protection remains the main approach to the prevention of legal or illegal drugs. According to the ReLION survey (see above: "The monitoring of current drug prevention activities" for the methodology), 86.5% of the activities recorded fall under the "universal prevention" heading, with 8 cases out of 10 concerning the school environment.

The national prevention policy in school environments

The governmental programme and the 2003-2008 prevention and education plan from the Ministry of Education both provide for a national prevention programme to be implemented in school environments. With this in mind, the MILDT and the Ministry of Education (assisted by several institutional partners) have drawn up an intervention guide for school environments, aimed at preventing addictive behaviour. This guide is today circulated to all French primary and secondary schools and may be consulted at www.drogues.gouv.fr and www.eduscol.education.fr.

What makes this guide so unique is the fact that it covers methodological and organisation aspects far more thoroughly than any other previous official document, which in itself is something of a breakthrough. Indeed, although the use of this guide is strongly encouraged but is not compulsory, it has the advantage of clearly presenting the authorities' position concerning the content of the drug prevention message, of the necessity for this message and of the need for a long-term strategy which is constantly developing and which tackles the problem at an early stage (for implementation during the pre-teen years). Four intervention plans, each adapted to a specific age group and to two class levels (CM2-6th, 5th-4th, 3rd-2nd, 1st- and final year[15]), propose a number of logical "stages" for intervention. The suggested programmes cover the 11-18 age group and discuss all drugs while at the same time focusing successively on tobacco, alcohol, cannabis and multiple consumption scenarios.

The use of this guide has not yet been assessed. We know however that the 1,393 activities in school environments listed by the ReLION survey as falling under the "universal prevention" heading, were carried out during the first year in which this guide was circulated. Among these, 83% concerned secondary school pupils, but only 7% were aimed at pupils in primary education. Furthermore, 46% of these 1,393 initiatives covered all drugs. If we consider the products concerned individually, legal drugs are the ones most frequently covered, ahead of cannabis, and well ahead of other illegal drugs, psychotropic medicines or even doping products (please see the table below).

15 From the last year of primary school to the last year of secondary school, (i.e. from the 4th to 11th grade).

Table 3.1. ReLION: Breakdown of activities according to the substances being targeted

Activities according to targeted substances (as a %)	N	%
All drugs	770	46%
Tobacco	792	47%
Alcohol	629	37%
Cannabis	519	31%
Ecstasy	192	11%
Psychotropic medicines	175	10%
Doping substances	110	7%
Heroin	129	8%
Cocaine	138	8%

Source: ReLION 2007, OFDT.

Universal prevention aimed at communities

This aspect of drug prevention witnessed no particular developments during 2006. As explained in the previous national reports, in France community-based targeting is relatively rare in the prevention field, regardless of the subject. One notable exception in a field closely related to our own is that of AIDS. This was the case for example with the national aids prevention campaigns in 2004 and 2005, with certain TV spots being specifically aimed at homosexuals or migrants from sub-Saharan Africa. Where drugs are concerned, no specific recommendations concerning community-based targeting have been issued by the political or professional institutions. Where this exists, it largely results from local initiatives taken by associations, and remains a relatively isolated practice.

Of the universal prevention activities recorded by the 2007 ReLION survey, 18% were carried out outside of a school environment. Half of them involved young people aged 11 to 25.

Universal protection aimed at families

This aspect of drug prevention witnessed no particular developments during 2006.

The telephone helpline

DATIS activity fell sharply following the change of telephone number in 2004. This decline continued in 2005 and 2006.

Table 3.2. Breakdown of DATIS calls by caller type: 2006.

Category	**Numbers**	**%**
Users	23,588	48.0%
Friends/family	19,979	40.0%
General public	3,530	7.0%
Professionals	2,272	5.0%
Total	**49,369**	**100.0%**

Source: DATIS.

The 49,369 calls recorded in the table are valid ones (i.e. explicitly referring to the use of psychoactive substances). Most of these were received from drug users themselves and/or their friends and family (88.0%). Most callers were female (61.2% compared to 38.6% of male callers, the rest being unknown). The raw data does not however enable us to state whether the call constitutes a genuine consultation following a realization that personal drug use has become a problem, or simply a request for information from concerned family members or friends.

Alcohol, cannabis and tobacco are the substances most often mentioned (41.4%, 35.4% and 10.3% respectively - several substances being possibly mentioned during the call). This ranking is slightly different when compared to 2005, (cannabis being the main substance mentioned during the calls). We should note the relatively high percentage of medicines, which remain in fourth position in the list of products mentioned (9.0%). Heroin, cocaine and substitution substances all follow to a lesser degree (8.2%, 6.7% and 6.3% respectively), although nevertheless showing an increase compared to 2005.

Budget

As stated in part 1.3, the current budgetary structure of the MILDT (since 2005) does not make it possible to specify the percentage accounted for by each category within the budget.

3.2 Selective prevention

The ReLION survey supplies an indicator concerning the relative weight of selective prevention in France. Among the nine regions having participated in the ReLION survey in 2007, 13.5% of the 2,378 activities recorded were aimed at persons dealt with by social or legal institutions.

Table 3.3. Activities aimed at persons dealt with by a social or legal institution (as a %).

Persons under institutional care	13.5 %
Persons covered by youth welfare measures	1 %
Persons subject to educational assistance measures (1)	2.2 %
Other persons under legal control (2)	1.9 %
Youths undergoing re-integration (3)	2.4 %
Adults undergoing re-integration (4)	2.4 %
Others	4.5%

Source: ReLION 2007 (OFDT)

The recreational environment

Marquis testing is forbidden by the decree dated 14 April 2005[16] which introduced a national benchmark for risk reduction activities related to drug use. In practice, other methods have been used (for example preparative layer chromatography (PLC)). Consequently, it appears that the Ministry of Health is keen to reopen dialogue on this subject and on the related quality criteria (including among others the rereading of results by a doctor, which is not currently carried out in practice).

16 Decree no. 2005-347 of 14 April 2005 approving the national benchmark for risk reduction activities aimed at drug users, further reinforcing the public health code, NOR: SANP0521129D.

At risk groups

No new guidelines were issued for at risk groups in 2006.

Indicated prevention

Since February 2005, 250 "outpatient cannabis abuse clinics" announced in the governmental programme opened throughout France. Aimed at young people in difficulty as a result of their consumption of cannabis or other drugs and at their families, these reception and support centres are anonymous and free of charge. These clinics are covered by the RECAP information system (Recueil commun sur les addictions et les prises en charge, coordinated by the OFDT) used in the CSSTs and the CCAAs. However, they have been the subject of a specific survey following their launch (Obradovic 2006), which was commented on in the previous national report. This survey was repeated in 2007. It should make it possible to carry out an analysis of the outpatient visits, of the profile of those visiting the clinics, and particularly of those referred by the legal system, while at the same time making it possible to track changes in their drug consumption as the visits progress. This survey should be presented in the next report.

However, we should note that during the first year of operation, these outpatient clinics welcomed some 15,200 young drug users but also numerous visitors drawn from among the users' friends and families (accounting for 28% of visitors), these being most often the users' parents (usually mothers).

4. Problem use

Problem use: general context

Estimated prevalence: several estimation methods have been used in France in order to produce a national estimate of the prevalence of problem heroin and cocaine use in 1999 (Costes et al. 2003). The number of problem opiate or cocaine users is between 150,000 and 180,000, which corresponds to prevalence levels among the 15-54 age group of between 3.9 per mil and 4.8 per mil [Epidemiological table no. 7].

In 2005 and 2006, the New Multicentric OFDT Study (NEMO) was used in order to generate local estimates of the prevalence of the problem use of opiates, cocaine, as well as other stimulants and hallucinogens in six French urban areas (Lille, Lyons, Marseilles, Metz, Rennes and Toulouse) and in an overseas *département* (Martinique). The provisional results from this study cited prevalence levels within the 15-64 age group varying from 7.6 per mil in Rennes to 10.8 per mil in Lille. These local estimates, which are calculated using the capture-recapture method, will be used in order to update the national estimate of the prevalence of problem drug use at the end of 2007. In 1999, the prevalence levels for the use of opiates and cocaine (heroin, Skenan®, Subutex®, methadone and cocaine) varied from 15.3 per thousand persons aged 15 to 59 years old in Nice to 6.5 per thousand persons from 15 to 59 years old in Toulouse. (Chevallier 2001) [Epidemiological table no. 8].

There are currently several approved French language instruments making it possible to assess the abuse or harmful use of cannabis among adolescents or young adults. These include two tests translated from English and a specific cannabis test designed at the OFDT, the CAST (*Cannabis Abuse Screening Test*).

While awaiting the creation of a European definition, the definition of problem cannabis use adopted in France is as follows: “use likely to result in major health and social problems for the person concerned or for others”.

A system for recording treatment applications meeting the European protocol [TDI; epidemiological table 3 and 4] was introduced in France in 2004. The RECAP survey *(*Recueil commun sur les addictions et les prises en charge, i.e. Data Retrieving for Drug Treatment Demands*)* now provides access to individual data collected on a continuous and theoretically exhaustive basis for all patients treated in the Specialised Drug Addiction Treatment Centres (Centres de soins spécialisés pour toxicomanes, CSSTs). These treatment centres are of three types: outpatient treatment centres, inpatient treatment centres and prison treatment centres. The RECAP survey was carried out in 2005 for the first time at a national level (Palle et Vaissade, 2007). The RECAP results for 2006 make it possible to identify the main socio-economic characteristics and to describe the consumption habits of drug users who began treatment between 1 January and 31 December 2006 in the outpatient treatment centres, i.e. new patients. The analysis of the RECAP data also allow to identify a more specific profile for those patients treated for the first time in their lives, the first-treatment patients.

In 2006, a specific survey (PRELUD) was carried out among users attending low threshold structures (reception centres and syringe exchange programmes). Implemented on nine urban sites (Bordeaux, Dijon, Lyons, Lille, Marseilles, Metz, Paris, Rennes and Toulouse), it follows on from the so-called “front line” survey

carried out up until 2003 on the 12 sites included in the French Monitoring of Recent Trends programme (TREND). It makes it possible to describe the profiles of users attending front line structures. The 2006 data was compared to that of 2003, for these nine sites.

In 2006, among the users of front line structures[17], the illicit substances most frequently consumed during the month gone by (apart from cannabis) were cocaine, chiefly in the form of hydrochloride, heroin, amphetamines and ecstasy. If we also include medicines, HDB was the substance most frequently consumed, particularly for therapeutic reasons. (Cadet-Taïrou et al. 2007).

Based on observations performed involving several social risk groups where drug use is concerned, we note that cocaine use is ever more widespread and now concerns increasingly diverse social profiles. Similarly, the use of ecstasy is increasingly found among street users in "urban" areas. Hallucinogens also seem to be increasingly consumed by the youngest users. (Bello, P-Y. et al. 2004b).

Incidences of HDB misuse have been identified, apparently facilitated by the availability of this product on underground urban markets. For this substance, injecting and snorting have been highlighted among users of 'front line' structures, as has non-substitutional use (primo-use and primo-dependency) (Bello, P-Y. et al. 2004b; Bello, Pierre-Yves et al. 2003; Cadet-Taïrou et al. 2007; Escots et al. 2003).

Since 2001, recent injecting has decreased while snorting seems to be becoming more widespread (Bello, P-Y. et al. 2004b; Bello, Pierre-Yves et al. 2003; Ceip De Marseille 2004; Kopp et al. 1998). Consequently, heroin users today more frequently start off by snorting, and may then begin injecting at a later stage than was previously the case. However, the quantitative and qualitative information collected in 2005 and 2006 reveal differing situations: recent injecting has stopped falling in the specialised centres and risk reduction organisations, while ethnographic observations reveal groups of young and highly vulnerable users in which the practice of injection is on the rise (Cadet-Taïrou et al. 2007; Centre D'évaluation Et D'information Sur La Phamacodépendance (Ceip) De Marseille 2006).

Among those persons who injected during the month gone by, it was found that in 2006, 30% of injectors shared implements (needles, spoons or filters). Among the snorters, 30% also shared their straws (Cadet-Taïrou et al. 2007)..

New developments in the field of consumption are described in [Epidemiological table no.17].

4.1 Estimated prevalence and incidence

No new information available

4.2 Profiles of the persons receiving treatment

We have two sources of information concerning persons receiving treatment: the use of the data supplied by the Specialised Drug Addiction Treatment Centres (Centres de soins

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

spécialisés en toxicomanie, CSSTs) and the information gathered from the low threshold structures.

4.2.1. Users dealt with by the CSSTs.

The profile of the persons receiving treatment presented in this paragraph corresponds to that of new patients beginning treatment in 2006, in the outpatient treatment centres only.

In 2006, 125 specialized drug addiction treatment centres (CSSTs) participated in RECAP, this representing 63% of the outpatient treatment centres. The data shown below concerns almost 36,000 patients who started treatment in these centres during the year.

Persons requesting treatment for the first time in their life (first-time patients) accounted for 32% of the new patients received. For the other patients, their request concerned a new request for treatment or the resumption of treatment following a break in contact with the treatment centre in excess of six months. The proportion of "first-treatment patients" among all patients should be considered with caution in as far as information regarding the existence of prior treatment is unavailable in 33% of cases.

In the description of "consumption habits" presented below, it should be borne in mind that out of the total number of replies to the question concerning the main drug type, approximately 5.8% of the responses stated "no substance consumed".

Patients receiving treatment (All treatments): Profile

Some 80% of new patients are male and are on average 28.3 years old, with three quarters being aged between 15 and 35. The age groups most prevalent are the 20-24 year olds (accounting for a quarter all patients) and the under 25s, accounting for 41% of the total. Almost one patient in eight is aged over 40. The age breakdown is shown in Table 4.1.

Table 4.1. Breakdown of patients by age (as a %), en 2006.

Age	All treatments	First treatments
< 20 y.o.	15.5	24.2
20-24 y.o.	25.2	35.4
25-29 y.o.	19.4	19.4
30-34 y.o.	15.4	10.1
35-40 y.o.	12.3	5.3
40 and over	12.2	5.6
Total	100.0	100.0

Source: RECAP / OFDT - 2006

More than a third of patients sought treatment themselves (36%) while 29% of requests resulted from a decision by the courts or the police. These are followed by requests for treatment initiated by a family member or friend (11%) and those initiated by another specialized centre for drug users (5%). The data concerning the reason for treatment is shown in table 4.2.

Table 4.2. Breakdown of patients according to the reason for treatment (as a %), in 2006.

Reason for treatment	All treatments	First treatments
Patient's own initiative	35.8	26.6
Family or friend	10.5	11.2
Other specialized centres for drug users	5.2	1.4
General practitioners	6.9	6.2
Hospital or other medical establishment	4.8	3.6
Social services	4.9	4.1
Police, courts or court-ordered treatment	28.6	43.6
Other	3.2	3.3
Total	100.0	100.0

Source: RECAP / OFDT – 2006.

Patients most often live with their parents or alone (41% and 26%) and most have a stable housing situation (77%). However, 20% declare that they live in unstable housing conditions. Concerning their socio-professional situation, patients who are economically inactive or unemployed account for 45%, while only 24% have a regular job and 16% are still secondary school children or students (please see table 4.3). In terms of education, 64% of the individuals treated in 2006 by the CSSTs had reached secondary school level. More than 5% of users have not got past primary school level and 31% declared that they had an educational level above the *baccalauréat* (A-level/High School Diploma).

Table 4.3. Breakdown of patients according to their professional situation (as a %), in 2006.

Professional situation	All treatments	First treatments
Regular job	24.0	27.1
Student or school pupil	15.7	23.4
Not economically active (e.g. housewife)	19.9	14.1
Unemployed	25.1	19.5
Other	15.3	16.0
Total	100.0	100.0

Source: RECAP / OFDT – 2006

Drug consumption

Table 4.4 provides details of the breakdown of patients and their average age, according to their declared main drug.

Almost half of the patients (47%) made use of the treatment centres in 2006 for their problems related to cannabis use. On average, they were aged 24.3 years old. Most of them (54%) declare that they used cannabis on a daily basis. For 18% of the sample, their consumption is frequent (between two and six days a week), while for 12% the substance was used once a week or less, with occasional users accounting for 15%.

This was followed by problems related to opiate use, mentioned as the main drug by 41% of respondents, aged on average 30.5 years old: 79% declared that they consume heroin, less

than 3% methadone and 18% other opiates (including HDB)[18]. Among the opiate users, almost 80% are daily consumers and 11% frequent consumers (several days a week). The opiates are mainly snorted (53%) and injected (25%).

Table 4.4. Breakdown (as a %) and average age of patients according to the main drug taken, 2006.

Main drug	All treatments		First treatments	
	%	Age	%	Age
Opiates	41.38	30.51	30.60	27.31
	32.82	29.74	26.35	26.66
	1.16	31.53	0.50	27.57
	7.40	33.76	3.75	31.86
Cocaine (total)	6.29	32.25	4.24	29.57
	4.92	30.94	3.62	28.51
	1.37	36.94	0.62	35.79
Stimulants	1.06	26.90	0.89	24.09
	0.30	27.35	0.30	24.62
	0.71	26.70	0,53	23.78
	0.05	29.07	0.06	24.00
Hypnotics and sedatives	2.35	35.36	0.97	35.32
	0,06	36.07	0.01	33.00
	1,81	34.85	0.63	35.50
	0.49	37.13	0.33	35.09
Hallucinogens	0,43	27.13	0.19	21.46
	0.30	26.16	0.17	21.50
	0.13	29.40	0.01	21.00
Glue and solvent	0.20	26.74	0.11	22.50
Cannabis	47.37	24.15	62.41	22.76
Other drugs	0.92	32.44	0.59	26.88
Total (all products)	100.00	28.34	100.00	24.80

Source: RECAP / OFDT – 2006

Cocaine is the third main drug: this was mentioned by more than 6% of patients, with an average age of 32 years old. The cocaine users declared that they consume this product every day (41%) or frequently (24%). Cocaine is snorted (52%) or smoked (34%) but is also injected by a non-negligible proportion of patients (13%).

Among all patients seeking treatment in 2006, three quarters (74%) declared that they had never used injection as a consumption method. Those patients having already used intravenous means were broken down into two equally-sized groups: half (13%) had not used this practice recently and the other half (13%) declared that they had injected during the month prior to the interview. Those having used injection during the month gone by were mainly opiate users (80%): 53% were heroin addicts and 26% declared that they used other opiates (including HDB (Subutex®)) as their main drug. Nevertheless, a non-negligible percentage of people using injection were treated for cocaine use (8%).

[18] For methadone and HDB, this means consumption not for therapeutic use.

First treatments: profile

Patients treated for the first time in their lives (referred to as first-treatment patients) can be distinguished from other patients due to their different demographic and socio-economic characteristics.

On average, they tend to be younger (24.8 years old vs. 29.3 years old for the other patients). 60% (vs. 36%) are under 25 years of age. They have a higher tendency to live with parents (50% vs. 38%) and are less likely to live alone (20% vs. 29%). Most of them live in stable accommodation (86% vs. 75%). A higher percentage of this group has a regular job (27% vs. 23%) or is still at school or studying (23% vs. 13%). Nevertheless, their educational level is not different from that of the other patients. The first-treatment patients stand out in particular due to the fact that a significantly higher proportion of them come for treatment after a court decision (44% vs. 24%) while fewer of them come forward of their own accord (27% vs. 39%).

Drug consumption

Since the launch of the "young consumers" clinics in 2005, it should come as no surprise to discover that cannabis has been mentioned as the main drug for most of the first treatment patients, with 62% of them consuming cannabis as their main drug in 2006. The prevalence of cannabis among requests for treatment is consequently higher among patients coming for the first time in their life to the CSSTs than for the other patients (62% vs. 43%). First treatment users of cannabis tend to have lower consumption frequencies than the other cannabis-consuming patients. They more often tend to be occasional users (17% vs. 15%) and are less likely to be daily users (51% vs. 59%).

After cannabis, opiates are the second most frequently cited "main drug" by patients treated for the first time in their lives (27% vs. 44%), followed by cocaine (4 % vs. 7 %). Among opiate users, the first-treatment patients are on average younger than the other patients (27.3 years old compared to 31.2 years old). Their consumption practices differ from those of the other opiate users. Their consumption frequencies seem to be higher: daily uses are more numerous (84% vs. 79%) to the detriment of occasional uses (3.7% vs. 6.5%), although an analysis of their consumption methods appears to indicate that injection is less frequently used by first-treatment patients (15% vs. 28%) who prefer snorting (68% vs. 50%).

Those individuals coming to the centres for the first time in their lives for cocaine use were aged on average 29.5 years old (compared to 32.8 years old for the other cocaine users treated by the CSSTs). A lower percentage of first treatment users of cocaine use this drug on a daily basis (37% vs. 44%), and they tend to use it less frequently by intravenous means (8% vs. 14%).

As shown by the analysis of consumption methods by substance group, those persons welcomed by a CSST for the first time in their lives are less likely to use drugs by intravenous means than patients who have already received treatment. Consequently, in 2006, 89% of first-treatment patients (considering all drugs together) had never used injection as a usage method (compared to 71% among the other visitors to the centres).

Conclusion

As in 2005, the 2006 RECAP data clearly underline the heterogeneity of the various individuals received in the outpatient CSSTs. Two main groups can be distinguished: firstly, those persons treated for problems related to cannabis use, and secondly those receiving opioid substitution treatment and declaring problem drug use for opioids and/or cocaine.

The profile of the patients treated in 2006 is very similar to that of the patients treated in 2005. Nevertheless, a number of differences may be noted: the average age is slightly higher (28.3 years old compared to 27.9 years old), they are more likely to live alone (26.3% vs. 24.8%) and are more likely to be unemployed (25.1% vs. 21.9%). The patients received in 2006 by the CSSTs have a higher tendency to be referred there following a decision by the courts or the police (29% vs. 26%) and are less likely to have been referred there by another social/health establishment (17% vs. 21%). The percentage of first treatment patients" among all new patients is similar to that seen in 2005 (32 % vs. 34 %). The prevalence of cannabis among treatment applications in 2006 was very close to that of 2005 (47.4% vs. 48%) while that of cocaine and opiates increased (47.7% vs. 45.5%). Cannabis use was less likely to be daily (53.6% vs. 57.4%). Where the consumption method for drugs is concerned, the prevalence of injection (11.1% vs. 12.9%) and, to a lesser degree, that of smoking/inhalation, fell in 2006, faced with an increase in snorting (24.6% vs. 20.6%). These changes in the means of consumption of drugs were particularly marked among girls.

The continuing high prevalence of cannabis among treatment requests in 2006, which was particularly significant in the first treatment patients sub-group, can be explained by the existence within many CSSTs of specialised clinics for young consumers of cannabis or other substances[19]. Furthermore, the many young cannabis users referred to the CSSTs by the courts or the police also tend to explain the high prevalence of cannabis among treatment requests. It should be noted that 27.5% of cannabis users tend to consume this product on an occasional or infrequent basis.

Treatment requests for problem uses of opiates remain at a high level and today concern increasingly older patients. Recent injecting (during the month gone by) is used in order to consume the main drug for 13% of drug users. Nevertheless, if we exclude the users of cannabis as their main drug, the proportion of patients having opted for injection as the administration method during the month gone by totals 21.4%.

These average figures obtained from all patients and from within the first treatment patient sub-group, appear to hide a number of disparities between the sexes, in particular concerning the substances consumed and consumption habits. Consequently, the prevalence of cannabis in treatment requests for girls tends to be lower, and that of opiates, cocaine and psychotropic medicine tends to be higher. Compared to the boys, the girls more often snort, eat or drink drugs, and are less likely to smoke or inhale them.

4.2.2. Users attending low threshold structures.

The survey among the users of low threshold structures offers the only quantitative and regular source of information concerning active users visiting drug centres located in towns.

The average age of the persons surveyed was 31.2 years old and 82% of these were men, with 25% under 25 years old and 35% at least 35 years old. Among these, 68% were childless and 20% had a child. Only 8% live with at least one child. Almost half lived alone (46%), 21% with a partner, and 20% with friends. A total of 15% had reached *baccalauréat* (A-level/High School Diploma) level, regardless of whether or not they had passed the exam and 44% had reached BEP or CAP level (a secondary school level vocational diploma). During the last six months, one in five was without income (22%), while 27% received a salary or unemployment benefits, and 45% received social welfare payments. Over the same period, 22% undertook an intermittent or continuous paid activity, 18% were

[19] The "young consumers clinics" were set up as part of the *2004-2008 Governmental programme addressing illicit drugs, tobacco and alcohol*, in order to provide a solution for young people who may possibly be in difficulty as a result of their consumption of cannabis or other substances. Some 75% of these clinics were set up within a specialised drug addiction treatment centre (CSST).

unemployed, 35% were inactive and 2.5% were students (with no paid activity). Where access to care is concerned, 57% were covered by the "CMU" (the *Couverture Maladie Universelle*, i.e. free health care scheme) and 10% had no cover whatsoever.

Among users questioned in low threshold structures in 2006 (N=1017), cannabis remains the most frequently consumed substance, ahead of alcohol (74% declare consuming alcohol at least once a month, including 65% who drink at least five glasses on each occasion).

A third of the users interviewed had consumed heroin during the previous month, this being four percentage points higher than in 2003. This last figure marks an upturn, compared to the regular falls observed since 2001 (Beck, F. et al. 2006b; Bello, Pierre-Yves et al. 2002; Bello, Pierre-Yves et al. 2003; Bello, Pierre-Yves. et al. 2004c). In 2006, we should note the growth of snorting and inhalation as a means of using heroin, particularly among younger users and among those also present on the "party" scene (N=349, including injecting: 54 %, snorting: 54 %, and inhalation: 34 % - Cadet-Taïrou et al. 2007)).

The results show that it is now high dosage buprenorphine which has become the most widely consumed opiate among users of front line structures. Among the 44% of users who stated that they used this drug during the previous month, only 49% used it for therapeutic reasons (please see the misuse details in chapter 5, point 5.3). Moreover, the misuse of morphine sulphates is also increasing locally at numerous sites including Paris and Rennes in particular, but also Marseilles to a lesser degree (among the sites participating in the TREND network), and particularly among socially marginalised young people. Among the entire sample surveyed by PRELUD, use during the previous month rose from 9% to 16% between 2003 and 2006, and usage for the sole aim of "getting stoned" rose from 3.2% to 9% over the same period.

The use of cocaine, the frequency of which has increased among the entire population appears to be remaining relatively stable among those persons attending low threshold structures. The major change concerning cocaine use lies in the increased use of injecting. Whereas in 2003 (N=320) 46% of cocaine hydrochloride users injected, this figure had increased to 54% by early 2006 (N=348). We should also note that for 13% of drug users having already injected a substance, the first substance injected during their lifetime was cocaine. The staff in the front line structures report the existence of drug users in a state of complete physical and psychological exhaustion, as a result of their compulsive injection practice.

The use of MDMA and amphetamines among users in the front line structures is chiefly limited to those who are also closely associated with the "techno/party" scene. Indeed, only 9% of users having participated in party events fewer than 10 times during their life took MDMA during the previous month, compared to 30% of the others. The same applies where amphetamines are concerned. The practice of injecting MDMA and amphetamines seems to be rising among the users attending front line structures. (MDMA: 13 % in 2003 N=294, 19 % in 2006, N=204, amphetamines, 22 % in 2003, N=201, 40 % in 2006, N=224). Snorting is also becoming increasingly frequent (rising from 15 % in 2003 to 18 % in 2006).

The use of natural or synthetic hallucinogens by this group remains moderate, and no major changes have been witnessed.

Table 4.5. Consumption frequency during the individual's lifetime and during the last month, among users attending low threshold structures (2006).

	10 times or more during lifetime	Previous month	Every day*
At least 10 glasses of alcohol per occasion	-	30 %	21 %
Cannabis	95 %	86 %	54 %
Heroin	77 %	34 %	11 %
HDB	69 %	44 %	31 %
To get stoned only		*12 %**	
Methadone	44 %	24%	16.5 %
To get stoned only		*4 %**	
Morphine sulphates	34 %	16 %	7 %
To get stoned only "		*9 %**	
Codeine	33 %	16 %	1.2 %
To get stoned only "		*45 %**	
Poppy heads	36 %	5 %	-
Cocaine or crack	79 %	40 %	7 %
Hydrochloride		*34 %*	*5.3 %*
Base		*16 %*	*2.6 %*
Ecstasy	65 %	20 %	0.9 %
Amphetamines	60 %	22 %	2 %
BDZ	56 %	30 %	18 %
To get stoned only		*11 %**	
Hallucinogenic mushrooms	53 %	8 %	-
Ketamine	30 %	9 %	0.6 %
Solvents / poppers	46 %	10 %	0.9 %

Sources: Prelud 2006, TREND / OFDT (Cadet-Taïrou et al. 2007)

Usage method.

In 2006, 68% of users attending low threshold structures had already experimented with injecting (for 62%, more than 10 times). The percentage of recent injectors among users attending low threshold structures, which plunged between 2000 and 2003, stopped falling in 2006 (43.6% in 2003, 46.2% in 2006). From a quantitative point of view, we are seeing an increase in injecting for HDB and for stimulants (Table 4.6). Qualitative monitoring (via the TREND scheme) has revealed an increase in injecting among the most vulnerable and precarious user groups. This concerns mainly young, marginalised males living in extremely precarious situations and attending both front line centres and "alternative" party gatherings on a somewhat "opportunistic" basis.

Table 4.6. Changes in injection frequency for products consumed during the last month, among users of front line structures between 2003 and 2006

	2003 (N=855)		2006 (N=1017)	
Heroin	53 %	(135/255)	54 %	(188/348)
Cocaine (hydrochloride)	46 %	(147/320)	54 %	(189/348)
HDB	47 %	(71/367)	58 %	(260/446)
Ecstasy	13 %	(38/294)	19 %	(39/204)
Amphetamines	22 %	(44/201)	40 %	(90/224)

Source: PRELUD / TREND / OFDT 2006 (Bello, P-Y. et al. 2004a; Cadet-Taïrou et al. 2007).

In the front line structures, the proportion of people experimenting with snorting during their lifetime is as high as 90%, whereas 42% of users have used this during the month gone by, as in 2003. Those having attended an alternative techno dance event at least 10 times during their life tend to have used it more frequently (60% during the last month).

Although in 2006, 59% of all drug users attending front line structures had smoked drugs at least once in their life (for a substance other than tobacco or cannabis), only 27% of them used this administration method during the last month. We are witnessing the increasing prevalence of "contamination" between the various administration methods specific to each substance.

Consequently, this year field observers and/or available quantitative data confirm the increased use of snorting and smoking for heroin, the increased use of cocaine, traditionally snorted, by injecting or inhaling, greater visibility of the practice of injecting and sniffing ecstasy in addition to the increased use of amphetamine injection. The high level of "porosity" between the techno/party scene and the risk reduction structures in urban areas via young, marginalised people in addition to polydrug use have doubtless contributed to such crossovers of drug administration practices.

Among the 471 recent injectors, 13% stated that they have shared their syringes, 23% their spoons and 20% their filters during the last month. A total of 42% stated that they reused their own syringes, of which 8% stated more than five times. Among the 427 users who snorted during the month, 30% shared their straws, (with more than half stating that they shared it more than 5 times).

5. Treatments

Treatments: general context

Where treatments are concerned, the strategy adopted by the public authorities is aimed at offering a diverse range of therapeutic responses and services, making it possible to provide everyone concerned with a response best suited to their situation while at the same time constantly seeking to improve the quality of care. Three systems are used when treating illicit drug users: a care system specialised in addictology (in medico-social establishments), the general care system (hospitals and general practitioners) and the risk reduction system.

1. The specialised system

Since the early 1970s, treatments for illegal drug addictions have been based around the so-called "specialised structures". These structures developed following the adoption of the law of 1970 which included a number of provisions guaranteeing anonymous and free treatment for all illicit drug consumers keen to be cured of their addictions. Virtually all French *départements* today have at least one Specialised Drug Addiction Treatment Centre *(*Centres spécialisés de soins aux toxicomanes or CSST*)*.

Originally financed by the state, and now financed (since 1 January 2003) by the social insurance schemes as medico-social establishments, these structures have the task of jointly providing medical, social and educational support which includes help with social rehabilitation or reintegration.

Three types of CSST exist:

- Outpatient treatment centres (there were 209 of these in 2005);
- Inpatient treatment centres (41 in 2005);
- Prison treatment centres (16 in 2005).

The outpatient CSSTs satisfy patients' requests for outpatient detoxification treatment. They can also organise and support patients wishing to attempt detoxification treatment in a hospital environment. Where substitution treatments are concerned, from 1993/1994 and up until recently (2002), the doctors working in CSSTs were the only ones authorised to initiate methadone treatments, with prescriptions subsequently passed on to GPs. Patients can also be prescribed HDB via a CSST. As part of the scheme, patients may also seek psycho-therapeutic support and help with social integration.

In France, the concept of "drug free treatment" is not really used and it is difficult to match this to any type of institution or treatment. However, the new 2004-2008 five-year programme recommends the expansion of substitute-free programmes, and particularly the use of "therapeutic communities".

2. The general system

The expansion of the specialised care system does not make it possible to meet all treatment requirements for illicit drug users. During the 1990s, the focus shifted to improving the way in which patients with addictions are handled by the general health care system (hospitals and general practitioners).

2.1 The hospitals

Within the hospitals (health establishments), the treatment of addictions is based on addictology treatment and liaison teams, city-hospital networks and the

availability of hospital beds for detoxification and the performance of medical-psychological-social assessments.

Created by the circular dated 3 April 1996, the addictology treatment and liaison teams (which generally comprise three people including a hospital doctor) have the task of training and assisting the hospital's care teams, drawing up treatment protocols, and responding to the needs of hospital patients and emergencies. These teams must also forge links with the care system which allow for the medical-psychological-social monitoring of patients. They carry out prevention, information and awareness building activities within the establishment. In 2003, around 100 health care establishments had active teams. However, the activities of these teams are largely devoted to alcohol and tobacco addiction.

The city-hospital networks were also created by the circular dated 3 April 1996. In 1998, 67 networks were operational, spread throughout the whole of the country. In 2002, a total of 114 addiction networks were running, 107 of which were located in mainland France. These are jointly financed by credits from the health insurance scheme and credits granted by the state.

Finally, we should note that since 2002, all doctors practising in a healthcare establishment are authorised to prescribe methadone.

2.2 The general practitioners

Today, the general practitioners play a central role when it comes to prescribing opioid substitution treatments. Since 1996, they have been allowed to prescribe HDB to patients addicted to opiates. They may also prescribe methadone after initiating treatment via a CSST.

Moreover, the general practitioners are the first to intervene when dealing with patients just beginning illegal drug use. Consequently the public authorities intend to introduce specialised training aimed at general practitioners in order to enable them to identify such consumption and to implement the therapeutic solutions best suited to the circumstances.

Based on data from the *Caisse primaire d'assurance maladie* (CPAM) - Primary Medical Insurance Fund - it had been established that 35% of general practitioners in 13 different cities had prescribed a substitutiton treatment during the second half of 2002. However, the prescription activity (whether concerning methadone or HDB) is often concentrated upon a limited number of doctors. The average standard dose received by a patient treated using Subutex® is 9.6 mg (maximum recommended dose: 16 mg per day). This dosage level is 98.4 mg for a patient receiving methadone (maximum recommendation: 100 mg per day) (Cadet-Taïrou et al. 2007).

3. The harm reduction scheme (please see panel 7 "responses to health problems").

Epidemiological table no.21 provides information concerning various treatments used in France and their availability. Structured questionnaire no. 27 supplies additional information concerning the available treatment programmes.

The use of opioid substitution treatment is relatively recent in France (1993) and motivated by the need to deal with the HIV epidemic.

In 2003, the estimated number of people enrolled in treatment processes was between 63,000 and 69,000 (Cadet-Taïrou et al. 2007), i.e. less than half of the total number of estimated opioid users in France.

The prescription of methadone substitution treatments by town doctors (following initial treatment in a specialised establishment) was authorised in 1995. The latest estimate of the number of people receiving methadone substitution from

their GPs based on sales data (SIAMOIS / OFDT) dates back to 2005 and concerned between 14,100 and 20,177 people.

Due to the fact that access to substitution treatments in specialised centres was insufficient in order to meet requirements, a separate range of treatments based on the use of HDB was set up alongside the methadone treatments from 1996 onwards. The enrolment and prescription methods are more flexible than those used for methadone. Treatment can be authorised by prescription by any doctor with no particular practice requirements. The maximum prescription is for 28 days broken down into 7-day allocations unless stated otherwise. In 2005, between 75,087 and 87,253 people received Subutex®. It had been estimated three years earlier that out of all users receiving Subutex® approximately 65% were enrolled in a medical treatment scheme whereas 28% received prescriptions for substitute products on an irregular basis, and 6% often had these treatments prescribed in order to resell the drugs (Cadet-Taïrou et al. 2007).

In addition to the beneficial effects noted following the introduction of substitution treatments (including a positive impact both at a social and health-related level), adverse consequences related almost exclusively to HDB were also observed. These incidences of misuse are chiefly related to the flexible prescription terms for the product. This involves the injection of HDB including for patients under medical supervision, use outside the medical protocol (non-substitutional use), and its use with other substances (benzodiazepines or alcohol, etc.).

5.1 System

No new information available

5.2 "Drug free treatment"

No new information available

5.3 Medical treatments (detoxification, substitution)

5.3.1. Detoxification carried out or monitored by Drug Addiction Treatment Centre Staff.

In 2005, on average almost 16 patients per centre underwent an outpatient detoxification treatment via a CSST (table 5.1), and almost 10 patients underwent detoxification in a hospital environment with support from the centre. The average number of patients having undergone outpatient detoxification treatment appears to have increased sharply between 2003 and 2004. The use of a new activity report in 2004 (in which the question concerning detoxification through the reduction of prescribed doses of substitution treatments was deleted) may have had an influence on changes for this specific indicator. Indeed, we may assume that a number of the positive responses to this last question were transferred across to the question concerning outpatient detoxification treatment. The question of detoxification in a hospital environment was not posed in activity reports predating 2004.

Table 5.1. Average number of patients having undergone detoxification, per CSST, 1998-2005.

	1998	1999	2000	2001	2002	2003	2004	2005
Average number of patients per CSST having undergone outpatient detoxification treatment provided by the CSST	6.8	5.7	6.2	8.4	10.6	11.0	16.8	16.1
Average number of patients per CSST having undergone detoxification in a hospital environment with support from the CSST (per centre)	na	na	Na	na	na	na	10.3	13.2

Source: The processing of standard activity reports from the CSST (outpatient drug addiction treatment centres) 2005, DGS/OFDT.

Reading notes: on average, for each CSST 6.8 patients underwent outpatient detoxification treatment provided by the CSST in 1998. Note: the calculation was carried out by excluding those structures having performed more than 150 detoxification operations or those which failed to answer the questions concerning activity levels. The total number of patients having undergone detoxification is calculated by extrapolating the average number of detoxification operations for all CSSTs having less than 150 new intakes of patients undergoing detoxification. To this figure should be added the total for those centres excluded from the previous calculation due to the sheer quantity of new intakes of patients having undergone detoxification.

According to the data supplied by the CSSTs, we may estimate the number of patients having undergone detoxification in 2005 to be approximately 9,000 compared to 7,500 in 2004. This increase is related to the increase in the average number of detoxification operations carried out in hospital environments, and to a rise in the number of detoxification operations carried out by the centres, which performed more than 150 of these.

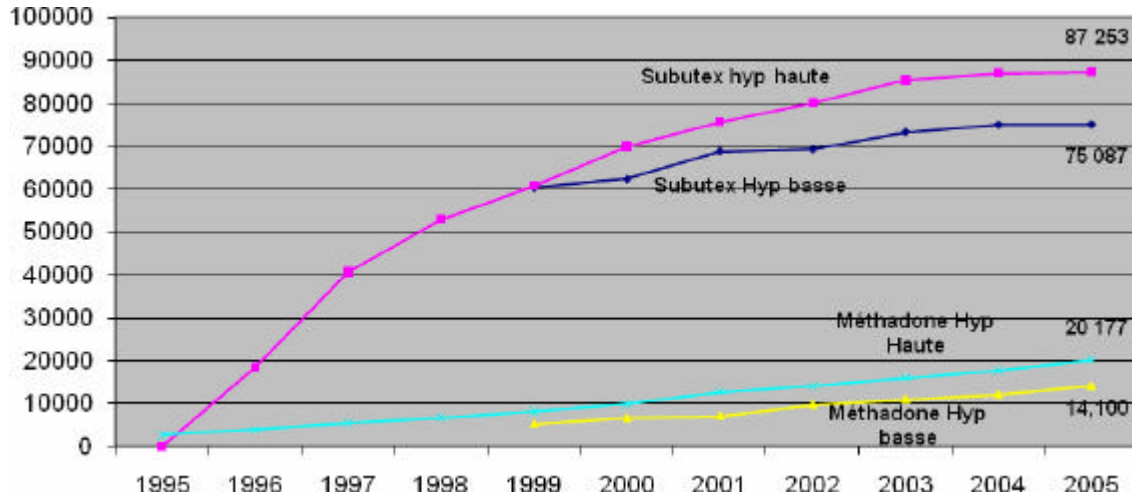
5.3.2. Substitution treatments.

Two medicines are used for opioid substitution treatments: methadone (the prescription of which can only be initiated by the CSSTs and the care establishments) and High Dosage Buprenorphine (HDB) or Subutex® which can be prescribed right away by any doctor. Following its launch in 1996, HDB has quickly become the leading substance for treating opioid dependence in France in quantitative terms.

In 2005, HDB represented approximately 80% of the substitute treatments, with between 75,087 and 87,253 people receiving it. The proportion of patients receiving methadone rose slightly in 2005 (between 14,100 and 20,177 people, i.e. between 15 and 20% of all patients receiving substitution treatments), with the ease of access to methadone also being included among the recommendations made by the Substitute Treatments Consensus Conference in June 2004. We should also note that since 2006 Subutex® has no longer been the only substance available as HDB generic speciality products are also appearing on the market.

Graph 5.1 below shows the estimated number of patients treated in France using HDB and methadone. This data is derived from the refunds issued by the social security system, based on two hypotheses (low and high scenarios).

Graph 5.1. Opioid substitution treatments: number of drug users treated with high dosage buprenorphine (Subutex®) and methadone – 1995-2005.



Sources: GERS/SIAMOIS/InVS and CNAMTS/estimations OFDT

However, it should be stipulated that a certain proportion of the prescribed buprenorphine is used illegally and is not always consumed as part of the treatment process. Indeed, according to data supplied by the health insurance system from 2002, out of the 79,000 patients having received at least one prescription, it can be estimated that 65% of them were enrolled for a medical treatment course, that 28% of them received prescriptions for substitute products in an irregular manner, and that approximately 6% of them had these treatments prescribed (often by several doctors at the same time) with the aim of reselling the drugs.

Patients monitored via the CSSTs.

An average of almost 80 patients per structure received a methadone prescription via the CSST, this figure being slightly higher than in 2004 (65 people). An average of 56 patients received an HDB prescription. The figures from 2005 appear to show an increase in the prescription of substitution treatments, particularly for methadone. The total number of patients having received a substitution treatment prescription from a CSST in 2005 can be estimated at approximately 36,000 (with slightly over 19,000 for methadone and almost 17,000 for HDB).

Table 5.2. Average number of patients per structure having received a prescription for a substitution treatment within the structure, 1998-2005.

	1998	1999	2000	2001	2002	2003	2004	2005
Average number of patients per structure with methadone substitution treatment	35	47	50	59	69	70	65	79
Average number of patients per structure with HDB substitution treatment	41	49	50	52	57	55	46	56
Average number of patients per structure with other substitution treatment	3	3	3	2	2	4	1	na

Note: figures revised vis-à-vis the 1998-2001 data.
(1) Structures having supplied activity data. Additionally, data has not been taken into account from two CSSTs whose new patient intakes exceed 1400 people, and whose presence or absence in the database is likely to

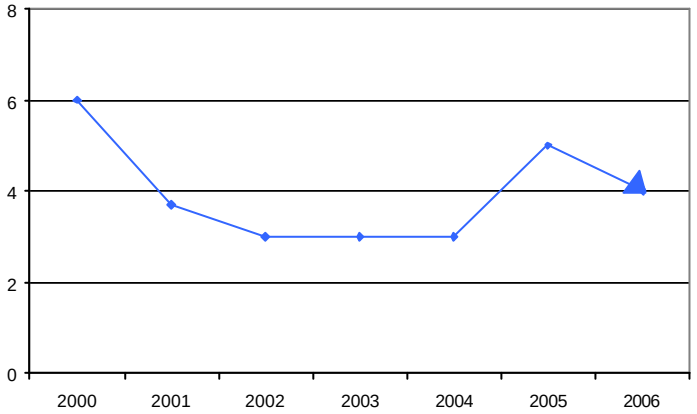
result in major variations from one year to another. Finally, in order to optimise the comparison of the data, in 2004 the figures from the methadone bus were not included.
Source: the processing of standard activity reports from the CSSTs (outpatient drug addiction treatment centres) 2005, DGS/OFDT

The misuse and trafficking of HDB.

From 2004 onwards, the health insurance system implemented a plan aimed at limiting incidences of prescribed buprenorphine diverted to the black market. The checks and balances put in place were chiefly aimed at identifying dealers ("patients" but also, in a number of cases, doctors and pharmacists) via refund data, and at supervising users having at least five prescribers or receiving an average dose in excess of 32 mg. With the exception of the city of Toulouse, it appears that these measures have had little impact upon the availability of HDB on the black market. Certain regions, including in particular the Paris region, the Marseilles region and to a lesser extent eastern France have seen the emergence of trafficking networks which are today better organised than was previously the case, including fewer users reselling their surplus, but better organised frauds perpetrated against the health insurance system by a collective "Doctor Shopping" organisation (including the theft of health refund cards, and the use of "false users", or consultations in several *départements*. At the same time, the scale of international trafficking towards eastern and northern Europe has intensified in these regions (data provided by the TREND scheme) (Cadet-Taïrou et al. 2007). In 2005, HDB became the second medicine to be the subject of fake prescriptions (Centres D'évaluation Et D'information Sur La Pharmacodépendance (Ceip) 2006).

The impact of price measures was perceptible in 2005, with a fall to previous price levels in 2006 (approximately €4.00 per 8 mg tablet, with price variations based on specific local situations).

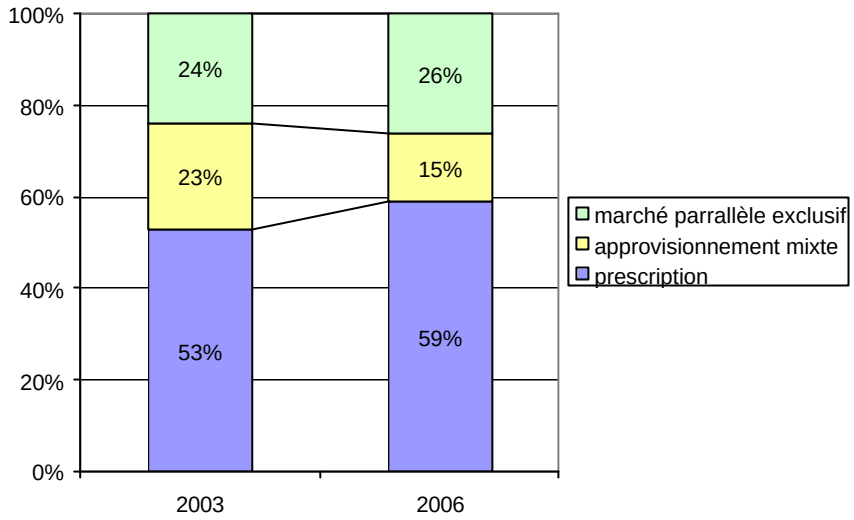
Graph 5.2. Price of an 8 mg buprenorphine tablet on the black market between 2000 and 2006.



Source: TREND / OFDT

Although these measures have not succeeded in reducing the actual trafficking of these drugs, they do however appear to have made it possible to effectively supervise users receiving treatment. The graph below shows that the percentage of users attending low threshold structures obtaining HDB both by prescription and on the black market declined between 2003 and 2006.

Graph 5.3. Sources of supply for users attending low threshold structures having consumed high dosage buprenorphine during the previous month (N= 353, N =436), 2006.

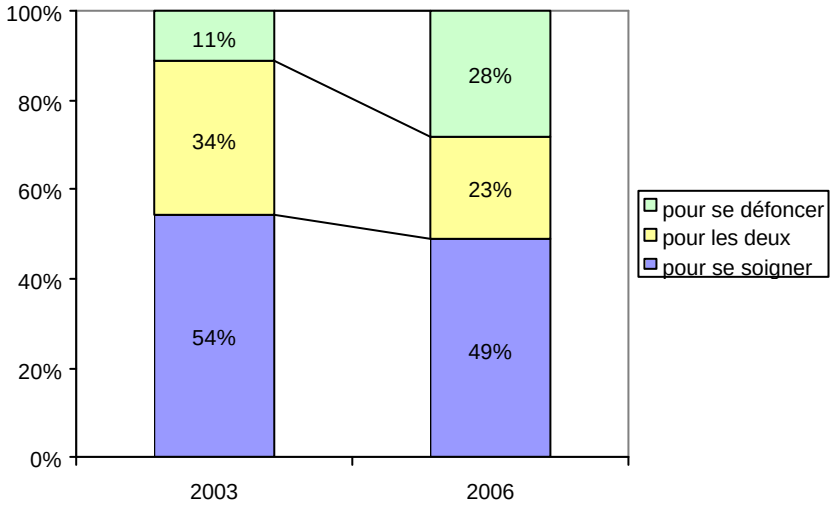


Sources: Première ligne 2003, Prelud 2006, TREND / OFDT

Drug use to get stoned only

The same seems to apply concerning the intentions behind the use of drugs. We are witnessing a reduction in mixed use (drug use aimed at "getting stoned" and at receiving treatment or at getting off heroin), while at the same time we should note an intensification of "addict" uses among certain vulnerable homeless youngsters or former heroin users from Eastern Europe. It is particularly among the latter that the practice of injecting is today increasing. Indeed, we have seen an increase in the use of injecting as an administration method among users having taken HDB during the last month, these levels rising from 47 % in 2003 (N=467) to 58 % in 2006 (N=446).

Graph 5.4. Intentions underlying the use of high dosage buprenorphine among users attending front line structures having consumed the drug during the preceding month (N=360, N=445), 2006.



Sources: Première ligne 2003, Prelud 2006, TREND / OFDT

Among those buprenorphine users seeking simply to get stoned, 32% totally or partially obtained their supplies by prescriptions (table 5.3). On the other hand, 16% of those using it with a therapeutic goal (with the aim of ceasing or reducing heroin use) obtained it exclusively on the black market.

Table 5.3. Sources of buprenorphine supplies for users attending low threshold structures according to intended use, 2006.

		"For treatment", n=213	"To get stoned", n=121	Both, n=102	Total
Prescription	% line	61	14	25	100
n=257	% column	74	31	62	59
Non-prescription	% line	30	58	12	100
n=114	% column	16	55	14	26
Both	% line	34	28	38	100
n=65	% column	10	15	25	15
Total	% line	49	28	23	100
	% column	100	100	100	100

Sources: Prelud 2006, TREND / OFDT

Those persons encountered in the low threshold structures taking HDB purely in order to get stoned frequently live in extremely unstable situations: 68% of them live in unstable housing conditions (unable to spend six months in the same accommodation) while 54% are homeless or live in squats. Furthermore, 39% have no legal resources and 18% are without health cover.

Injecting and snorting

Injecting HDB seems to be gaining ground among the "unstable" population groups. At the same time, long-term patients of substitution treatments are seeking wherever possible to adopt snorting instead, due to the condition of their veins, and a large percentage of new HDB consumers begin their consumption of this product by snorting which is considered less of a stigma (qualitative data from the TREND scheme). (Cadet-Taïrou et al. 2007).

In 2006, the injection of HDB during the individual's lifetime concerned 67% of users attending low threshold structures and having consumed HDB more than 10 times during their lives. HDB is the first substance used for 6% of lifetime prevalence IDU and for 9% of lifetime prevalence HDB IDU (IDU: injection drug users). Among recent users, 58% injected this drug during the month gone by (compared to 47% in 2003).

Among the drug users interviewed within a therapeutic framework (in specialised centres), injectors were fewer.

Snorting is preferred by 22% of users attending low threshold structures (Cadet-Taïrou et al. 2007).

Methadone misuse

Despite the appearance of the increasingly visible misuse of methadone alongside its official distribution, this nevertheless remains moderate when compared to that for HDB.

In 2006, of those users encountered in low threshold structures having consumed the product during the last month, 29% had obtained it exclusively or partially on the black market (22% in 2003).

Partial or exclusive misuse concerned 29% of methadone users attending low threshold structures (compared to 24% in 2003).

Less than 2% of methadone users stated that they had injected it during the previous month (Cadet-Taïrou et al. 2007).

6. Health consequences

Health-related consequences: general context

Mortality linked to drug use:

The information system available in France is based on several schemes each covering parts of the causes of death related to drug use. These concern deaths:

- By overdose, when the death is covered by a legal procedure (OCRTIS) [epidemiological tables 5 and 6]. The statistical source covers only those deaths notified to the police and gendarmerie, and does not cover the overdose deaths of French citizens abroad or deaths occurring in hospitals.

The number of overdose deaths recorded by the security forces is constantly falling (-90 % since 1995 with 57 cases deaths recorded in 2005). Apart from the problems of recording such deaths, the reduction in the number of overdoses in France is the result of a combination of several factors including: the introduction of substitution treatments, the existence of risk reduction structures and schemes, or changes to the substances consumed and their consumption methods among users. Most overdose deaths recorded by the security forces are related to heroin, although medicines (including Subutex® and methadone) have seen their share increase between 2002 and 2004 (accounting for almost a third in 2004), and despite the fact that a sharp rise in deaths caused by cocaine was recorded in 2004 (this drug accounting for a fifth of deaths). In 2005, more than half of deaths were a result of a heroin overdose[20]. The OCRTIS has not supplied updated information showing a breakdown of causes for the year 2006.

- By drug dependency (CepiDc-INSERM) [Epidemiological table 5]. This category concerns all deaths for which the death certificate mentioned drug dependency. For reasons related to the nature of the information circuit, it is not particularly effective at recording overdoses, which are often listed in the group "unknown cause of death". The number of deaths through drug dependency fell between 1995 and 2000 (the year in which the WHO international pharmacopoeia, 10th revision was implemented) and remained unchanged between 2000 and 2005.

- With the presence of psychotropic substances in the blood: the DRAMES scheme (Décès en relation avec l'abus de médicaments et de substances - AFSSAPS) lists those cases of death for which a legal inquiry was launched, and consequently makes it possible to identify those deaths which were not declared to the INSERM or the OCRTIS. Two retrospective studies were carried out for the years 1998 and 2002, in addition to a forward looking study in 2002 with 7 medico-legal toxicology laboratories volunteering to take part. Subsequently, 16 laboratories were included in 2003 and 2004. A reduction in the number of recorded deaths was noted in 2003 (64 compared to 131 in 2002), followed by a slight increase in 2004 (91 cases). With regard to the substances encountered, in line with the findings of the OCRTIS data, cocaine was found to have increased sharply in prevalence during 2004, achieving prevalence identical to that of heroin which for its part, was declining. The role of substitution treatments concerned 38% of recorded deaths in 2004 with methadone being identified in more than three quarters of cases (Arditi et al. 2006). In 2005, the DRAMES data revealed 66 cases of fatal overdoses: heroin was responsible for most deaths (23

[20] Central Office for the Repression of Narcotics Trafficking - *Office central pour la répression du trafic illicite de stupéfiants* (OCRTIS), Usage et trafic des produits stupéfiants en France en 2005, Nanterre, OCRTIS, 2005, 123 p.

cases). Cocaine was responsible for 7 deaths (compared to 20 in 2004) but the number of cases combining heroin + cocaine is rising (11 cases compared to 2 in 2004). In line with the findings of the OCRTIS data, the percentage of deaths involving substitution treatments fell in 2005, concerning 19.6% of deaths, with methadone being identified in virtually all cases (11 cases out of 12). No updated data is available for the year 2006.

- Related to AIDS among intravenous drug users (InVS). The number of AIDS deaths among intravenous drug users has been falling since 1994. The share of these deaths among all AIDS deaths has remained stable since 1998, at between 22 and 27% (23% in 2004).

For want of a cohort survey meeting the criteria laid down by the EMCDDA (i.e. the involvement of users in treatment centres), the OFDT has carried out a cohort study based on those persons arrested for substance use. The Standardised Mortality Ratio (SMR) figures show that the men arrested for heroin/cocaine/crack use generally have a risk of death level five times higher than other French males. This risk is 9.5 times higher for women. The survey shows a significant fall in mortality among persons arrested for heroin/cocaine/crack between the two periods concerned (1992/93 and 1996/97), with the mortality rates calculated over the four years following the arrest falling from 10.3 to 6.2 per thousand people/years. This fall coincides with the introduction of triple antiviral therapies, the development of a harm reduction policy in France and the availability of opioid substitution treatments (Sansfacon et al. 2005).

Morbidity related to drug use:

1. Infectious illnesses account for the bulk of somatic morbidity cases observed. Estimations of prevalence among drug users are based on:

- The declared prevalence of HIV, HBV and HCV: the so called "November" survey based on patients visiting the CSSTs (Tellier 2001), with this survey replaced by data derived from the RECAP scheme from 2005 onwards in addition to the survey among users of "front line" structures (Bello, P-Y. et al. 2004b; Bello, Pierre-Yves et al. 2003) [Epidemiological table 9] itself replaced by the PRELUD survey from 2006 onwards. Based on the RECAP 2006 data, the prevalence of HIV among patients having already used injection and of known serology is almost 9% and that of HCV is 52 %.

–The biological prevalence of HIV and HCV (blood samples) among users thanks to the Coquelicot survey (Jauffret-Roustide et al. 2006). This study, which is intended to eventually become a national information system, has highlighted the variations existing between the declared and measured prevalence of hepatitis C, in particular among the youngest patients. It also shows that riskpractices continue, offering favourable conditions for the continued spread of HCV and HIV.

–The biological prevalence of HIV and HCV (saliva samples) among users of front line centres: the PRELUD survey which started in February 2006, in five French cities. The results from this study are currently pending.

- Estimated incidence levels concern cases of AIDS and HIV infection. The notification of aids cases (InVS) has existed since the early 1980s and has been compulsory since 1986. A new anonymous declaration scheme was set up in 2003 via the circular from the General Health Authority (Direction Générale de la Santé or “DGS”) - (no. 2003/60 dated 10 February 2003), which also made it compulsory to declare HIV infections. This system is combined with the virological monitoring of HIV.

The number of new AIDS cases related to injectable drugs has been constantly falling since 1994 (1,377 in 1994 compared to just 98 in 2005) as has its overall percentage among all declared AIDS cases (36% in 1991, 19% in 1997 and 8% in 2005). The number of AIDS cases diagnosed among intravenous drug users shows a similar pattern regardless of gender, with the number of male cases still being higher than the number of female cases (with a ratio of approximately four men for every woman).

2. Psychiatric comorbidities: the limited number of investigations in France do not make it possible to draw any consistent conclusions concerning the prevalence of various psychiatric illnesses among drug users (Wieviorka 2003).

3. Other pathologies related to drug use: there is no systematic data collection scheme in place for gathering data concerning other pathologies which may accompany or arise from the use of drugs (other infectious complications, cardiovascular complications, trauma, etc.). The survey carried out as part of the TREND scheme among the users of "front line" centres supplies indications concerning their perception of their state of health in addition to the appearance of certain pathologies (Bello, P-Y. et al. 2004b; Bello, Pierre-Yves et al. 2003). Illness was more frequent among those persons living in conditions of greatest precariousness, with a third of those surveyed stating that they felt that they were in poor or very poor physical health. Almost 70% stated that they suffered from fatigue during the month gone by, with 44% experiencing a loss in weight, 4% an overdose, and 2% jaundice. The frequency of complications stated as being related to drug injection has also been estimated.

4. Driving: the law dated 3 February 2003 made it a criminal offence for any person to drive a vehicle when blood tests reveal the presence of narcotics. The driver in question can be sentenced to two years' imprisonment and a fine of €4,500. These penalties can be increased to three years' imprisonment and a fine of €9,000 if alcohol is consumed simultaneously. Drivers are automatically tested in the event of a fatal accident, but such screening may also be carried out for any road traffic accident, any infraction of the highway code or whenever there are reasonable grounds to suspect substance use (Ofdt 2005).

6.1 Mortality related to drug use

Trends.

Three sources of information concerning mortality related to illegal drug use are available in France: the DRAMES file (which includes 16 medico-legal institutes participating on a voluntary basis), the OCRTIS file (Office central de répression des trafics de stupéfiants) and the CépiDc file from the INSERM.

The most recent DRAMES data concerns deaths recorded in 2005, and was presented in the previous report. The DRAMES file has been compared with the OCRTIS data. In its 2007 report, the OCRTIS published no detailed data concerning overdoses in France during the year. The official explanation put forward was the lack of DRAMES data in 2006, required in order to be able to confirm the information gathered by the police.

The table below shows overdose deaths based on three information sources. For comparative reasons, the list only begins from 2000 onwards, the date the ICD 10 was introduced in France.

Table 6.1. Overdose deaths in France based on three available sources.

Year	OCRTIS	DRAMES	CépiDc*
2000	120	101	138
2001	107	NA	155
2002	97	74	140
2003	89	64	148
2004	69	86	163
2005	57	68	171
2006	NA	NA	NA

NA: Not available. *Selection B.
Source: OCRTIS, DRAMES, CépiDc, Misc. reports.

A very clear contrast has appeared between on the one hand a downward trend and the increasingly lower levels shown by the OCRTIS and DRAMES data, and on the other hand an increase in the number of overdose deaths (selection B from the EMCDDA[21]) according to the CépiDc data, followed by a lower than anticipated reduction. As reminder, the CépiDc operates as a national mortality register. By its very definition, it is required to exhaustively centralise data concerning deaths, and consequently should be considered as a benchmark information source. It listed 235 overdose deaths in 2005 including: 130 men (with an average age of 55.5 years) and 105 women (average age 55.9).

The causes of death.

To date, the OCRTIS has not supplied information concerning the overdose deaths recorded in 2006. Only the CépiDc makes it possible to obtain a more accurate idea of the causes of these overdoses.

[21] Faced with the vast diversity of national definitions used in the member states of the EC, in 2002 the EMCDDA introduced a common definition of Drug-Related Deaths (DRD). The specific extraction includes those deaths listed under the following ICD 10codes: F11-12, F14-16, F18 and F19; and X41, X42, X61, X62, Y12 and 11, these last six being combined with the T40 (0-9) and T43.6 codes. This selection of common codes is known as the Selection B.

Table 6.2. The causes of overdose deaths in France: selection B based on the cépiDc data.

	F11	F12	F14	F15	F16	F19	Total	%F19
2000	19	0	2	0	0	112	**133**	84,2
2001	21	0	2	2	0	124	**149**	83,2
2002	23	0	3	3	0	110	**139**	79,1
2003	18	2	2	3	0	123	**148**	83,1
2004	33	2	7	2	0	119	**163**	73,0
2005	22	1	5	1	0	142	**171**	83,0

Source: CépiDc, various reports.

Three particular points should be noted:

1. There are no deaths through poisoning as defined in selection B by the EMCDDA.
2. Opioids remain the main cause of death when only a single substance was detected, followed by deaths related to cocaine use. This result is very much in line with the increased prevalence levels noted among the general population in recent years.
3. In the vast majority of cases, death occurred as a result of polydrug use, without it being possible to determine which substances were detected.

Are the records underestimated?

The under-recording of overdose deaths is a recurrent problem in France and has been for several years now. The classification of many such deaths as "death by unknown causes" (Péquignot et al. 1999) has contributed to maintaining a certain degree of scepticism concerning the trends revealed by the CépiDc-INSERM register, and has encouraged people to consult alternative sources such as the OCRTIS and DRAMES data. However, their collection methods suffer from a number of shortcomings:

- The OCRTIS can only record so called "explained" overdoses, i.e. those cases occurring in a scenario in which the drugs are clearly found at the place of death. The doctor called to the scene in order to confirm the death is required to avoid signing the death certificate, which leads to the launch of a police investigation. However, the office is not always kept fully briefed of any possible additional toxicological analysis results.
- DRAMES operates based on a network of medico-legal laboratories, which are limited in number and non-representative. Moreover, participation in the scheme is voluntary (consequently, in 2005 only 6 of the 16 participating laboratories submitted information).
- The data from the CépiDc is also subject to numerous shortcomings: firstly, numerous cases are classified as "death by unknown causes". Secondly, in a number of cases it is necessary to wait for the results of any toxicological analysis tests, which may possibly be requested by the courts[22], leading to delays in recording the death. Thirdly, an overdose death in France automatically results in the launch of a legal investigation, while some of these cases may be the subject of phoney certificates issued in order to protect the families.

[22] In the event of suspicions of a death related to the use of psychotropic substances, the doctor certifying the death cannot fill out the death certificate, which is sent back to the INSERM. In theory, the causes of death are attributed only following the receipt of any possible analyses allowing for the application of the ICD 10. In practice however, the doctor may state the reasons for his doubts on the certificate. In the case of drugs, code R99 may be synonymous with "case pending".

This "classification" problem illustrates a chronic problem existing in France regarding the application of certification rules (Desesquelles 1997), and may have an impact upon the recorded levels. In order to envisage any possible under-estimation of overdose deaths, two comparisons of the available information are currently being carried out. The first concerns the OCRTIS and CépiDc data (for the years 2001 and 2002), while the second concerns the OCRTIS and DRAMES data (for the years 2004 and 2005). The final results should be available by late 2007.

6.2 Infectious diseases related to drug use

The HIV infection monitoring scheme: new AIDS cases

Between 2003 and 2005, each year between 6,000 and 7,000 people discovered that they were HIV positive in France, corresponding to the discovery of more than 12,000 HIV cases since the compulsory HIV notification system was introduced (March 2003). Contamination through intravenous drug use accounts for only 2% of these new infections. The most frequent contamination method is heterosexual intercourse (accounting for 55% of cases), and in particular among women (78% of cases) followed by homosexual intercourse (23% of cases, including 40% among men).

Table 6.3. The discovery of HIV infection in 2003-2005, broken down by contamination method (France, data from 31/03/06).

	Women		Men		Total	
Contamination method	n[a]	%	n[a]	%	n[a]	%
Heterosexual intercourse	3,811	78	2,765	39	6,576	55
Homosexual intercourse	-	-	2,816	39	2,816	23
Drug injection	52	1	199	3	251	2
Others[b]	50	1	70	1	120	1
Unknown	951	20	1,323	18	2,274	19
Total	4,864	100	7,173	100	12,037	100

a: Number of provisional, non-rectified cases within the declaration periods
b: 90 mother-to-child transmissions, 20 homosexual drug users, 9 transfusion recipients and 1 haemophiliac contaminated in the 1980s.
Source: the compulsory notification system for HIV infection, InVS (data from 31/03/06)

Regarding the number of new AIDS cases among intravenous drug users, this figure has continued to fall from the mid 1990s onwards. Although such cases accounted for a quarter of the people diagnosed with AIDS at that time, they represented just 8% in 2005.

Table 6.4. New AIDS cases among intravenous drug users, 1998-2006.

	1998	1999	2000	2001	2002	2003	2004*	2005*	2006**
Intravenous drug users	357	309	246	258	204	170	155	98	25
Total new AIDS cases	1,948	1,835	1,732	1,673	1,637	1,457	1,340	1,227	494
Intravenous drug users as a %	18.3%	16.8%	14.2%	15.4%	12.4%	11.6%	11.5%	8%	5%

*: Provisional, non-rectified data from 30/06/06, **: data from January to June 2006
Source: AIDS monitoring system, InVS. (data from 30/06/06)

The Coquelicot data

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

Coquelicot is a cross-disciplinary, multi-centre survey which covers five cities (Lille, Strasbourg, Paris, Bordeaux and Marseilles), carried out among drug users (DU) having snorted or injected at least once during their lives. Participants are recruited from among the various centres and organisations participating in the specific treatment of drug users (specialised treatment centres, low threshold structures and several general practitioners), based on a complex sampling process aimed at establishing a random sample. In addition to the socio-behavioural questionnaire filled in by the survey staff, the DU supplies a blood sample which he takes from his own finger using blotting paper. The search for anti-HIV and anti-HCV antibodies on the blotting paper swabs is carried out by means of Elisa tests. In all, 1,462 of the 2,389 DU to whom the questionnaire was proposed (61%) agreed to take part.

The overall seroprevalence of HIV is 10.8% [95% CI: 6.8-16.6]. This increases regularly with age: it was virtually zero among those under the age of 30 (0.3%) and reached 17% among the DU aged between 35-39 and the over-40 age group. For its part, the seroprevalence of HCV was 59.8% [95% CI: 50.7-68.3] and also increases with age: although already high among the under 30 age group (28%), this rises to 71% in the 40 + group. In total, 27% of DU wrongly believe themselves to be HCV-free. The level of dual HIV/HCV infection cases stood at 10.2% [95% CI : 6.3-15.9]. Virtually all HIV-infected users were also contaminated by HCV.

An analysis carried out based on the year of birth shows that the reduction in the seroprevalence of HIV begins with the cohort born after 1970 (i.e. those currently aged under 34), while for HCV the reduction is most pronounced for the cohort born after 1980 (i.e. those currently aged under 24).

More than 95% of users declared that they had already been tested at least once during their lifetime for HIV and 91% for HCV. The under 30s declared a lower level of screening for HIV than the older DU (89 % versus 97 %, $p<0.001$), but the probability of being screened during one's lifetime naturally increases with age. The survey revealed a high level of awareness among the DU of the main infection methods for HIV and HCV: the main HIV contamination methods (the sharing of syringes, and unprotected sex) are known by 90% of the DU and those for HCV (the sharing of syringes) are known by 84% of the DU. On the other hand, when it comes to sharing implements, the knowledge level falls to 71% for HIV risks and 65% for HCV risks. Additionally, it should be noted that the under 30s were less informed about the risks of HIV contamination as a result of tattooing (63 % versus 75 %, $p=0.02$) and piercing (63 % compared to 76 %, $p=0.004$) than the over-30 age group.

During the last month, 13% of DU shared their syringes, while 38% shared implements and 25% shared snorting straws. The high prevalence of HCV among young DU leads us to suppose that contamination took place when the individual first began taking drugs. Risk practices continue, offering favourable conditions for the spread of HCV but also of HIV.

The PRELUD data

The first PRELUD survey carried out by the OFDT in 2006 (which replaced the front linesurvey), was intended to combine the collection of saliva samples with the collection of declared information among CAARUD[23] users in order to measure the prevalence of HIV and HCV infections in five cities (Dijon, Lyons, Metz, Rennes and Toulouse). Declared data

[23] Active drug users (opioids or cocaine) with a high percentage of injectors.

supplied by users attending these centres are now available from among the 1,017 active users registered on a drug addiction programme, having attended one of the nine sites covered by the PRELUD survey.

Hepatitis C.

Table 6.5. Changes in the prevalence of declared hepatitis C infection in front line structures, between 2003 and 2006.

	2003	2006	2003 %	2006 %	2006 injectors/life
< 25 y.o.	131	193	17.6%	8.4%	12.2%
25-34 y.o.	299	344	45.8%	29.4%	40.9%
> 35 y.o.	213	273	55.9%	54.4%	64.5%
All	643	852	43.4%	34.0%	44.6%

Source: PRELUD.

The declared data, which is the only data currently available making it possible to track changes in France, reveal a reduction in declared hepatitis C infection levels among the youngest age group.

This phenomenon is not linked to a fall in injection levels among this latter group. Indeed, among users aged under 25 the proportion of injectors/life increased from 51% in 2003 to 59% in 2006, while the percentage of people having injected more than 10 times during their life increased during the same period from 41% to 50%. However, we are also witnessing more frequent screening among young people in 2006 than in 2003, which may be responsible for changes in the profile of the respondents (as only those having undergone screening may answer the question). Among the under-25 age group, the percentage of users who have never undergone screening fell from 39% to 25% between 2003 and 2006.

Table 6.6. Changes in the prevalence of declared hepatitis C infection according to injection frequency during the users' lifetimes, in front line structures between 2003 and 2006.

	N 2003	N 2006	2003	2006
No, never	125	205	4.8%	2.9%
Yes, less than10 times	55	50	23.6%	10.0%
Yes, 10 times or more	464	548	56.7%	47.8%
All	644	803	43.8%	34.0%

Source: PRELUD.

Among those people having already experimented with injecting and/or snorting, the prevalence of declared infections was 35.7%.

HIV

As for hepatitis C, we should note that the prevalence of declared HIV infection has appeared to decline between 2003 and 2006. At the same time, we have also seen an increase in screening frequency, particularly among the under-25 age group. Although in 2006 some 25% of them had never been screened for HIV infections, this figure had fallen to 15% in 2006.

Table 6.7. Changes in the prevalence of declared HIV infection in front line structures between 2003 and 2006.

	N 2003	N 2006	2003	2006	2006 injectors/life
< 25 y.o.	143	201	4.9 %	0.3 %	0.8%
25-34 y.o.	305	359	8.2 %	4.3 %	5.8%
> 35 y.o.	221	314	16.3 %	13.8 %	14.7%
All	669	874	10.2 %	7.1 %	8.3%

Source: PRELUD.

According to the first data issued by the PRELUD survey, the declared prevalence of HCV infections among the under 25s interviewed in front line structures and aware of their results declined between 2003 (the most recent TREND front line survey) and 2006 (the PRELUD survey) dropping from 17% to approximately 8% (see the following table). However, these levels of declared HCV infection among the under 25s vary according to the sites concerned, ranging from 2.9% in Rennes to 15.6% in Lyon.

The RECAP data.

The RECAP survey carried out in 2005 for the first time at a national level (Kopp et al. 1998), makes it possible to describe the characteristics of patients welcomed throughout the year in specialised drug addiction treatment centres (CSST) and questioned all patients concerning their infection status, particularly for hepatitis C and HIV (please see table 6.8).

Table 6.8. Declared HCV and HIV infection among drug users having injected at least once in their lives, in 2006, by age group.

	HCV		HIV	
	Known infection	Positive	Known infection	Positive
<25 y.o.	515	73 (14.0%)	511	1 (0.2 %)
25-34 y.o.	2,158	742 (34.0 %)	2,107	44 (2.0 %)
<35 y.o.	3,644	2,453 (67.0 %)	3,523	499 (14.0 %)
All	6,317	3,268 (51.7 %)	6141	544 (8.8 %)

Source: RECAP / OFDT – 2006

In 2006, 104 outpatient CSSTs replied to the RECAP survey, covering a total of 43,494 patients. We now have information concerning the use of injection for almost three quarters of patients (i.e. 32,053). Among these, 31% declare that they have used injection as an administration method during their lives, (i.e. 9,820 patients). HCV infection is known for half of injectors (52%) and HIV infection is known for 62%. Declared prevalence levels are 52% for HCV and almost 9% for HIV.

6.3 Psychiatric comorbidities

No new information available

6.4 Other comorbidities related to drug use

The so-called “TREND/Electronic Music” survey (see drug use within specialised groups) made it possible to interview 1,496 people having associated with the “techno/party” scene in 2004 or 2005.

Three quarters of the people interviewed were drivers. Among these, more than half (533/1,122) consider that they had driven at least once during the last month with a blood alcohol level of more than 0.5 g, and almost half declare that they had driven after having smoked cannabis during the same period (48 % - 511/1,118).

At the same time, driving under the influence of another psychoactive substance concerned 29% of these potential drivers. Calculated proportionally vis-à-vis the number of drivers, it is in the “alternative” group (users chiefly visiting free and rave parties) that the highest declared incidence of driving under the influence is to be found (Reynaud-Maurupt et al. 2007).

7. Responses to health-related problems

Responses to health problems: general context

The prevention of deaths related to drug use: no national or specific intervention policy exists in France aimed at reducing overdoses. Access to substitution treatments in addition to the risk reduction programmes are *de facto* the indirect means used to avoid deaths related to opioid use. Please refer to structured questionnaire number 29 for further details.

<u>The prevention and treatment of infectious illnesses related to drug use:</u>

The risk reduction policy is defined as all measures implemented in order to avoid contamination by aids and hepatitis viruses, but also problems and complications arising as result of using or attempting to obtain drugs. This chiefly involves seeking to prevent health complications related to the intravenous use and injection of products under poor hygiene conditions (including abscesses, overdoses and septicaemia).

In France, the scheme is based on preventive actions aimed at facilitating access to sterile injection equipment and the circulation of preventive messages, in addition to access to screening services for risk groups.

A large number of the activities are developed by associations operating outside the specialised scheme, who are often supported by the state or by local authorities.

The scheme has been built up around a number of complementary activities:

- The unrestricted sale of syringes in pharmacies (sold without prescription since 1987);
- Vending machines selling “Stéribox®” type injection packs (with a total of 225 in 2002) or intended for the recovery of used syringes (153 in 2002);
- Syringe exchange programmes run by the associations (118 in 2001)
- “Reception” or contact centres for drug users (40 in 2001);

Overall, the risk reduction scheme covers most of France (covering a total of 87 *départements*).

Theoretically, screening is facilitated by the existence of free, anonymous screening centres (Centres de Dépistage Anonymes et Gratuits, CDAGs). In 2002, there were 386 of these operating outside the prison system and 109 inside prisons. A plan also exists to combat hepatitis B and C (2002-2005), the key objectives or which are: to reduce transmission, to improve screening and the care system, to improve access to treatment, while at the same time boosting clinical research, monitoring and assessments. The prevention of contamination by snorting, (an issue which is controversial in France but in which several associations are involved), does not appear to be a priority for the public health authorities.

Structured questionnaire no.23 [risk reduction measures for the prevention of infectious diseases among drug users] provides an overview of the resulting political choices and initiatives actually undertaken in France.

The locations and which syringes are available in addition to estimates of the quantities distributed are shown in epidemiological table no. 10.

Treatment related to psychiatric comorbidities: there is no service strictly specializing in the treatment of drug users with associated psychiatric problems. A number of psychiatric hospitals have developed the ability to treat drug users over the last few years, but these nevertheless remain rare. Since 1998, three different circulars issued by the General Health Authority (DGS) have sought to improve treatment, recommending heightened cooperation between the departments and services concerned (CSSTs, psychiatric departments in hospitals, etc.) but cooperation is currently carried out on an "as needs" basis (Wieviorka 2003).

7.1 The prevention of drug-related deaths

Although frequently referred to in circulars concerning public health issues, there is no real national policy (where the coordination of departments and services is concerned) regarding the prevention of drug-related deaths. We should note the highly effective role of the CAARUD (a term which since 2006 has been used to refer to low threshold structures directly financed by the health insurance scheme), whose task it is to prevent overdoses. Activities include syringe exchange programmes and the publication of information leaflets etc. (awareness building meetings with peers are not a standard practice in France). However, the introduction of opioid substitution methods has considerably reduced the number of overdoses caused by opioids in recent years. The overdoses currently concern other substances taken alone or in combination with other drugs, for which very little is done.

7.2 The prevention and treatment of infectious diseases related to drug use

All low threshold structures distribute condoms, and produce information leaflets explaining how sexually transmitted diseases are transmitted (chiefly HIV and hepatitis).

7.3 Initiatives related to psychiatric comorbidities

No new information available

7.4 Other initiatives targeting health aspects related to drug use

Sterifilt®

The Sterifilt® is a filter specially designed to eliminate impurities other than microbes. It reduces risks related to the injection of particles and limits the appearance of abscesses, phlebites, oedemas and "dust". It eliminates 100% of all particles of more than 10 µm in size (the filtered liquid is then transparent). It prevents infectious contaminations related to the sharing, reuse and borrowing of filters. Finally, it should be stressed that this is a single use filter which cannot be used by several people. Its membrane clogs after use.

Since 2005, and particularly in 2006, the health professionals working at several sites involved in the TREND scheme have reported a reduction in the frequency of problems usually linked to the injection of Subutex® among others. They have attributed this to the circulation of the Sterifilt® and its increasing use during injection. It appears that this tool is fairly easily adopted by drug users at the drug centres when the centres organise active educational programmes.

An initial assessment of the issuing of Sterifilt® was carried out in 2003 involving volunteer pharmacies in Ivry sur Seine as part of a "decentralised syringe exchange programme" based on four key principles: the training of the volunteer pharmacies to participate in an injection equipment exchange programme, the provision of the Stéribox for users (containing this new Sterifilt® single use filter) the recovery of used equipment and the referral of drug users to HCV screening consultations. With this in mind, six pharmacies were selected and this made it possible to interview 20 pharmacists and 17 drug users. Ten of those met during the various interviews stated that they chiefly use Sterifilt®, the use and adoption of which was greatly facilitated by the prevention and risk reduction work carried out by the medical teams (Bonnet 2006).

In 2005, sales of Sterifilt® stood at between 120 000 and 150 000 units per month in France (Apothicom data).

8. Social consequences

Social consequences: general context

Social exclusion: the social and economic situation of drug users may be appraised via the socio-economic characteristics identified during their stay in reception facilities (Specialised Drug Addiction Treatment Centres/*Centres spécialisés de soins pour toxicomanes* or CSSTs, or first line facilities). The level of their precariousness varies according to the facilities frequented. Users attending the so-called "first line" facilities are characterised by a greater degree of social exclusion than those encountered in the CSSTs: a higher proportion of unemployed (50% live on welfare in first line facilities compared to about 30% in CSSTs), unstable housing (40% in first line versus 30 in CSSTs), more single persons and fewer parents with dependent children, etc.

By reconstructing the users' personal history, their lifestyle and their relation to risk (in particular heroin), it is possible to gain a better understanding of the contexts and progressive instability (economic and social vulnerability, dropping out of school, weakening of family ties) associated with the onset of a problem of drug addiction. For Bouhnik and Touzé (2002), the increased insecurity of users' living conditions together with repression and repeated incarcerations help to magnify high-risk behaviour. According to Jamoulle (Jamoulle 2001), users have to contend with several forms of insecurity: economic, social (as a citizen), health and psychological.

Among the homeless, drug addiction usually predates the individual's marginalisation (Dabit et al. 1999; Declerck et al. 1996; La Rosa 1998). On the other hand, exclusion generates a keen sense of loss of status which is liable to push an individual towards drug addiction when he has not already deliberately opted for marginalisation. In the case of alcohol, it emerges that the most extreme uses observed among the homeless population are linked to the most extreme cases of insecurity. The proportion of persons with major risks of alcohol problem use appears much greater in the homeless population than in the population as a whole, in particular in the most difficult social situations (Beck, F. et al. 2006a). But substance abuse may also be a means of coping with the violence of life on the streets: "recourse to psychoactive drugs emerges as a means of coping with problems, and this recourse in itself brings further difficulties, precipitating instability sooner" (Jacob et al. 2000).

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

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

Arrests for infringements of the Drug Law are classed in two broad categories: simple use and trafficking (subdivided into dealing, local trafficking and international trafficking) [Epidemiological Table No. 11]

Convictions recorded by the National Criminal Records Bureau (CJN) show sentencing of people taken to court for Infringements of the Drug Law. A

conviction may include several offences, but, conventionally, the convictions are presented according to the principal offence. The statistical categories used are as follows: illicit drug use, being helped to use by others, possession/acquisition, manufacturing/work/transport, supply, possession and acquisition, importation/exportation, other infringements of the Drug Law.

Since 2003, driving under the influence of substances or plants classified as narcotics has been an offence (Law No. 2003-87 of 3 February 2003, NOR: JUSX0205970L). The offence is subject to two years of imprisonment and a 4500€ fine simply for using narcotics. The penalty is more serious when it is combined with alcohol consumption. Screening is compulsory for all drivers involved in a fatal accident, and systematic if consumption is suspected, in all accidents where physical harm is done. Random testing may also be used.

Use in Jail [Epidemiological Table No. 12]: A study carried out in 2003 shows that 33% of people entering jail declare long-term, regular use of illicit drugs or misuse of detoxification drugs in the year preceding incarceration (Mouquet et al. 1999). In the general population, 6% of 18-25 year olds and 2% of 26-44 year olds consumed illicit drugs in 2002 (Beck, François et al. 2002). These figures show a clear over-representation of drug users in comparison with the general population.

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

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

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

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

Social cost of drugs: Public spending on all drugs has reached 115,912 million euros for the year 2003; most of this was on illicit drugs (80%), while the smallest

portion was consigned to tobacco (5%). Ultimately, the proportion of spending attributable to the fight against licit and illicit drugs was 0.33% of total public spending in 2003. The social cost of alcohol, tobacco and illicit drugs was 2.37%, 3.05% and 0.18% of GDP respectively for the year 2000 (Kopp and Fenoglio 2006).

8.1 Social exclusion

No new information available.

8.2 Crime and drug-related offences

Information from the Ministry of Justice

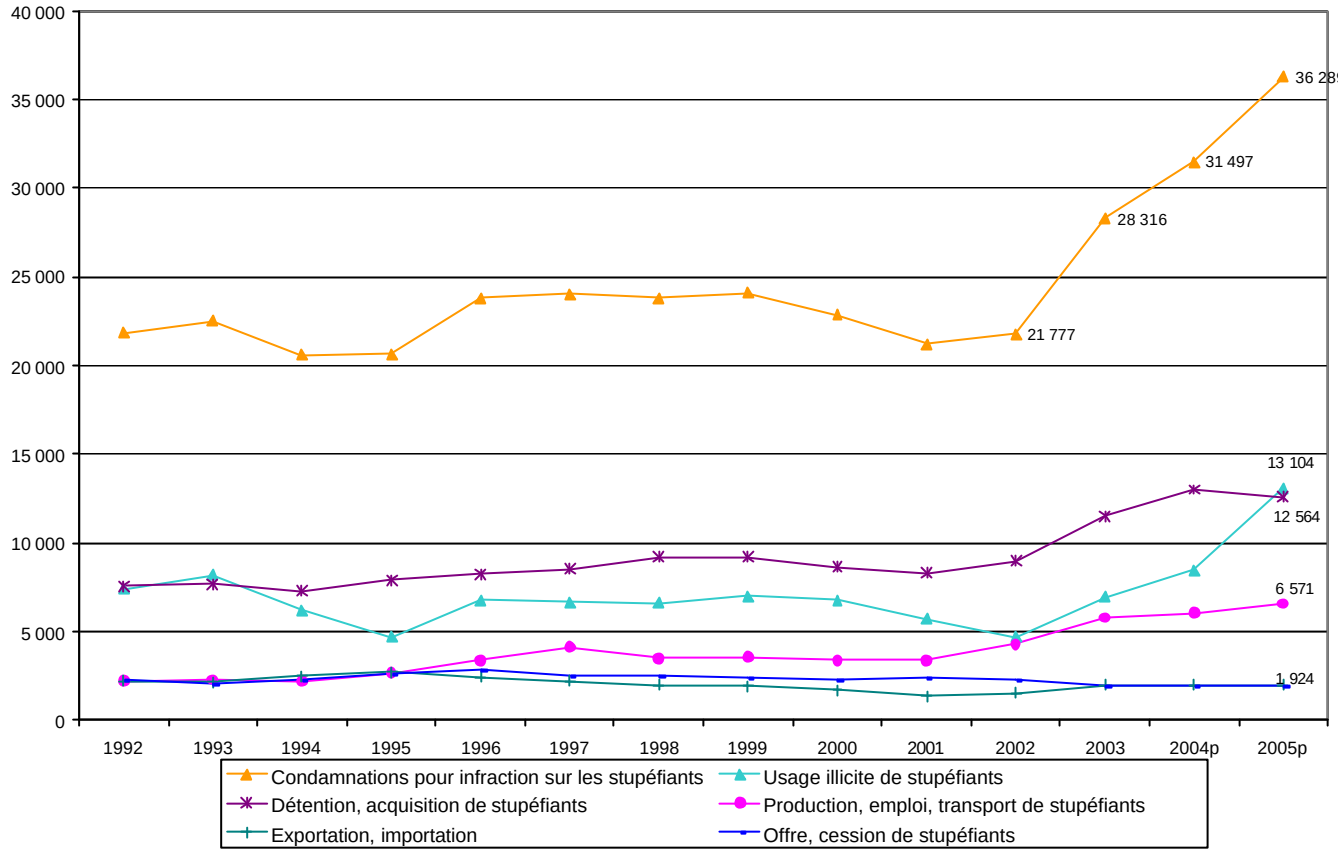
Statistics pertaining to convictions, for drug-related offences as much as for alcohol-related offences, are published with a time lag of two years (Ministry of Justice 2006). The figures are presented in stock format (no information on offences that led to conviction when detainees were moved). Therefore, the following information refers to the year 2005, and it is not officially considered definitive.

36,289 convictions were pronounced in 2005 where an Infringement of the Drug Law was the principal offence[24], i.e. 15% more than in 2004. Among the 39,790 detainees convicted at 31/12/2005, 5,718 were convicted with an infringement of the Drug Law as the principal offence (14.4%).

The following data relates to the convictions:

[24] A conviction may cover several offences (common in Drug Law infringements). The principal offence is the first one written on the criminal record, but it is not always the most serious. The sum of offences of rank 2 and above show the number of Drug Law Infringements punished to be 101,000 for the year 2004. There is as yet no information available for 2005.

Graph 8.1. Convictions for Infringement of the Drug Law pronounced in France.



[*Convictions for narcotics offences/ possession-acquisition of narcotics/ exportation, importation/ illicit narcotics use/ production, use, transport of drugs/ supply and dealing of narcotics*]
2004p and 2005p: provisional data.
Source: Data from the Statistical Directory, Ministry of Justice (special extract).

This growth applies to virtually all Infringements of the Drug Law, and especially the most frequently punished:

- 13,104 convictions for use (+55.3%) and 6,571 convictions for production, use or transport (+8.6 %).
- Where Infringements of the Drug Law are the principal offence, the breakdown of convictions has been stable for several years. Trafficking (import-export) is penalised as the principal infraction in 1,968 convictions, or 5% of Drug Law Infringements; 36% of convictions are for use and possession-acquisition still accounts for around 34% of them (falling by 3% over the year 2005).

Overall, in 2005, an infringement of the drug law as the principal offence is penalised by imprisonment in 34% of cases (either a mandatory sentence or combined with partial deferment in half of all cases), by a fine in 23% of cases and by substitution in 7% of cases: a fine to pay off days in prison, or a community service order. Dispensations are rare. Educational measures, of which 1,518 were pronounced in 2005, make up 5% of Drug Law infringement convictions.

The profile of individuals convicted for an infringement of the drug law is similar to that of all convicted people. The vast majority of those convicted for Drug Law infringements are men (94.5 %).

Minors account for 7.3%, with significant disparities between those convicted for trafficking, (where only 1% are minors); and possession, use or supply (8%, 9% and 10% minors respectively).

Overall, 13% of convicts for drug law infringement are foreigners, but the disparities are even greater: 6% of foreigners are convicted for use, 37% for trafficking (import-export), and between 12 and 20% for other offences.

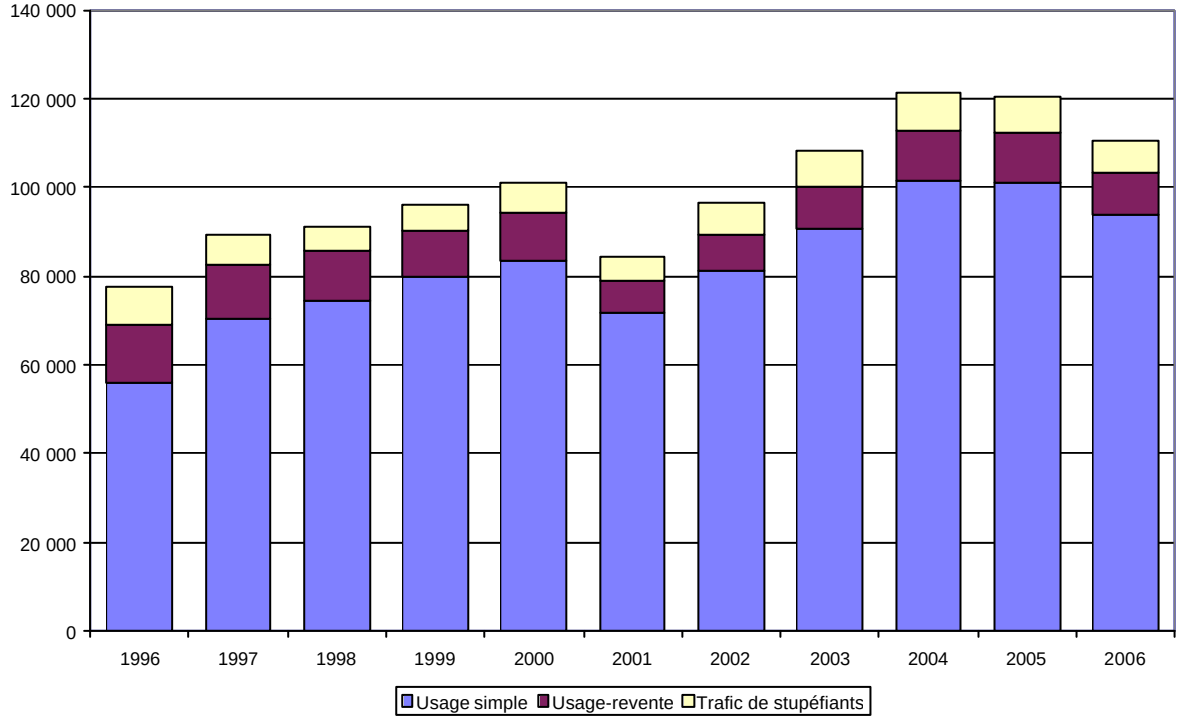
Information from the Ministry of the Interior (OCRTIS 2007)

Arrests for infringement of the drug law. General data:
Contrary to the previous trends, there has been a fall in arrests for Infringements of the Drug Law by the police, the Gendarmerie and Customs since 2005: 0.8% in 2005 and 8% in 2006 (Central Office for the Repression of Narcotics Trafficking/ *Office Central Pour La Répression Du Trafic Illicite Des Stupéfiants* (Ocrtis)). This decrease concerned all the categories of arrests, but is slightly more striking for cases of use/dealing (-16.5%) and for trafficking (-9.1%) than for simple use (-7.2%).

Reasons for arrest:
Simple narcotics use is the principal reason for arrest: out of 93,817 arrests, 85% were for Infringements of the Drug Law in 2006, a figure which has remained stable since 1998.

9,376 arrests were recorded for use/dealing, the second most common reason for arrest (8.5% of all arrests for drug infringement). Arrests for trafficking are divided into: 1,516 arrests for international trafficking and 5,777 for local trafficking (forming 6.6% of total arrests for Drug Law infringement).

Graph 8.2. Arrests for Drug Law Infringement since 1996.



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

The drug involved.
Cannabis is the main drug concerned in Drug Law Infringement arrests, whatever the reason for arrest: in 90% of arrests for use, in 77% for use/dealing and in 52% of cases for trafficking (see Table below).

Overall, heroin and cocaine are the next most common: the former is more common among arrested users and dealers, whilst the latter is more common in cases of trafficking.

Classically, for France, there is a relatively high number of arrests for prescription drugs (especially Subutex®, but also undetermined drugs: these are users who have no medical prescription to justify their possession) and for magic mushrooms.

Table 8.1. Arrests for Drug Law Infringement per drug, 2006.

	Us	% in column	Use-dealing	% in column	Trafficking	% in column	Total	% in column
Cannabis	83,980	89.5%	7,158	76.3%	3,784	51.9%	94,922	85.9%
Heroin	4,955	5.3%	1,164	12.4%	936	12.8%	7,055	6.4%
Cocaine	2,943	3.1%	597	6.4%	1,964	26.9%	5,504	5.0%
Crack	454	0.5%	62	0.7%	140	1.9%	656	0.6%
Ecstasy	753	0.8%	230	2.5%	250	3.4%	1,233	1.1%
Prescription drugs (1)	287	0.3%	66	0.7%	47	0.6%	400	0.4%
Amphetamines	191	0.2%	49	0.5%	29	0.4%	269	0.2%
Mushrooms	134	0.1%	12	0.1%	8	0.1%	154	0.1%
Others (2)	120	0.1%	38	0.4%	135	1.9%	293	0.3%
Total	93.817	100%	9,376	100%	7,293	100%	11,0486	100%

(1) Subutex®, Methadone, Skenan®, Rohypnol®, others.
(2) Khat, Methamphetamines, LSD, opium, morphine, solvents, others
Source: FNAILS, OCRTIS.

Where drugs are concerned, the fall in the number of arrests masks considerable variations for the drug in question:

- The increase in arrests for heroin use, use/dealing and trafficking (a growth initiated in 2005 and continuing in 2006): +6% more arrests, +10% of users arrested. These figures seem to mark the end of the decline recorded throughout the 1990s. At the same time, the age of arrested heroin users has stopped rising.
- Cocaine is another drug that is seen more and more frequently in arrests: +5% among arrested users, +8% among traffickers (cocaine is the drug predominantly found among international traffickers, more than half of whom are arrested in Paris airports). However, there has been a 21% fall in arrests of users/dealers.
- The marked increase since 2001 of arrests for use and, to a lesser extent, use/dealing and trafficking of amphetamines: from 86 arrests in 2001 to 191 in 2006, with a peak of 263 arrests in 2004.
- Breaking with the upward trend of the past few years, a decrease has been observed in arrests for cannabis use (-8%) and a more striking reduction in arrests for use/dealing and especially for trafficking (-17% and –12% respectively).
- The fall in arrests for ecstasy en 2005 is confirmed in 2006 (-40.8%).
- There is a sharp fall in arrests for crack (-38%); the decrease is clear for use (-34%). It should be remembered that these figures are small compared to the drugs previously cited, and have fluctuated around 1,000-1,400 arrests since 1998. In 2006, there was a pronounced fall with 656 arrests, mainly in the overseas departments and in the Paris region.

Some characteristics of individuals arrested for Drug Law Infringement in 2006:

- The average age of arrested users is stable at 23.5 years in 2005 and 2006.
- Users of crack, heroin and prescription drugs (Subutex®) are the oldest: 31.4-28.8 and 31.1 years old respectively. Cannabis users are still the youngest (22.9 years old), followed by magic mushrooms (22.1) and ecstasy (24.4 on average).
- Those arrested for Drug Law Infringement are predominantly men (no change).
- The majority of those arrested for Drug Infringement remain French (9 out of 10), except in the case of international trafficking, where only 32% were of French nationality in 2005 (28% in 2004).
- Where SES is concerned, there is also a distinction between cannabis users on the one hand (35% no occupation or of indeterminate professional status, 26% labourers and 22% students/school pupils) and heroin or cocaine users on the other (43-51% no occupation or of indeterminate professional status, 11-26% labourers or employees, and 5% or less students or school pupils). Ecstasy users occupy a more or less intermediate position (no change).
- Lastly, around 90% of individuals arrested for an Infringement of the Drug Law are only arrested once over the year. Multiple arrests are slightly more common in heroin users.

Driving after using narcotics: checks and penalties in 2005-2006[25].

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

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

Screening in 2005 and 2006.
Since 2004, the Ministry of the Interior has published statistics on all screenings and offences relating to drugs at the wheel[26]:

[25] Ministry of the Interior (...), *Evaluation of road user conduct, 2006,* 77 p. (http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere); special extract from the national criminal record by the sub-directorate of statistics, studies and documentation.
[26] Figures published for 2003 were incomplete and only covered screenings carried out between July and December 2003 by the national police services (without the national Gendarmerie).

Table 8.2. Screenings for narcotics at the wheel.

	2005			2006		
	Number of screenings	Number of positive results	% positive	Number of screenings	Number of positive results	% positive
Accidents:	11,305	1,899	16.8%	10,450	1,685	16.1%
Fatal (immediate)	5,248	629	12.0%	4,485	563	12.6%
Bodily harm (not fatal)	5,547	1,041	18.8%	5,503	951	17.3%
Damage to property (recorded by the police)	510	229	44.9%	462	171	37.0%
Offences	2,446	1,979	80.9%	2,322	1,971	84.9%
Suspected use (no accident or offence)	7,284	4,095	56.2%	8,130	5,255	64.6%
Total number of screenings	**21,035**	**7,973**	**37.9%**	**20,902**	**8,911**	**42.6%**

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

In 2005-2006, 21,000 narcotics screenings were carried out each year on the roads. Most of them (60%) were carried out following an accident, especially if the accident had fatal consequences (compulsory screening) or had caused bodily harm (screening also compulsory in cases of suspicion).

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

These figures cannot be taken as a measure of narcotics consumption by drivers on the roads, nor of driving under the influence of narcotics on the same roads. The only cases where screening is (usually) systematic are those involving a fatal accident. In these cases the positivity rate was 12% in 2005 and 12.6% in 2006.

Offences penalised in 2005 and 2006.

Table 8.3. Offences for driving after substance use.

	2005	2006
Driving a vehicle after substance use	4,246	6,552
Driving a vehicle after substance use and under the influence of alcohol	922	1,212
Refusing to undergo screening for narcotics	435	193
Total	**5,603**	**7,957**

Source: Ministry of the Interior, Evaluation of behaviour of road users 2005 and 2006 (http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere)

During the second full year in which the narcotics screening programme was applied, in 2005, more than 5000 charges were made for driving after substance use, either alone (in 4,246 cases) or mixed with alcohol (in 922 cases). The figures for 2006 are beyond comparison, since more than 7,700 offences for driving after substance use were recorded, including more than 1,200 for substance use combined with excessive alcohol consumption.

These rises reflect the progression of the programme as it is implemented, but the complexity of the narcotics screening programme is universally acknowledged, which discourages the police from carrying out checks (by comparison, 11 million alcohol tests were carried out in 2006, of which 9,061,804 were for preventative purposes- before any accident or offence occurred- and 166,128 offences of driving under the influence of alcohol were recorded).

Convictions in 2005.
In 2004, 601 convictions were pronounced for driving after substance use. In 2005, this went up to 3,325, to which were added 2,553 offences of driving under the influence of drugs and alcohol, and 155 cases of injury or manslaughter by drivers under the influence of narcotics. Finally, there were 52 convictions for refusing to undergo analysis or examinations as required by the law.

Table 8.4. Convictions of drivers under the influence of substance use in 2005.

	Total convictions	Prison sentences	Fines	Alternative sentences	Educative measures	Dispensations
Total offences by drivers after substance use	3,325	1,769	1,015	523	14	4
Driving after substance use	2,553	1,208	908	425	8	4
Driving after using narcotics and under the influence of alcohol	562	394	89	74	5	0
Injury or manslaughter by drivers under the influence of narcotics	155	139	5	11	0	0
Driver refusal to undergo analyses or examinations	52	26	13	13	0	0

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

53% of all these convictions are punished by a sentence of imprisonment (only 11% with mandatory sentences, either partially or totally). Around 30% were sentenced to a fine and 16% to an alternative penalty (likely to be suspension of driving licence).

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

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

8.3 Use in prison

At the beginning of 2008 the TREND unit will coordinate a study on use in prison. At the time of writing, the first part (bibliographical revision) is complete.

8.4 Social cost

No new information available.

9. Responding to social problems

Responding to social problems: an overview

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

Within the various facilities, social assistants and specialised educators work with users to facilitate the reintegration process. See also Structured Questionnaire No. 28 [social integration].

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

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

Aid for uses in prison:

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

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

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

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

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

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

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

<u>Alternatives to legal proceedings and substitution sentences:</u>

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

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

Social studies and personality studies (on arrested individuals) should allow the sentence to be tailored to the individual, and the most appropriate measure chosen. The diversification of penal responses is highlighted: court-ordered treatment, conditional discharge with a drug treatment referral and discharge subject to alternative measures; socio-educational court monitoring, with compulsory treatment, parole with surveillance, for pre-sentencing measures.

The pursuit of alternatives to imprisonment is the initiative of the Penitentiary Service for Reintegration and Probation (SPIP). At a local level, and under the supervision of the sentencing judge, the SPIP identifies social structures, medical or otherwise, which would enable court-ordered rehabilitation to take place.

On the subject of court-ordered treatment, which is an excellent and highly appropriate alternative measure for individuals under arrest who have an addiction problem, the national trend is towards stagnation, in spite of numerous circulars attempting to re-launch it. (in particular the Guigou circular of 17 June 1999).

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

9.1 Social integration

No new information available.

9.2 Prevention of drug-related crime

As part of the fight against substance abuse while driving, and pursuant to the Law of 3 February 2003, making it an offence to drive under the influence of cannabis, cocaine, amphetamines or opiates, the Ministry of the Interior announced, on 18 June 2007, the launch of a campaign to test saliva kits, with a view to "*checking the efficacy and reliability of the saliva kits on offer from the manufacturers and to increase public awareness*[27]. These kits are supposed to detect the presence of substances such as cannabis, cocaine, ecstasy, amphetamines and opiates. The dates for the trial went from 15 June to 15 September 2007, the target being 30,000 tests applied in Paris, Lyons, Marseilles, Bordeaux, Toulouse, Strasbourg, Rennes, Montpellier, Lille and in the Pays de la Loire, Centre and Lorraine regions of France. Three kits have been tested, with the final selection to be made in autumn 2007. If the results are validated, the Ministry of the Interior hopes to be able to extend their use to national level and reach 100,000 tests in 2008.

In April 2007, a new tool was prepared in collaboration with the French Federation of Insurance Companies (Fédération française des sociétés d'assurance-FFSA) and validated by MILDT[28]. It consists of a kit for teachers designed to help them lead classroom discussions and an interactive space for young people and parents. The kit contains a CD, a DVD and an accompanying teacher's booklet. It is distributed free of charge by the association's departmental committees. It includes "eye-witness" accounts by young accident victims, interviews with experts, reports and explanatory diagrams.

It should be remembered that the ROSITA report (*ROadSIde Testing Assessment*), submitted to the European Commission in 2006, questioned the clinical validity of the saliva tests for cannabis. The THC present in the urine and the blood was detected in less than half the tests (46%).

[27] The press release may be consulted at: http://www.interieur.gouv.fr/sections/a_la_une/toute_l_actualite/securite-interieure/tests-salivaires-drogues/downloadFile/attachedFile/Communique_deplacement_Ministre_test_salivaires_drogue_17_06_07__2_.pdf?nocache=1182156365.78

[28] Available at www.preventionroutiere.asso.fr

10. The market and supply

The market and supply: an overview

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

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

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

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

- Surveys of the general public on the accessibility, supply and perceived availability of the various illegal substances.

Availability and supply:

- Cannabis (resin and grass) is the most available illegal drug in France. In recent years, there has been a certain infatuation for grass, which may be explained by the current fashion for products considered as "natural". This is also reflected in the increase of home-grown cannabis herb, which would seem to concern about 200,000 people (estimate of people having grown cannabis at least once, based on the ESCAPAD 2005 and Baromètre Santé surveys).

- The availability of cocaine continues to grow in France, now encompassing an extremely heterogenous social mix. This trend has been facilitated, over the past ten years, by the steady fall in the price of a gram of cocaine, now situated around the 60-euro mark. In contrast, cocaine hydrochloride in its base form, crack, remains confined to a special, highly marginalised milieu living in the Paris region. There is a use of “base” cocaine hydrochloride, referred to as "free base", among habitués of free parties and raves.

- After cannabis, ecstasy is the most common illicit substance on the party scene, whether commercial or alternative. In the last few years, there has been a craze among a fraction of users for a variety circulating in powder form, reflecting a certain lassitude for tablets.

- Heroin is a drug which is not widely available and not highly visible. This situation has been exacerbated by the disappearance of open scenes and by dealers turning to cocaine, which is more profitable. However, the situation is perhaps now beginning to change, and its availability would seem to be on the increase in both urban and party environments and it would seem that it is affecting new sectors of the population.

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

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

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

The following trends, per drug, have been observed:

- The most numerous seizures involve cannabis, particularly resin, of which the quantities seized increased starting in 2002, before falling since 2005.

- Since the end of the 1980s, a sharp growth in seizures of cocaine and crack, right up to the present day.

- After an increase in the quantities of heroin seized in the 1980s which continued until 1994, the subsequent downward trend seems to have been reversed since 2002.

- Since the early 1990s, the number of seizures of ecstasy and the quantities seized have grown sharply although the growth in seizures of amphetamines has been more moderate.

- The size and number of seizures of LSD declined over the period 1990-2006, after peaks in 1992 and 1993, and then in 2003 and 2004.

For the quantities seized and the number of seizures carried out over the past four years, see Epidemiological Table No.13.

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

In Epidemiological Table No. 14, the purity of drugs over the last three years is shown. The composition and prices of the main illicit drugs are in Epidemiological Tables Nos. 15 and 16.

- Cannabis

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

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

- Opioids

The average price of brown heroin in metropolitan France in the light of surveys conducted with low threshold structures would seem to come to about 40 euros per gramme in 2006. Purity rates are predominantly between 0 and 20%.

The median price of an 8 mg Subutex® (BHD) pill on the black market fell from 6€ to 3€ between 2000 and 2002. In 2006, after climbing to 5€ in 2005, the medium price per 8 mg pill would seem to be about 3€.

- Cocaine

The prices of powder cocaine and base cocaine (crack) vary according to the site and the social areas under observation. In metropolitan France, in 2006, the average price of a gramme of powder cocaine was 58.5€ euros, as in 2005: one

of the lowest recorded in seven years. The purity rate of seized cocaine is usually between 60 and 100%. It is most commonly cut with lidocaine, phenacetine and procaine.

- Ecstasy

The average price of an ecstasy pill has settled at around five euros per unit. However, the price can fall much lower when the pills are bought in lots. In 2003, among pills collected by SINTES, 89% contained MDMA and 90% at least an amphetaminic derivative. The average is 54 mg of MDMA per pill (versus 56 mg in 2002, 63 mg in 2001 and 74 mg in 2000). Nearly 4% of pills contain strong doses (>100mg). The dose of powders and gel-caps containing MDMA is on average double that found in pills (51% MDMA in powders (33 doses); 53% in gels (34 doses) and 24% in pills).

10.1 Availability and supply

The information detailed below relates the principal trends observed by the TREND observatory throughout the year 2006.

Heroin

In France, the predominant form of heroin in circulation is so-called “brown” base heroin, the so-called “white” hydrochloride form being much rarer.

For the first time since 1999, observers from the TREND observatory are unanimous in noting a substantial increase in the availability of heroin in the two areas investigated (in urban and party settings). In the north of France, it would even seem that, in street trafficking, brown heroin is more prevalent than cannabis.

In the alternative party scenes close to the techno-scene current, the use of brown heroin, in the context of managing the descent phase following the intake of stimulants, is more visible. These observations are consistent with the observation of a new type of consumers who now belong to more privileged and younger social milieus than the traditional consumers.

High-dosage buprenorphine (Subutex®)

HDB is an agonist/antagonist molecule containing morphine which is prescribed as a substitution treatment for heroin. Since its authorisation in 1996, it has over the years constituted a black market affecting vulnerable sectors of the population. In 2005, the authorities introduced stricter measures for the prescription of this substitution treatment in order to prevent sales on the street. However, these measures do not seem to have affected this dynamic black market. In 2006, Subutex® seemed as available as ever in marginalised milieus, as witness the median price per 8 mg pill, which has fallen to 3€ after a brief surge in 2005.

Cocaine

Cocaine, in its hydrochloride form, is a highly available product. In 2006, it became even more available, irrespective of the area of investigation (urban or party scene). This trend is driven by cannabis or heroin dealer networks switching to the sale of this substance, or adding it to their traditional sales. In certain popular districts, cocaine, like heroin, is becoming more prevalent than cannabis.

The base form is also present, but circulates under two different names: free base and crack. Free base is consumed in different social circles to crack. While the latter is present in very marginalised user groups and limited to very specific geographic zones (Paris, French Guiana and Martinique), free base is essentially consumed by groups closely associated with the party scene (nomads, travellers). It would seem that free base consumption is on the increase and reaching new social circles keen to experiment with an administration mode other than snorting and to experience more radical sensations – the inhalation of free base procures effects close to intravenous injection. It seems, too, that this administration mode is considered to be less dangerous than snorting.

Ecstasy, amphetamines and other designer drugs

Ecstasy is available in three principal forms: pills, gel-caps and powder. Depending on what form it takes, its availability according to the type of event varies. Consequently, pills and gel-caps are very common on the commercial dance scene, in clubs and discos, while the powder form circulates more easily in the so-called alternative or underground scenes. As in previous years, the powder form would appear to be increasingly available, expressing a lassitude on the part of users for the pill form. It seems, indeed, that, rightly or wrongly; consumers are complaining in increasing numbers of the poor quality of the ecstasy pills in circulation, not to mention the fact that the latter are often considered "old hat". The use of powder, circulating under the name of MDMA is a way of "standing out in the crowd".

Certain TREND sites report the appearance of a forth form known as crystal.

Hallucinogens

In France, LSD is available in two forms: absorbents (soaked in the drug) and micropoint solutions. In the last year, some observers have noted the emergence of a third, gelatinous, form. This last form would appear to find favour with a younger public than the usual LSD user.

In 2006, most sites reported a certain return of LSD availability, particularly in the rave and free party milieu.

10.2 Seizures

In 2006, a fall was recorded in seizures carried out by the police, gendarmerie and customs services: 78,287 seizures, compared with 86,932 in 2005 (-6.7%) and the quantities are reduced for many products (Central Office for the repression of narcotics trafficking (OCRTIS, 2005). This fall goes against the growth trend of the past few years.

Analysis per drug for 2006 shows the following trends:

- Fall in the number of cannabis seizures (-8 %), much more pronounced for quantities (-17 % compared to 2005). The fall mostly concerns resin, down by almost 19% in 2006.
- A greater fall in seizures of crack (-36 % seizures compared to 2005 and -19 % in quantities seized).
- Ecstasy seizures return to their pre-2005 level, with almost 1,500,000 doses seized. In 2005 there had been a fall of 56% in seizures.
- A 96% rise in the quantity of cocaine seized: from 5,186 kg in 2005 to 10,166 in 2006.
- 1,051 kg of heroin seized compared to 749 kg in 2005 (+40%), the largest volume seized. The quantities had already been on the increase since 2002, but as with all

the substances, the trend in quantities is less striking since it depends more on exceptional seizures.

- Amphetamine seizures in 2006 were down 30% on 2005.

Table 10.1. Number and quantities of the main illicit drugs seized in France, 2005-2006.

	2005		2006		Evolution (in %)	
	Number	**Quantity**	**Number**	**Quantity**	**Number**	**Quantity**
Cannabis (kg)	73,986	86,603	68,049	71,762	-8%	-17%
resin	62,396	83,471	57,848	67,892	-7%	-19%
grass	10,202	3,062	10,201	3,774	0%	23%
Heroin (kg)	3,242	749	3,212	1,052	-1%	40%
Cocaine (kg)	3,278	5,186	3,135	10,166	-4%	96%
Crack (kg)	687	11	441	9	-36%	-18%
Amphetamines (kg)	317	111	232	78	-27%	-30%
Ecstasy (doses)	1,620	833,648	924	1,488,919	-43%	79%
Magic mushrooms (kg)	195	26	120	15	-38%	-42%
Total	**83,932**	**--**	**76,113**	**--**	**-7%**	**--**

Source: FNAILS, OCRTIS 2006.

Origin and destination of the main drugs seized in France:

In its summary, OCRTIS points out that:

- Cocaine supply from South America has increased on European markets and France is still a transit country (17% of cocaine seized is destined for the French market). This justifies the rise in cocaine seizures
- the increase in heroine seizures can be explained by the sharp rise in seizures of heroin in transit, destined mainly for the UK; "activism in trafficking networks (Turkish, Albanian, Chinese) and the return to production on a grand scale in Afghanistan threaten to renew and exacerbate supply". Seized heroin comes predominantly from Turkey (30% of heroin seizures), Belgium (19%) and the Netherlands (18.2%)
- The sharp fall in ecstasy seizures can be explained by the virtual absence of large seizures, contrary to previous years. The Netherlands is the principal source country (84% of pills seized), while 45% of the total volume seized is destined for Spain and 29% for the French market

Table 10.2. Number of seizures and quantity seized of the main drugs in France, 2003-2006.

	2003		2004		2005		2006	
	No[1]	Qty[2]	No[1]	Qty[2]	No[1]	Qty[2]	No[1]	Qty[2]
Cannabis (kg) [3]		82,512	75,770	107,748	73,986	86,603	69,525	71,762
Resin		78,347	63,701	103,705	62,396	83,471	57,848	67,892
Grass		3,994	10,205	3,932	10,202	3,062	10,201	3,774
Feet		84	1,492	81	1,141	54	1,300	36
Oil		49	26	3	15	2	22	2
Seeds		38	346	26	232	14	154	58
Heroin (kg)	2,560	545	2,828	558	3,242	749	3,212	1,052
Cocaine (kg)	2,636	4,172	3,175	4,484	3,278	5,186	3,135	10,166
Crack (kg)		12	761	18	687	11	441	9
Amphetamines (kg)	181	274	252	76	317	111	232	78
Methamphetamines (kg)		4	0	0			2	
Ecstasy (doses)	1,864	2,211,727	2,135	1,893,226	1,620	833,648	924	1,488,919
LSD (doses)		10,383	101	19,374	99	6,323	78	5,589
	No(1)		No(1)		No(1)		No(1)	
All drugs	76,124		85,810		83,932		78,287	
Evolution, base 100 in 1998	159.8		180.1		176.2		164.3	

(1) number of seizures during the year. (2) quantities seized during the year. (3) In 2003, in the total of quantities seized, only cannabis resin and grass are counted.
Source: FNAILS, OCRTIS.

10.3 Price and purity

Cannabis

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

The average price of a gramme of resin is around €5, in line with the previous years, and may fall to four or even three euros when bought in bulk. The average price of a gramme of grass is slightly higher than in previous years (€6.4), since users are increasingly tending to favour a quality drug.

Heroin

In 2006, the average price of brown heroin came to about €40 per gramme.

Cocaine

In 2006, the median price of a gramme of cocaine was €60, stable compared to 2004. The average price is situated slightly below the €60 mark, i.e. the lowest price recorded for six years.

PART B: SELECTED ISSUES.

11. Public expenditure attributable to illegal drugs in France in 2005

Introduction

It is necessary to highlight the costs borne by the community as a direct result of legal or illegal drug consumption. Firstly, this will help us to identify the costs of public policies introduced in order to combat, prevent and treat drug addiction, but also the indirect costs related to the consumption of psychoactive substances including for example the resulting loss of revenue or productivity. Additionally, and importantly, highlighting these costs can help influence assessments (via cost - benefit analyses) of programmes aimed at dealing with drug addiction, whether these are introduced by the legal or health authorities, and consequently to make public decision-making easier and clearer.

In analysing the social costs of drugs, numerous in-depth examinations of expenditure committed by the public authorities aimed at combating, preventing and treating drug addiction have been undertaken for several years now in a number of countries. This wish to see a thorough analysis carried out is particularly understandable as drug-related public expenditure provides an effective dissuasive tool where drug consumption is concerned (Saffer et al. 2001). Consequently, encouraged by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), keen to harmonise the collection of data concerning public expenditure related to illegal drug use, and following a study which may be described as exploratory, (Kopp et al. 2003), we are today seeing the emergence of a common methodology for all European countries (Reuter 2006; Reuter et al. 2004). A number of methodological disagreements still need to be resolved however, such as the decision as to whether a top-down or bottom-up approach should be employed (Potsma 2004).

In France, public expenditure committed to combating, preventing and treating drug addiction has already been the subject of numerous studies. (Rosa 1994; Rosa 1996) focused on the social costs of tobacco consumption and its economic impact on public finances. In 1998, Kopp & Palle explored the possibility of measuring the cost of illegal drugs and in 2000, Kopp & Fénoglio widened the investigative field for this problem by considering not only illegal drugs but also alcohol and tobacco. Due to the controversy surrounding the results put forward by the studies of the social cost of tobacco from Rosa (1996) and from Kopp & Fénoglio (2000), a cost – benefit analysis of drugs and in particular of tobacco demonstrated the negative impact of tobacco consumption (and that of illegal drugs) on the public finances (Kopp & Fénoglio 2004). The cost of diseases related to the consumption of legal and illegal drugs was explained in detail in 2005 (Kopp & Fénoglio 2006a) and finally, the public expenditure deployed in order to combat and treat the effects of legal and illegal drugs in France was carefully assessed (Kopp & Fénoglio 2006b). The expenditure carried out by the public authorities specifically budgeted under the heading of “drugs” or for reasons related to illegal drugs was estimated at 907.03 million euros in 2003 compared to 699.45 in 1995 (Kopp & Fénoglio 2006b).

The present study seeks to update the assessments of the expenditure carried out by the French public authorities aimed at combating, preventing and treating illegal drug use for the year 2005. This work differs from previous French studies in two areas. Firstly, in order to ensure harmonisation at a European level, the presentation of the expenditure will not be broken down on an authority-by-authority and substance-by-substance basis, but rather by referring to the description of the public budgets and related expenditure. Secondly, the

method used to calculate the expenditure is based on a top-down approach, as opposed to the bottom-up approach used by Kopp & Fénoglio (2006b) (please see Postma 2004). This change in methodology will make it possible to compare the results and to assess their coherence.

Consequently, we will begin with an overview of the public budgets specifically devoted to drug addiction, and secondly we will examine the costs of the activities and initiatives carried out by the various authorities related to illegal drugs (but not specifically referred to as such).

1. Authorities and public expenditure specifically dedicated to combating, treating and preventing illegal drug use

The authorities involved in combating, preventing and treating drug addiction can be distinguished according to these three aspects. However, it has been noted that the budget credits allocated to these missions are only rarely described in detail.

The situation regarding the public budgets of the authorities concerned by illegal drug use.

Before describing the budget credits specifically described as "drug related", we should begin by identifying the ministries concerned by this study, as a result of the various activities which they may carry out.

Identifying the ministries concerned

The fight against illegal drug use is managed jointly by the Ministry of National Defence, the Ministry of the Interior and the Ministry of Justice thanks to the respective activities of the National Gendarmerie, of the National Police Corps and of the legal and prisons services. The Ministry of the Economy, Finance and Industry also participates in the fight against illegal drug use in as far as the Directorate-General for Customs and Indirect Taxes (*Direction Générale des Douanes et Droits Indirects or "DGGDI"*) is a branch of this ministry. Finally, although difficult to classify categorically, the Ministry of Foreign Affairs is also involved in the fight against illegal drugs via the international cooperation which it carries out aimed at combating and disrupting the international drugs trade.

Those authorities supporting activities aimed at preventing the consumption of illegal psychoactive substances are more difficult to identify. Nevertheless, the Ministry of National Education participates in activities aimed at preventing addictive behaviour, through the work of the Health and Citizenship Education Committees (*Comités d'Éducation à la Santé et à la Citoyenneté or "CESCs"*). The same applies for the Ministry of Youth and Sports.

Finally, the Ministry of Health and Solidarity is also involved in the treatment and prevention of drug abuse.

Table 11.1 shows the total budgets for these ministries in 2005.

Table 11.1. Total budget for ministries involved in combating, preventing and treating the use of illegal drugs, France, 2005.

In euros	**Budget 2005***
Ministry of Foreign Affairs	4 275 479 596
Ministry of National Defence and War Veterans	45 926 274 392
Ministry of National Education, Research and Higher Education	72 561 049 685
Ministry of the Economy, Finance and Industry	62 756 651 581
Ministry of the Interior and of Land Management	13 863 121 461
Ministry of Youth, Sports and Community Life	531 790 099
Ministry of Justice	5 265 116 740
Ministry of Health and Solidarity	10 824 231 923
Total State budget	281 585 501 260

* Payement appropriations.

It is from within the budgets for these ministries that public expenditure referred to as "drug-related" will be identified.

"Drug-related" budgets

The Ministry of Health and Solidarity contributes to the treatment and prevention of addictive behaviour. We find budgets allocated to these issues in the "Public Health and Prevention" category, under action no.2: "Health determinants". More precisely, the title of this budgetary item is "Combating High-risk Practices", and a total of 25.8 million euros was allocated to it in 2005. Of these credits, 8% are the responsibility of the central administration, while the remaining 92% were decentralised.

The central administration uses these credits to finance risk reduction associations and health professionals, etc. For the decentralised services, these credits make it possible to support local organisations working to prevent and combat drug abuse including the drug abuse networks in local hospitals, reception centres for vulnerable drug addicts, special units for those recently released from prison, back-to-work workshops and syringe exchange programmes, etc.

It should also be stressed that at both a national and local level, these actions are closely related to the problem of HIV infection.

The Ministry of Foreign Affairs also makes a contribution to tackling the problem of illegal drugs throughout the world by financing a number of European and international organisations. These budgets can be found in the budgetary sections dealing with voluntary contributions made as part of international cooperation initiatives. In 2005, France contributed 244.5 million euros in the field of international cooperation via its Ministry of Foreign Affairs. The Pompidou Group, the Inter-American Drug Abuse Control Commission (CICAD) and the United Nations Programme for the International Control of Drugs (UNPICD) received subsidies paid for from these voluntary contributions. For 2005, the exact contributions received by these organisations have unfortunately not been stipulated. However, in 2003, these totalled 1.03 million euros for the UNPICD, and 20,000 euros for the Pompidou Group, although the latter was paid for from the MILDT's financing package. No information is available concerning financing for the CICAD. The 1.03 million euros allocated to the UNPICD are listed as financing specifically allocated by the Ministry of Foreign Affairs for the theme of illegal drugs in 2005.

Where the Ministry of Education is concerned, the budgets for the CESCs participating in the prevention of addictive behaviour by school aged youngsters are difficult to identify. A sizeable number of their activities are financed on a project-by-project basis by the MILDT,

the Regional Departments for Health and Social Affairs (*Directions Régionales des Affaires Sanitaires et Sociales or "DRASS"*), or the national health insurance system (*Assurance Maladie*). Furthermore, it is impossible to know whether or not these activities concern legal or illegal drugs. The financing of the Ministry of Education's *CESCs* is therefore not taken into account within the scope of this study, in order to avoid the possibility of any double accounting. The same applies for the Ministry of Youth and Sports.

In the accounts for the other ministries, no other budgetary items explicitly allocated to illegal drug use or drug addicts have been identified. It is by calculating the values assigned under several different budgetary categories that we can highlight the total budgetary expenditure in these fields. Previously, the expenditure of authorities and public operators other than the ministries were considered, including in particular the Interministerial Mission for the Fight against Drugs and Drug Addiction (*Mission Interministérielle de Lutte contre les Drogues et les Toxicomanies or "MILDT"*) and the national health insurance system (Assurance Maladie).

The MILDT and the national health insurance system

The budgetary credits identified as being specifically allocated to combating, preventing and treating drug addiction are not only found in ministerial budgets as such. Indeed, the MILDT and the *Assurance Maladie* account for a large number of budgetary items allocated to action to combat to illegal drugs.

The Interministerial Mission for the Fight against Drugs and Drug Addiction

The MILDT's budget is listed in the Ministry of Health's "drugs and drug addicts" programme. A total of 39.3 million euros were allocated to this interministerial mission in 2005. A portion of the MILDT's credits are themselves allocated to ministries carrying out activities in the field of drug addiction. It is in the budgetary categories intended for the ministries that the expenditure commitments made by the various administrations when it comes to combating, preventing and treating the consumption of illegal drugs can be found. However, these items of expenditure are not always clearly labelled as "drug-related".

The MILDT's budgets are also used to finance public interest groups (such as the French Observatory for Drugs and Drug Addiction (*Observatoire Français des Drogues et des Toxicomanies*) and *Drogues Alcool Tabac Info Service* (the Drugs, Alcohol and Tobacco Info Service), etc), and local organisations, (Resource Centres for Drugs and Drug Dependence or *Centre d'Informations et de Ressources sur les Drogues et les Dépendances*). They also subsidise a number of local associations and key players operating in the drug-addiction field.

The fact nevertheless remains that a major part of public expenditure is accounted for by the payments made by the French social security system.

The national health insurance system ("Assurance Maladie")

Since January 1, 2003, the *Assurance Maladie* has assumed part of the financing package for the Specialist Drug Addiction Treatment Centres (*Centres Spécialisés de Soins aux Toxicomanes or "CSST"*), for the Alcohol Ambulatory Treatment Centres (*Centres de Cure Ambulatoire en Alcoologie or "CCAA"*) and for the Therapeutic coordination apartments (*Appartements de Coordination Thérapeutique or "ACT"*) (Circular No. 2004-395), and since January 1, 2006 that of the Reception and Risk Reduction Support Centres for Drug Users (*Centres d'Accueil et d'Accompagnement à la Réduction des risques pour Usagers de Drogues or "CAARUDs"*) (Circular No. 2006-493). Additionally, it also refunds part of the cost of the required medicines for opioid substitution treatments.

We only require details of the financing provided by the *Assurance Maladie* concerning the *CSSTs* and the *ACTs*, in addition to other organisations and schemes recently set up (cannabis consultations, etc.) as the *CCAAs* fall outside the scope of our study and the *CAARUDs* were financed from the Ministry of Health and Solidarity's budgets prior to 2006.

In 2005, the financing of these drug addict treatment organisations totalled 162.3 million euros, broken down as follows: 141.7 million for the *CSSTs*, 17 for the *ACTs* and 3.6 million euros for "cannabis consultations". Additionally, slightly more than 87 million euros were paid out by the social security system for opioid substitutes (source: Assurance Maladie 2006).

In total therefore, 249.3 million euros were specifically allocated by the *Assurance Maladie* to the treatment of drug addicts.

Other key players such as the National Institute for Prevention and Health Education (*Institut National de Prévention et d'Éducation à la Santé or "INPES"*) or the National Cancer Institute (*INCa*) are also involved in the field of illegal drug addiction in France. Just like those for the research centres, following the example of the National Institute of Health and Medical Research (*Institut National de Santé et de Recherche Médicale or "INSERM"*) or the universities, their budgets are only rarely specifically devoted to illegal drugs. The latter are not included in the data for the present study.

2. Public expenditure allocated to combating, treating and preventing illegal drug consumption

The attributable fractions that we have highlighted can be used to identify the percentages of public budgets accounted for by illegal drug use.

The percentages of public budgets attributable to illegal drug use.

The percentage of the public budgets which are not specifically referred to as "drug-related" but which are nevertheless devoted to illegal drugs needs to be highlighted. To do so, we will be using the top-down approach recommended by the EMCDDA, and based on the following methodology: expenditure which is not specifically "drug-related" but which is nevertheless committed by an authority for dealing with effects of illegal drugs will be equal to the expenditure of this authority multiplied by the attributable fraction of this budget devoted to illegal psychoactive substances. With this in mind, one quickly appreciates that the difficulty of carrying out this exercise lies in determining the attributable fractions concerned.

Security and public order

The State's missions of security and public order are broken down among the activities of the National Police Corps, of the National Gendarmerie, of the DGDDI (*Customs Dept*.), of the Justice Department and of the prisons service. For each of these missions, the attributable fractions are determined according to the activities carried out by these authorities.

In order to determine the percentage of the National Gendarmerie's and the National Police Corps' budget accounted for by illegal drugs, we have assumed that the type of crimes listed in the recorded incidents correspond in percentage terms to the financial and human resources committed to dealing with the same crimes. Table 11.2 shows that infractions of the Narcotics law account for 4.35% and 3.63% of the total number of incidents recorded respectively by the Gendarmerie and the National Police Corps. These percentages will be used as the attributable fractions of the National Gendarmerie's and the National Police Corps's budget accounted for by illegal drugs.

Table 11.2. Narcotics offences as a percentage of the activities of the National Gendarmerie and Police Corps, France 2005.

		National gendarmerie	National Police
Total number of offences		1 039 378	2 736 460
Narcotics law infractions		45 219	99 342
Of which	- Trafficking / resale without use	*1 083*	*5 025*
	- Use - resale	*7 065*	*9 131*
	- Use	*26 908*	*82 673*
	- Other narcotics offences	*10 163*	*2 513*
		4,35 %	3,63 %

Source : DCPJ (2005).

Similarly, it is thanks to the "field" activities of the customs officers that the percentage of the DGGDI's budget attributable to illegal drugs is calculated. The customs department records concern four main areas (table 11.3) and the percentage of cases concerning drug trafficking accounts for 19.9% of all cases. It is this percentage which will be used as the attributable fraction.

Table 11.3. Percentage of recorded incidents noted by the Customs Department concerning action against narcotics, France 2005.

	Incidents
Action to combat the black economy	23 254
Action against counterfeiting	11 419
Tobacco smuggling	10 112
Underground financial networks	1 723
Action against narcotics	19 910
Heritage protection	929
Natural heritage	719
Ecological taxes	158
Cultural heritage	52
The fight against economic and financial crime	55 995
Commercial fraud: industrial and agricultural products	43 697
Commercial fraud: indirect taxes	12 298
Total recorded incidents	100 088
Narcotics as a % of the total	19,9 %

Source: DGDDI (2006).

When calculating the fraction of the Justice Department's budget attributable to illegal drugs (excluding the budget for the prisons service), as a working hypothesis the activity levels of public prosecutors in the field of illegal drugs is considered as being representative of the cost of illegal drugs where the justice budget is concerned. Unfortunately, data from 2005 is not available, although we may take an average of the public prosecutors' activity levels concerning illegal drugs as providing an approximate figure for the desired attributable fraction (table 11.4).

Table 11.4. Sentences for narcotics offences and no. of cases referred to the courts in France, 2000-2004.

	Court referrals for criminal offences	Sentences for narcotics offences	As a fraction (%)
2000	5 007 674	22 831	0,46
2001	5 385 826	21 203	0,39
2002	5 501 482	21 777	0,40
2003	5 309 811	28 316	0,53
2004	5 399 181	31 497	0,58
Moyenne			0,47

Source: Ministry of justice (2006).

We will consequently take an average of 0.47% as the fraction attributable to illegal drugs as part of the justice budget (excluding the prisons service).

On December 31, 2005, a total of 5718 people were incarcerated in France for drug offences. Out of a total of 38,790, these prisoners represent 14.74% of the total number of people incarcerated in 2005. Since 2001, this percentage has remained in a band ranging from 12 to more than 15% (source: Ministry of Justice, 2006). We will therefore take this level of 14.74% as the fraction of the prison service's total budget accounted for by illegal drugs.

Health

It would be very tempting to count the cost of treatments provided in hospital and via doctors, and refunded by the *Assurance Maladie* or financed from hospital budgets as public expenditure attributable to illegal drugs. This has already been carried out for France for the year 2003, and demonstrated that the cost of illnesses and diseases attributable to illegal drugs was estimated at somewhere between 573 and 632 million euros. The main portion of this expenditure was attributable to infectious illnesses (slightly more than 80%), (Kopp & Fénoglio 2006a). This estimate will not be updated and, *de facto*, will not be incorporated in the present study. Obviously, the cost of the treatments attributable to illegal drugs constitutes public expenditure, incurred indirectly due to the harmful effects of consuming psychoactive substances. But it is not the result of a clearly established political initiative, following the example of risk reduction policies (substitute medicines, or the creation of specific organisational structures for dealing with drug addicts).

Based on the cost allocation methods highlighted above, only those items of expenditure incurred in the implementation of the law will be assessed.

Public expenditure accounted for by the fight against illegal drugs.

The public expenditure figure attributable to illegal drug use is obtained by multiplying the public budgets of the authorities concerned, by the respective attributable fractions. However, in order to be as precise as possible, anything specifically attributable to another purpose has been removed from these budgets. As an example, following an examination of the activities covered by the National Police Corps' budget, it transpired that part of this budget is covered by the heading "road safety" .[29] The same applies for the National Gendarmerie's budget. Consequently, the figures from the budgets for the National Police Corps and the National Gendarmerie, (minus the figures for road safety), multiplied by the

[29] The road safety budget may be taken into account insofar as the screening of drivers for certain illegal drugs is now being carried out at the wheel. However, this is only just getting underway and for the moment the cost is certainly marginal compared to the total budgets allocated to road safety. Consequently the decision has been taken to omit these figures from the calculation.

attributable fractions highlighted elsewhere (table 2) enable us to obtain the total value of these budgets allocated to illegal drugs. Accordingly, the total police budget attributable to illegal drugs is estimated at 275.8 million euros, while that of the Gendarmerie is 243.9 million euros.

For its part, the DGDDI (customs department) has a twofold mission. Firstly it is a tax authority, with the task of collecting certain forms of taxation and duties, including in particular duties on products which are subject to indirect taxes (alcohol, tobacco and petroleum products), and secondly this authority has responsibility for investigating and combating fraud. This second activity naturally includes the fight against drug trafficking. The budget for the customs department totalled 517 million euros in 2005, and the DGDDI had a total of 19,000 operatives working in two separate areas of activity, namely the monitoring of commercial operations in addition to national and border surveillance activities. Half of the custom department's workforce is devoted to this second activity. The total budget for the customs authority has consequently been divided in two in order to consider only those budgetary items allocated to the prevention of trafficking, with the other half of the customs department's workforce being engaged the collection of taxes and duties. The fraction attributable to illegal drugs as a total percentage of the activities carried out by the "uniformed" customs staff is estimated at 19.9% (table 3). The budget for the customs department attributed to illegal drugs is therefore estimated at 51.5 million euros.

The budget for the Ministry of Justice totalled 5.26 billion euros in 2005, of which 1.87 billion was devoted to the prisons service. It is based on the remaining 3.39 billion that public expenditure in the justice field attributable to illegal drugs has been assessed. However, before applying the relevant attributable fraction (table 11.4) the sums allocated to civil justice are removed from this budget, leaving only the standard and above all penal budgets. Following these deductions, and by applying the attributable fraction of 0.47%, the expenditure of the Ministry of Justice directly attributable to illegal drugs is 13.1 million euros. That of the prisons service, (using the attributable fraction of 14.74%) totalled 270.2 million euros.

Table 11.5. Budgets allocated to combating, preventing and treating illegal drugs, France 2005, in Euros.

Ministry / Authority	Action	Cofog	Classification: Reuter 2006	Level	Amount
Ministry of health and solidarity		7	1,2,4		**25,8**
	Subsidies	07.4		Central	2,1
	Subsidies	07.4		Regional	23,7
Ministry of foreign affaires	International cooperation	02.3	3	Central	**1,0**
MILDT			1,2,3,4		**39,3**
	Interministerial credits			Central	5,0
	Subsidies			Central	12,0
	Subsidies			Regional	21,0
	Support funds			Central	1,3
Assurance Maladie (nat. health ins)			2,4	Regional	**886,0**
	Opioid substitutions	07.1			87,0
	Treatment centres	07.3			162,3
	Hospitals	07.3			287,1
	GP	07.2			349,6
Ministry of Interior	National police	03.1	3	Central	**275,8**
Ministry of Defense	National Gendarmerie	02.2	3	Central	**243,9**
Ministry of the Economy	DGDDI (custom dpt)	03.2	3	Central	**51,5**
Ministry of Justice			3	Central	**283,3**
	Legal services	03.3			13,1
	Prisons services	03.4			270,2
				Total	**1806,**

Source: OFDT.

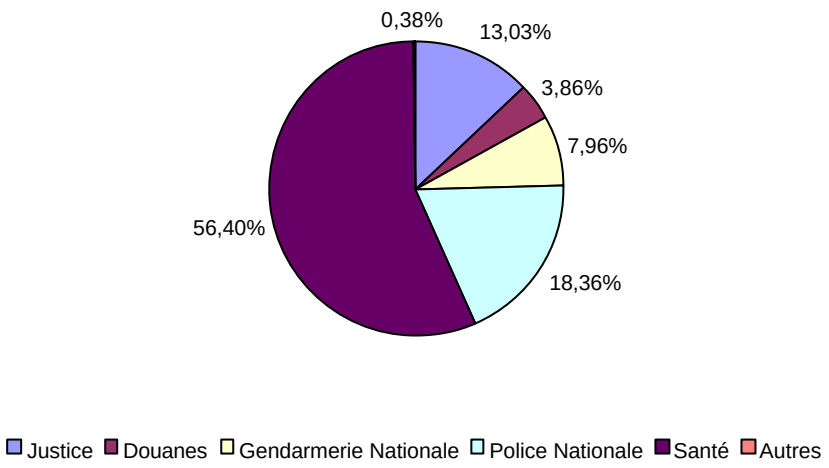
Conclusion.

To conclude, public expenditure attributable to illegal drugs in 2005 can be estimated at a total of 1170 million euros (table 11.5). This is approximately 263 million more than the latest estimate from Kopp & Fénoglio (2006a) for the year 2003. This variation may be explained by a possible increase in public expenditure allocated to illegal drugs *per se*. However, if we compare the budgetary items identified in Kopp & Fénoglio (2006a) and those of this study, no major differences are noted. These 263 million may therefore be explained more realistically by differences in the calculation method used.

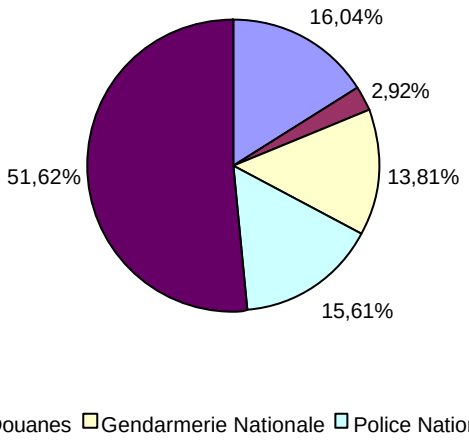
Indeed, unlike the top-down method, the use of a bottom-up approach does not require the use of an attributable fraction which may wrongly represent the percentages actually attributed to actions concerning illegal drugs. The identification of expenditure using this second approach may appear to be more precise but favours the omission of certain nameless budgets which nevertheless contribute to policies deployed vis-à-vis illegal drugs.

As an example, where legal services are concerned, Kopp & Fénoglio (2006a) have estimated a figure of 92 million euros compared to 13.1 in our study. Similarly, the expenditure of the prison service is assessed at 89 million euros by Kopp & Fénoglio (2006a) whereas our calculations total 270 million euros. Nevertheless, the repartition of public expenditures did not show major changes (graph 11.1 and 11.2):

Graph 11.1. Public expenditures due to illicit drugs according to Kopp & Fénoglio (2006a, 2006b), France, 2003.



Graph 11.2. Public expenditures due to illicit drugs according to Kopp & Fénoglio (2006a, 2006b), France 2005.



Consequently, it is difficult to categorically say which approach is better. The bottom-up approach nevertheless features a number of problems, in that it appears to be far more costly in terms of information collection.

Despite these differences, a comparison of these methods and the resulting estimates enables us to consider that in France, the total public expenditure attributable to illegal drugs is approximately one billion euros.

Acknowledgements.
We would like to thank Marie-Claude Roisnard (OFDT), Monique Reuzé (MILDT) and Christelle Lemieux (DGS) for all the information and clarifications concerning public accounting that they have been able to supply to us in the preparation of this study. Comments from Julie-Émilie Adès, Laurence Callard, Éric Janssen, Hélène Martineau et Isabelle Michot were appreciated.

12. Vulnerable groups of young people.

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Foreword

For several years now, the EMCDDA's attention has been focused via various published national reports on the recurring theme of drug use by vulnerable groups of young people. The main difficulty in carrying out any in-depth analysis lies in the definition of this notion of vulnerability, which covers numerous aspects and for which a standard definition has never been established, with each study in this field imposing its own, variable limits. What exactly do we mean by vulnerability?

We can distinguish three major aspects: are we dealing with groups of individuals with specific characteristics which increase their exposure to risk – if so, what kind of risk is referred to? How does that risk connect to regular or excessive use of psychoactive substances? Alternatively, are we dealing with a population group which has already gone the whole way through addiction since they started experimenting, and which now find themselves in situations of psychological, social, economic and/or health related distress? Or are we referring to (ex-) drug addicts currently receiving treatment but who are nevertheless fragile and at risk of a relapse at any time throughout this complex process?

Each of these questions is perfectly valid, and illustrates the diversity of the population groups which can be described as "vulnerable". Additionally, each of these approaches proposes its own specific sources of information and methodologies, which will be presented here. Consequently, it is not possible to "rank" the value of these approaches and even less so to justify the choice of one of the possibilities described over all the others. This decision underpins the chosen organisational method, in which the quantitative contributions of surveys carried out among the general population are applied. These include qualitative results from the TREND scheme and those of the RECAP data collection programme.

I. The contribution of surveys carried out with the population at large.

Thanks to the surveys regularly carried out among the general teenage population, we today know that the number of people experimenting with cannabis, cocaine and ecstasy has been rising since 2000 to the extent that where cannabis is concerned France tops the list of the European nations. In 2005, at 17 years of age, 4 teenagers out of 10 stated that they smoked cannabis during the previous year and 5% smoke it every day (an increase of 25% compared to 2003). Similarly the number of people experimenting with cocaine virtually tripled between 2002 and 2005. It stands at a level of 2.5%, which means that this is today one of the products most experimented with in the late teenage years, along with cannabis, poppers, ecstasy and amphetamines, often being consumed in festive/party environments.

The users of legal and illegal drugs are also getting younger: the average age for experimenting with cigarettes has fallen over recent years, even though smoking as a whole is declining, and the average age for experimenting with cannabis has fallen from 15.3 years for the 17-year olds interviewed in 2000 to 15.1 years in 2005 ($p<0.05$) (Beck et al. 2000, Legleye et al. 2007). However, precocity has long been recognised as one of the features most likely to indicate subsequent drug abuse or addiction (Robertson, Miller et al. 1996; Aarons, Brown et al. 1999) and has an important influence on the occurrence of major social and health-related problems, particularly as a consequence of the resulting impairment of social skills (Pandina and Schuele 1983; Kandel, Davies et al. 1986; Pandina, Labouvie et al. 1990; Kandel 1996).

However, although many young people experiment with drugs, very few of these go on to become addicts. For the occasional users who choose not to continue their "career" in drug use beyond adolescence, the risks are related to the occurrence of accidents (road accidents for example), problems with the police and the legal system, or unprotected sex while under the influence of alcohol or illegal drugs. For the others, who represent only a minority, drug consumption intensifies and may result in the health problems and social difficulties so characteristic of drug addiction. Research has identified a series of risk (or vulnerability) factors which may encourage youngsters to go this extra step, including individual characteristics (mental problems) or family and environmental characteristics which are often compounded by one another (Hawkins, Catalano et al. 1992; Lloyd 1998; Petraitis, Flay et al. 1998). A number of approaches go beyond this definition, considering drug use as a vulnerability factor in itself. Accordingly, in 1998 the High Committee for Public Health identified "behaviour promoting the consumption of psychoactive substances" among the various vulnerability situations, this being considered as "risk-enhancing" behaviour, and stressing that by their very nature teenagers are vulnerable and that the effects of this primary vulnerability are multiplied as a result of the harmful effects of drug use (Haut Comité de la santé publique 1998).

Vulnerability is a relational, relative and volatile notion, and one which is difficult to define. Applied to a particular social group, it can be understood with reference to other social groups considered to be less vulnerable. This intrinsic relativity is combined with a further degree of relativity concerning the type of risks encountered. A group is only relatively vulnerable vis-à-vis another group and vis-à-vis certain risks or dangers which are not always clearly explained. Moreover, in practice the notion of vulnerability is commonly used to refer to the distance separating an individual or social group from a collectively accepted "stability" standard, established by common accord. Thirdly, because it describes a reference to risks in the modern sense of the term (Peretti-Watel 2001; Beck, Latour et al. 2003), vulnerability is linked both to the frequency of the exposure to risks (i.e. the probability that a problem will occur or a danger will appear) and to the seriousness of the resulting harm. Consequently, this notion does not help to make a distinction between the frequency of a problem and its seriousness. A group can therefore be considered vulnerable because it is more exposed to one problem than to another, but also because the individuals who are part of it possess few resources in order to remedy or minimise the consequences, or both of these factors combined. Finally, this is a volatile notion because it can only be true at a given moment of the individual's lifetime and in a given social situation, both being constantly changing factors which by their very nature defy all attempts to encompass them with a general definition.

Consequently, faced with the difficulty of defining a perimeter for the notion of vulnerability, we have chiefly sought to identify the factors associated with drug use during adolescence, considered by the public authorities as a key stage in life, during which outside intervention can play a decisive role. This work is based on a twofold assumption. It considers that the regular use of certain drugs such as alcohol and cannabis, but also experimentation with other products such as cocaine and heroin at this stage in life is a clear indicator of vulnerability or a risk in itself (to health, social integration, but also vis-à-vis the police and the legal system) and that certain social and family characteristics play their part in increasing exposure. In this respect, the concept of vulnerability is comparable with the notion of excessive risk[30]. Subsequently, the concept will be considered from another angle, that of the probable consequences of exposure, and an attempt will be made to carry out an analysis by the measurement of inequalities in terms of mental health and the way in which

[30] Moreover it was in this manner that this expression was used by the Council of the European Union in its resolution encouraging the member states to develop the early identification of vulnerable groups i.e. those considered as being more exposed than others to the risk of developing drug addiction problems (5034/4/03 – Cordrogue 1 of 13 June 2003).

this is treated. This exploratory measure will seek to define vulnerability criteria regarding the seriousness of the harm resulting from exposure.

Finally, this work will give thought to the limitations of the surveys through the exploration of non-replies: those concerning drug uses which are found to be related to underprivileged social and educational profiles, and those making it possible to assume insufficient basic educational skills such as reading and writing, which have been found to be extensively linked to high levels of drug use.

The discussion will nevertheless also propose a criticism of the notion of vulnerability, seeking to describe the logical arguments used to justify it.

Table 12.1. Factors associated with various forms of legal and illegal drug use (% and OR).

		Smoking (daily use)		Alcohol (regular use		Cannabis (regular use)		Ecstasy (lifetime use)		Cocaine (lifetime use)		Heroin (lifetime use)	
		(%)[1]	OR[2]	(%)[1]	OR[2]	(%)[1]	OR[2]	(%)[1]	OR[2]	(%)[1]	OR[2]	(%)[1]	OR[2]
Sex	Girls (48.9 %)	32.3	-1-	6.1	-1-	6.3	-1-	2.8	-1-	2.0	-1-	0.6	-1-
	Boys (51.1 %)	33.6 *	0.9 ***	17.7 ***	3.1***	15.0 ***	2.3 ***	4.2 ***	1.3 ***	3.0 ***	1.4 ***	0.8 ns	1.1
Situation	Pupils or students (84.2 %)	28.3	-1-	10.5	-1-	9.0	-1-	2.6	-1-	1.9	-1-	0.5	-1-
	Apprenticeship (11.4 %)	55.2	2.6 ***	21.7	2.0 ***	18.1	1.6 ***	7.0	2.5 ***	4.7	2.2 ***	1.7	2.9 ***
	Other (4.4 %)	64.8 ***	3.9 ***	17.1 ***	1.6 ***	27.0 ***	3.0 ***	12.7 ***	4.6 ***	9.1 ***	4.3 ***	2.0 ***	2.4 ***
Required to repeat a year at school	Never (49.9 %)	23.5	-1-	10.8	-1-	6.9	-1-	2.4	-1-	1.7	-1-	0.4	-1-
	Once (41.4 %)	41.8	2.0 ***	13.6	1.0	14.3	1.9 ***	4.3	1.5 ***	3.2	1.6 ***	0.9	1.5 *
	Twice (8.7 %)	45.4 ***	2.1 ***	12.3 ***	0.8 **	16.3 ***	2.0 ***	6.3 ***	1.9 ***	4.4 ***	2.1 ***	1.4 ***	2.2 **
Social background[3]	Very affluent (10.6 %)	30.6	-1-	13.1	-1-	11.1	-1-	3.5	-1-	3.3	-1-	0.6	-1-
	Affluent (27.8 %)	31.5	0.9 ns	12.3	0.9	10.5	0.8 *	3.5	0.9 ns	2.8	0.7 *	0.8	1.3 ns
	Average (13.0 %)	30.1	0.8 **	11.9	0.9 *	11.0	0.9	3.4	0.9 ns	2.3	0.6 ***	0.5	0.8 ns
	Modest (41.7 %)	34.8	0.9 *	12.2	0.8 ***	10.5	0.7 ***	3.5	0.7 *	2.2	0.5 ***	0.6	0.9 ns
	Under-privileged (7.0 %)	34.9 ***	0.7 ***	8.5 ***	0.5 ***	10.4 ns	0.6 ***	3.5 ns	0.6 ***	2.7 **	0.4 ***	1.0 ns	1.0 ns
Parents living together	Yes (71.3 %)	29.1	-1-	11.5	-1-	8.9	-1-	2.8	-1-	2.0	-1-	0.6	-1-
	No (28.7 %)	42.7 ***	1.6 ***	13.4 ***	1.2 ***	15.5 ***	1.7 ***	5.3 ***	1.6 ***	3.8 ***	1.6 ***	1.1 ***	1.6 **
Lives in the family home	Yes (88.7 %)	31.2	-1-	11.1	-1-	10.0	-1-	3.1	-1-	2.2	-1-	0.6	-1-
	No (11.3 %)	46.6 ***	1.8 ***	19.4 ***	1.9 ***	16.4 ***	1.7 ***	7.0 ***	2.2 ***	5.0 ***	2.2 ***	1.5 ***	2.3 ***

***, **, *, ns ; Pearson's Chi² test (for the percentages) or that of Wald (for the OR) significant at the 0.001, 0.01, 0.05 and ns thresholds.

1: For the percentages, this concerns the overall Chi², highlighting the interdependency of the variables.

2: Odds ratio adjusted to take account of the table's variables.

3: Assessed based on the highest PSC (professional and social category) of the parental couple, from among 11 options accompanied by examples of professions, based on the following breakdown: "Underprivileged" refers to the fact that the parents are stated by the child as being inactive, "modest" that they are factory or office workers, "average" that they have an intermediate level profession, "affluent" when only one of the parents has an executive-level post or is a company manager, independent craftsman or shopkeeper, and "highly affluent" refers to the fact that both occupy such positions. These are the parents' professions as declared by the child, which may sometimes differ widely from the real-life situation (due to a lack of knowledge of the posts actually held by the parents or difficulties in categorizing the posts, etc).

Source: ESCAPAD 2005, OFDT

I.2 Socio-economic factors related to the use of drugs during adolescence.

I.2.1 Successful pupils are less likely to take drugs.

The consumption of tobacco, alcohol, cannabis, cocaine and ecstasy appear to be associated with educational problems (table 1). Compared to pupils and students of the general education system, the proportion of regular users of cannabis is twice as high among apprentices or young people on sandwich courses, and three times higher among youngsters who have dropped out of the education system. Although the levels of experimentation with ecstasy, cocaine and heroin are well below those recorded for cannabis, the correlation with the drug user's educational environment is even more pronounced: the variation ranges from a ratio of 1 to 4. The correlation is similar when we consider the number of people needing to repeat a year during their schooling. It demonstrates that the difficulty of the educational route concerned and the enrolment (either chosen or forced) on short educational courses are factors associated with frequent drug use.

However, it must be pointed out that this analysis does not make it possible to distinguish between the cause and the consequences. In the case of cannabis for example, although consumption may be linked to low levels of achievement at school (including a lack of interest or demotivation on the part of the pupil and difficulties in concentrating, etc.), the decisive factors influencing failure within the school system are many and varied, and can probably be better explained by the pupils socio-cultural environment or his/her schooling during the early years, which have an influence on success levels at school due to the attitudes towards learning which these factors generate (Heckman and Masterov 2004). The same comment also applies concerning experimentation with other illegal drugs.

Nevertheless, certain situations seem to encourage the consumption of illegal drugs among 17-year old youngsters, including participation in training schools and sandwich courses, having repeated a year or having dropped out of the educational system altogether.

I.2.2 Consumption is more frequent in affluent circles.

From a socioeconomic viewpoint, the consumption of legal substances, alcohol-induced drunkenness, but also the regular consumption of cannabis are increasingly prevalent among young people from affluent backgrounds. The same applies regarding experimentation with ecstasy and cocaine. Conversely, heroin is equally prevalent among people of all socio-economic backgrounds. This differential can partly be explained by the greater social resources available to teenagers from affluent backgrounds (place of residence, social skills and supply networks, etc.), which make it easier for them to obtain drugs. This result is particularly pronounced for cocaine, the cost for which can be very high (at approximately 60 euros per gram compared to 4 or 6 euros for a gram of cannabis resin (Office Central pour la répression du trafic illicite de stupéfiants 2005; Cadet-Taïrou, Gandilhon et al. 2007). The nature of the social networks and networks of friends in the family's social and professional environment is also doubtless of some importance here.

Additionally, the impact that a lack of achievement at school can have on the levels of reported drug use appears all the more pronounced among young people from affluent social backgrounds. As an example, the OR associated with two repeated years at school with regard to the regular consumption of cannabis among young people from "under privileged" or "modest" backgrounds is 1.6, compared to 2.3 for those from "affluent" or "highly affluent" backgrounds. Where experimentation with cocaine is concerned, the results are respectively

1.8 and 2.531. These results are somewhat ambivalent: it is possible that family-imposed expectations concerning success at school are probably higher among affluent families, which can lead to greater psychological pressure, offset by the use of drugs. It is also possible however that teenagers from extremely affluent backgrounds are less concerned about educational success and do not change their behaviour patterns in the event of underachievement.

I.2.3 Increased consumption frequency in single parent families and among the more independent youngsters.

The family situation also appears to be a significant factor associated with illegal drug consumption. Young people whose parents still live together seem far less likely to experiment with or to consume drugs. Moreover, a young person living outside the family home (for most of the time during studies) is likely to consume cannabis, ecstasy, cocaine and heroin more frequently. These observations demonstrate that consumption opportunities among 17 year old youths are strongly related to the level of supervision by the family. With this in mind, living in the family home is a protective factor: teenagers who are in this situation have twice less chances to have experimented with ecstasy, cocaine and heroin at the age of 17 (table 1). These two effects often combine. The odds ratio associated with the combination of parental separation and residency outside the home is almost three (2.9 for the regular use of cannabis, 3.3 for experimentation with ecstasy and 3.1 for experimentation with cocaine or heroin).

I.2.4 Consumption is significantly linked to the level of sociability

The youngster's environment where friendship and sociability are concerned can play an essential role in the experimentation with drugs and more generally, in the patterns of use. Consequently, among all teenagers reporting that they have spent time with their friends in a bar (a café or pub) every day (or almost every day) over the last 12 months, 19.1% state that they have regularly smoked cannabis compared to 6.6% among those who state they never visit such establishments. The proportions are respectively 31.3% and 2.1% if we substitute evening trips to bars among friends. The same observation also applies for experimentation with ecstasy or cocaine: the proportion of young people having tried cocaine varies between 1.1% among those who never go out to bars with friends, and 5.8% among those who spend the evening out every day. On the other hand, there is no link between these "sociability" aspects and experimentation with heroin, this standing at approximately 1% regardless of how often the youngster goes out.

These results can be explained by the usage patterns for cannabis, cocaine and ecstasy which, just like tobacco and alcohol (and unlike heroin), are part of established collective, or festive habits, or which have become established interaction rites[32] characteristic of the teenage social habits (Goffman 1967). We should point out that these associations continue when, in the logistical models shown in table one, we add the sociability indicators presented here. More particularly, the use of drugs appears to be clearly linked to cultural and in particular to musical preferences (Legleye and Beck 2003).

[31] These results are derived from logistical models identical to those presented in table 1, but limited to the selected family environments ("underprivileged" and "modest" on the one hand and "affluent" or "very affluent" on the other. We should note that there is an interaction between the PSC of the parents and the number of repeated school years due to the regular use of cannabis and experimentation with cocaine.

[32] The notion of "interaction rites" is used here in Goffman's sense of the term.

This phenomenon highlights the social and inclusive role of the use of certain drugs (at least when this is not followed by harmful consequences) and suggests that we should also take into account these positive aspects when considering their intrinsically harmful nature.

I.2.5 Higher exposure to legal problems among young people with modest backgrounds and those using certain substances.

The illegal nature of the consumption and possession of drugs may result in penal consequences (legal action), administrative consequences (expulsion from school, dismissal from employment, etc.) or financial consequences (fines, and cancellation of insurance policies in the event of an accident). The risk of being caught in the act when taking drugs (particularly in the case of cannabis) varies with the age and the gender. In 2005, 94% of those arrested were men and 63% of the arrests for the use of cannabis (which is by far the leading substance concerned, with regard to arrests) involved youngsters aged 18 to 25 whereas general population statistics demonstrate that only 14% of young people of this age group declare that they have consumed this product during the last month (Office Central pour la répression du trafic illicite de stupéfiants 2005).

This difference can be explained by a number of factors. Studies demonstrate that arrests made by the police conform to numerous selective logics and criteria: the predominance of males among those arrested for drugs use is probably due to the usage circumstances, with males having a higher tendency than girls to consume drugs in public and in "gangs", but also in the social attitudes of the police and the gendarmerie staff who tend to see a higher "potential for delinquency" among men than among women (Barré 1996). A comparison of cannabis smokers interviewed as part of surveys representative of the general population and of arrested users has made it possible to objectively view the substantial difference between the two groups. In the police statistics, young people, males and those from modest backgrounds, with no professional activity, or from socially deprived neighbourhoods are over represented in the police statistics, whereas the diversity of drug users is far more apparent in the general population (Peretti-Watel, Beck et al. 2004).

The Escapad survey has made it possible to confirm a number of these hypotheses. The percentage of young people who claim that the last time they smoked cannabis they were in a public place (street or park, etc.) declines as we move up the social scale of the family environment. Among those who consumed cannabis during the last 30 days, all other factors being equal[33], the OR associated with the social environment taking the "very affluent" category as a reference, was 1.4 for the "under privileged" and "modest" categories, 1.3 for the "average" category and 1.2 for the "affluent" category (all significant at the 0.001 level). When they smoke cannabis, young people from modest backgrounds are consequently easier to spot by people from outside their circle of friends, and by the police and security forces. This result can be explained by the smaller size of the homes inhabited by youngsters from modest backgrounds or by the fact that one of the parents is more likely to be at home due to unemployment.

I.3. Mental health and access to treatment

I.3.1 Drug use and symptoms of anxiety and depression.

[33] In a logistical regression verifying the sex, educational status (pupil, student, apprentice, removed from the educational system), the number of times the individual has had to repeat a school year throughout his/her lifetime, (never, once, twice and more), the social level of the parents (5 classes as per table 1), whether or not the parents are separated, whether or not the youngster has left home and his/her cannabis consumption frequency over the period (once, twice, 3 to 5 times, 6 to 9 times, 10 to 19 times, 20 to 29 times and every day) .

Based on the Kandel scale used in the ESCAPAD questionnaire, we can identify a certain number of indicators for psychological suffering (Kandel, Davies et al. 1986). A score has been calculated for each individual via a calculation of the reported frequency of the anxiety and depression symptoms. The score varies from 0 to 24 and the average for boys is 6.8 compared to 10.1 for girls. Girls tend to report far more problems: among teenagers with a score in excess of 21 (i.e. 1.3%), girls outnumber boys 5 to 1. This result is in line with other observations showing that gender plays a large role in influencing the sensitivity of teenagers to the perception and declaration of these symptoms of anxiety and depression (Le Moigne 1999).

A correlative link appears to exist between drug use and the Kandel score, except for the regular consumption of alcohol for which the average scores do not vary. However, other variables also appear to be related to these problems including parental separation, success at school, and the socio-economic environment, etc. To verify these confounding factors, logistic regression models have been achieved. The measurement of the symptoms of anxiety and depression is the Kandel score variable broken down into quartiles. The following table shows the OR, adjusted for each of the quartiles compared to the first, which includes the 25% of young people featuring the lowest scores where symptoms of anxiety and depression are concerned.

Table 12.2. Logistical models of drug use according to symptoms of anxiety and depression measured using the Kandel score.

	Tobacco (daily)	Alcohol (regular)	Repeatedly drunk	Cannabis (regular)	Cocaine (life)	Heroin (life)
Quartile I	-1-	-1-	-1-	-1-	-1-	-1-
Quartile II	1.1 ns	1.2 *	1.3 **	1.5 ***	1.3 ns	1.1 ns
Quartile III	1.3 ***	1.4 ***	1.6 ***	1.7 ***	1.0 ns	0.7 ns
Quartile IV	1.7 ***	1.7 ***	2.3 ***	2.2 ***	2.3 ***	3.0 ***

***, **, *, ns ; Wald Chi² test significant at the 0.001, 0.01, 0.05 and ns levels.

The variables examined are: sex, the parents' PSC, schooling, school years repeated, the separation or otherwise of parents, whether or not the teenager has moved away from home, how frequently the youngster goes out to bars or spends evenings among friends during the year (never, less than once a month, 1-2 times a month, at least once a week, or almost every day).

N.B.: each quartile includes 25 % of the youngsters, according to their score on the Kandel scale: the first being the lowest scoring 25 %, the second being the next 25 %, etc.

The analysis demonstrates that all of the studied drug use variations are more frequent (ceteris paribus) when symptoms of anxiety and depression are more numerous, even if the difference between the first two categories of young people appears to be insignificant regarding the daily use of tobacco and experimentation with cocaine and heroin.

I.3.2 Access to treatment.

As numerous studies have shown, the probability of submitting an application for medical treatment is unequally distributed among the population. Requests for treatment are more frequent among women and more often motivated by a wish to prevent problems, whereas men generally consult a doctor for the treatment of pain (Aliaga 2002). Other studies suggest that persons from modest economic backgrounds are also less frequent consumers of treatment (XXXREFXXX). The question is to find out whether the factors associated with drug use and the use of drugs themselves have an affect on the individual's likelihood of requesting treatment. The Escapad survey makes it possible to verify that this result continues to be applicable in logistic regressions: the use of psychoactive substances

generally lead to more numerous consultations with a mental health specialist[34]. Indeed, for regular alcohol consumption and repeated alcoholic drunkenness, the OR are insignificant (OR=1.0 and 1.1), but the figures are respectively 1.5 for regular cannabis use and 1.9 for experimentation with ecstasy, cocaine and heroin.

However, an examination of these logistic models also shows that these consultations are less frequent among young people from less affluent social backgrounds. Thus, regardless of the use of the psychoactive substance concerned, compared to the «very affluent" socio-economic group, the OR for the "affluent" and "average" groups is 0.8 and that for the "modest" and "underprivileged" groups is 0.7. In other words, we find inequality in the treatment of mental problems depending on the economic environment.

This finding makes it more complicated to identify vulnerability factors where drug use is concerned. The use of legal or illegal psychoactive substances is more frequent among those from affluent backgrounds. This use is related to psychological suffering (although it is not possible to identify the cause and effect relationship here: the two may be linked for other reasons (family-related, social or other). However, this suffering is better treated among those from the more economically affluent families.

The identification of any possible complications resulting from drug use or a deterioration in mental health which may facilitate drug use is therefore less frequent or carried out later among poorer groups and among young males. This constitutes a key aspect of vulnerability with regard to the harm suffered or the means to overcome such harm, not only the exposure to a problem.

In order to take these social selection or self-exclusion effects into account, the public authorities have developed specific intervention strategies in the drug abuse field, tailored to certain clearly identified groups. As an example, this is the case with young cannabis users, who have been identified as a target group for the "cannabis consultations" set up in 2004/2005. The first assessment of this scheme has shown that those individuals considered to be at a higher risk of developing a cannabis habit (and particularly health-harming use or dependency) take part in this scheme: almost 9 out of 10 users are aged under 25 and boys account for 80% of the outpatients (Obradovic 2006). Those referred by the courts constitute 38% of the outpatients which means that court referrals are the leading reason for people attending the consultations, even if these referrals chiefly concern boys (42% *vs* 19% for girls).

The implementation of this specific scheme has shown that the identification of a target group is not sufficient to offset the selection mechanisms for certain types of client. Consequently, among those participating in the scheme, although boys are chiefly referred by the judicial authorities (42%), in other words forced to take part in the consultations, the girls are more likely to attend voluntarily (41%). The boys, who are more frequently regular or daily users of cannabis, seem less inclined to take part voluntarily. This observation clearly highlights self-exclusion mechanisms of certain groups, who will not enrol for the cannabis consultations even when it is they who are explicitly targeted by this new treatment scheme.

This paradox therefore leads on to a discussion of the objectivity of the methods and tools used to describe vulnerability and the presupposed basic factors for an analysis in terms of vulnerability.

[34] With all things being equal elsewhere within a model verifying sex, schooling, repeated years while at school, social background, the parental couple, whether or not the youngster has moved away from home, the Kandel score and the use of psychoactive products.

I.4. The under-representation of the most vulnerable young people in surveys carried out among the general population.

The surveys carried out among the general population used here present a number of shortcomings which limit the use that could be made of them in order to describe the most fragile groups in society. On the one hand, the coverage rate, (i.e. the proportion of people who are not interview due to the data collection methods used) and the level of refusals to participate in the survey among those questioned, makes it possible to assess the representativeness of the groups questioned, and to acknowledge that part of the population is not represented at all in the findings. Secondly, the level of people choosing not reply to certain questions in the survey makes it possible to assess bias in the measurements while at the same time not supplying detailed information concerning the grounds for these refusals to reply.

Where the data collection method is concerned, the ESCAPAD survey only concerns persons of French nationality attending the "Call-up for Defence Preparation" (CDP) day. Young people of foreign nationality, youngsters who are unable to attend for medical reasons or the most marginal youngsters outside the control of the public authorities are therefore not covered by the survey. A certain portion of teenagers presumed to be at risk are therefore not represented or described in the results. However, these shortcomings concerning coverage and participation are relatively minor with 99% of an age group of French nationality participating in the CDP days according to estimates from the National Service Dept for 2005, while the number of foreigners of the required age was low (approximately 4%) and the participation rate in the survey exceeded 99%.

Among those who failed to reply to certain questions, we should distinguish those who did not answer questions concerning drug use and those who did not answer all of the questions due to their limited reading and writing skills. We can suppose that a number of the most vulnerable young people fell into this category. Indeed, each year approximately 5% of those asked to attend are identified by the ministry of national education during the Call-up for Defence Preparation days as having very low skill levels where reading and writing are concerned. The fact that the survey is anonymous means that they can only be identified indirectly. Nevertheless, the analysis demonstrates that in 2005, 4.2% of the sample group refused to answer two or more of the questions concerning alcoholic drunkenness during the last 12 months, and experimentation with 12 legal or illegal psychoactive substances mentioned in the survey[35]. However, these young people are often outside the school system (11.8% compared to an average of 4.4%). They are far more likely to have repeated a school year than the others (67.8% compared to an average of 50.1%) and they are more often from modest or underprivileged families than the average (55.6 % vs 48.7 %). Although they are not particularly numerous, these non-respondents therefore display all of the signs of maximum social vulnerability.

A more detailed analysis of those who failed to respond to a number of questions concerning leisure (generally attracting higher response rates but located towards the end of the questionnaire) confirms that they are strongly related to socio-demographic indicators but also to the use of psychoactive substances. The non-reply rate to a question concerning the legal use of a product or to the regular use of cannabis is below 1% among the young people who answered all of the leisure-related questions while this figure stood at 20% among youngsters who replied to none of the 22 leisure-related items. However, among these youngsters who failed to reply to the leisure-related questions, the proportion of regular cannabis users is very high (24.8% vs 10.8% on average) and the same applies for other drug users. These young people generally state that they are from modest backgrounds,

[35] i.e.: Cannabis, hallucinogenic mushrooms, poppers, inhaled substances, ecstasy, amphetamines, LSD, crack, cocaine and heroin (Ketamine, subutex and GHB are not included here).

their parents are often separated, with the youngsters often living outside the family home, and their school achievement record is below average.

I.5. Discussion

Surveys carried out among the general population involving young people make it possible to identify a number of economic, family-related and educational factors which are heavily associated with experimentation with (or use of) psychoactive substances including: the economic affluence of the family, the difficulties experienced at school and the makeup of the family, but also mental health. These bivariate and multivariate analyses paint a complex picture: most of the links that we have observed seem to confirm the popular conceptions concerning drug users, with underachievement at school, single parent families, and time spent outside the family home being factors which seem to encourage the use of or experimentation with legal and illegal substances. Among young adults, the explicative factors are very similar: the level of education and participation in higher education instead of entering the world of work seems to reduce the likelihood of consumption whereas unemployment appears more likely to encourage drug use. [Beck *et al.*, 2007, Barometer, drugs chapter].

Notable exceptions nevertheless exist. The analysis also demonstrates that the link between these decisive factors and drug use can sometimes be counterintuitive. As an example, the higher the PSC of the parents, the more frequently drug use and experimentation with more expensive products (ecstasy and cocaine) take place. Additionally, most drug use seems to be heavily linked to the intensity of contact with friends, evening trips to bars, and social habits with friends, etc. This results in a level of social integration which should not be overlooked when interpreting the motives for drug use. (Peretti-Watel, Beck et al. 2007).

The analysis also shows that the young people consuming the drugs often display marked symptoms of anxiety and depression, and are more likely to consult mental health specialists, but that the treatment of psychological problems is more thorough for those from economically affluent backgrounds, which is liable to result in inequalities when it comes to identifying and treating drug users or dealing with the consequences of drugs for the individual.

This particular point means that we should consider the economic and family circumstances as fundamental factors where vulnerability is concerned, as it is clear that economic poverty contributes to underachievement at school and to the reduced consumption and medical care, both of these being factors related to the use of drugs and the accentuation of their probable consequences.

One of the original features of this work is the exploration of the margins of the survey tools used. Although not entirely free from coverage bias, surveys carried out among the general population nevertheless provide an opportunity to identify a certain number of sub-groups are particularly likely to consume drugs, through an examination of their own margins and limits including non-respondents, and those with reading difficulties, etc.

However, none of these indicators in their own right makes it possible to define a uniform social group more likely to consume drugs than the others. Only an appreciation of the complexity of the notion of vulnerability by the definition of a combined set of factors makes it possible to refine the analysis, considering identical groups from a social viewpoint. We may therefore consider that vulnerability is chiefly defined as the result of a cumulative process over time, which begins during the early years of an individual's life and which gradually continues throughout childhood and the teenage years (a time of development, by its very nature presenting higher risks) and finally throughout adult life.

II. Vulnerability among active drug users

The question of vulnerability must be viewed from a different angle among those sections of the population in which the use of psychotropic substances is highly prevalent, than for the population at large. Firstly, we may note to what extent a large proportion of young drug takers find themselves in situations of social and health-related vulnerability. Among this section of the population, who are already drug users, this observation alone is not sufficient to conclude that there is a causal relationship in either direction between social or health-related precariousness and the use of psychotropic substances (Sansfacon, Bachelard et al. 2005). On the other hand, it offers a momentary snapshot of the intricacy of these problems and in principle makes it possible to adapt the range of treatment services in order to be able to put forward a comprehensive medical, social and psychological assistance package.

Another approach involves identifying the most vulnerable groups among these high-level of use sections of the population, in order to be able to better tailor prevention and support activities. Among heavy users of illegal or illegally obtained psychotropic substances observed outside the care establishment, we clearly see that those with less "structured" consumption patterns (regarding the frequency of their drug taking, the combinations of drugs concerned, injection and the misuse of medicines…) are generally those who also appear to be the most vulnerable at a social level.

II.1. Available data

On the whole, the most active users of psychotropic substances seen in France, can be observed in two distinct environments:

- The so called "urban" environment which chiefly refers to the risk reduction programmes and drop-in centres, syringe exchange programmes, "low-threshold methadone", and "open areas" (in the street, squats, etc.). Most of the individuals encountered in this environment are problem users of illegal substances, with extremely precarious living conditions.
- The so called "techno party" environment which refers to the venues for events organized around this musical scene. It includes the so called "alternative" techno scene (free parties, rave parties and techno festivals) but also "techno evenings" held at clubs, discotheques and private parties.

Thus, the two above mentioned approaches are successively applied to two sections of the population among whom the prevalence of drug use is high: firstly young people visiting risk reduction programmes in urban settings. These are active users many of whom are not yet receiving treatment. Secondly, there are young people visiting "techno-party" environments. The vulnerability assessments show varying degrees according to the groups being observed.

Various sources of data are available concerning these environments and the people visiting them:

- For the urban environment, this is derived from the PRELUD survey carried out in early 2006 among low threshold user structures[36] situated in 7 urban areas participating in the TREND network and in two other participating urban areas[37] (N=1017). A total of 252 people under the age of 25 were involved (Cadet-Taïrou, Gandilhon et al. 2007).

[36] The terms "risk reduction structure in an urban environment" or "low threshold structure" are used interchangeably in this article in order to describe the CAARUD (Reception and Risk Reduction Support Centres for Drug Users).
[37] Bordeaux, Lille, Marseille, Metz, Paris, Rennes, Toulouse, in addition to Dijon and Lyon.

- For the "party" environment the data is derived from a survey based on an ethnographically adapted sample, carried out in 2004-2005 at five sites in France[38] (Quanti festif 2004-2005, N=1496). A total of 829 people under the age of 25 were involved (Reynaud-Maurupt 2007 awaiting publication).
- Finally, qualitative data has been collected continuously via the TREND monitoring programme. Intended to quickly identify new emerging trends, this programme is based on a network of seven local monitoring centres employing a common strategy and tools for the collection of information[39] (Cadet-Taïrou, Gandilhon et al. 2007).

In principle, the selected vulnerability criteria concern three main areas:

- Vulnerability vis-à-vis drug use: a high prevalence of drug use, high risk practices, etc..
- Social vulnerability: educational level, income, housing conditions and access to treatment covered by the social welfare system.
- Health-related vulnerability: physical or mental health data. Regarding this particular point, the lack of availability of data severely restricts investigation in this area (with no available data concerning psychological or psychiatric morbidity and very little data concerning somatic morbidity). Questions concerning the perceived health of individuals, whether physically or mentally, appear to offer very little scope to distinguish among them.

In practice, the lack of objective data concerning a number of points, in addition to the low number of participants under the age of 25 in the PRELUD survey restrict the available possibilities. Moreover, among these sections of the population characterised by their high drug use, a number of factors appear to be less distinguishing than they would otherwise be among the general population. As an example, among drug users the practice of injecting drugs or sharing equipment does not appear to be directly related to social vulnerability variables.

II.2. The social vulnerability of drug users under the age of 25 attending risk reduction structures.

II.2.1. General data.

The sample group under the age of 25 used for the PRELUD survey had an average age of 21.6 (1.9 years). The youngest was 15 years old. This group was 66% male, demonstrating a higher female percentage than among older groups (with men representing 87% of the 25 + age group).

Precariousness where housing is concerned.

Looking beyond usage frequency, the drug users attending risk reduction structures in urban environments present high levels of social vulnerability. Among these, 67% live in unstable accommodation (with no possibility of spending the next six months in the same accommodation, or lacking accommodation altogether): 31% are homeless, 15% live in squats, vans or caravans, etc., while the rest are housed in temporary accommodation. While 20% of this group have their own accommodation, only 11% are still living on a regular basis with relatives or relations (15% of the 15-20 year olds). Early departure from the family environment can also be seen by the fact that only 12% still live with one or both parents (18% for the 15-20 year olds), while 23% live alone, 27% live as a couple, and 29% live with friends.

[38] The Bordeaux, Metz, Nice, Rennes and Toulouse population centres and peri-urban areas.
[39] Ethnographic observations, interviews, focus groups and qualitative questionnaires.

A low level of education and vocational integration.
Where educational achievement is concerned, 25 % of them have at least reached baccalaureate level (whether or not they passed the exam)[40]. This figure appears to be well below that noted among the general population of the same age, in which the percentage of students passing their baccalaureate is in excess of 60% (Ministry of National Education, 2007). Among those having passed the baccalaureate, 5% had an educational level equal to or in excess of "baccalaureate + two years higher education" at the time the survey was carried out. Most of them (44%) had a vocational or secondary education diploma, with the others having reached lower secondary school level (29%). Most of the under-25 age group is inactive (45%) or unemployed (20%). However, a higher number than witnessed among the older age groups work on a continuous basis (8%) or intermittently (15%). The others are students or working on unpaid training placements.

No access to benefits.
Slightly less than a third of young people attending risk reduction structures have a source of income from employment or unemployment benefit (32%, with the breakdown being 21% and 11% respectively) demonstrating a level of professional integration which is on average slightly higher than the older age group (25% among those aged 20 +). We should note however that the youngest are virtually shut out of the benefits system, with half of them (47%) receiving no income at all, to which should be added the 3% who mentioned begging or drug dealing as their source of income. Only 9% receive benefits of some form (RMI [income support] 3%, disabled adults' allowance 2%, and child benefit or professional insertion benefit 3%). In this respect, the situation of the under-25s differs radically from that of the older group, approximately 60% of whom live off benefits.

Access to treatment.
The under-25 also appear to be more vulnerable than the older group where access to treatment is concerned. One in five (19%) has no health cover at all (neither health insurance nor state medical aid). Although 77% of them are registered with the social security system, more than half of these (43% of the entire sample) are dependent upon the CMU (free, universal sickness cover). Although effective access to paid services cannot be documented with the available data, it should be noted that young drug users make extensive use of screening services for HIV and HCV (which are available free of charge), with 85% of them having undertaken an HIV screening test and 80% having participated in an HCV test. However, half of them don't know whether or not they have been vaccinated against hepatitis B, and among those who are able to answer this question, only 34% have had at least two injections.
We possess very little health-related data: 26% of injectors have suffered from a cutaneous abscess during the previous month. A third of these same injectors (33%) feel that they are in poor or very poor physical health and 39% in poor or very poor psychological health.

Practices.
Of the under-25 age group, 59% have injected a substance at least once during their life and 50% more than 10 times. The injectors are proportionally less numerous among those living in stable accommodation (52 %, n=84, vs 62 % n= 167, NS). The main substances injected are heroin (47 %), cocaine (24 %), buprenorphine (10 %), amphetamines (5 %) and morphine sulfate (4 %). The average age at the time of the first injection was 17.6 years old, with the minimum age being just 10 years old. One person in five injected for the first time between the ages of 10 and 15. Among the injectors, 80% have injected during the last month. Homelessness or the possession of no declared income does not appear to be a risk factor when injection is concerned, among the sample group examined. The prevalence of

[40] The fact that they had not all reached the minimum age does not affect the results: only 5 users were under 18 and 21% of those over 18 had reached "baccalaureate" level (A-level/High School Diploma)

the use of substances during the month is by definition fairly high in view of the population group being examined (table).

II.2.2. The most vulnerable user groups: a quantitative approach.

The data described above reveals the presence of several different sub-groups within the under-25 age group. Firstly we have relatively well integrated young people, either students or possessing a paid job, and secondly youngsters in situations of extreme precariousness, often homeless, with no source of income and no social cover.

In order to be able to observe any possible variations in practices or situations between the "precarious" and "less precarious" sub-groups, homeless users or those with precarious housing (squats, vans, etc.) are compared below to users with less precarious accommodation (even if this accommodation is not permanent). Secondly, potential traits of membership of high vulnerability groups based on ethnographical data (cf. infra) have been tested, by describing the situation of users possessing these traits.

The homeless.

Table 12.3. Characteristics and practices of homeless drug users during the previous month (homeless, squats, vans), 2006.

	All	Homeless (n=115)	Non-homeless (n=136)	Sig.
No resources	47 %	67 %	30 %	P<0.01
No health cover	19 %	35 %	6 %	P<0.01
Reached secondary school level	26 %	14 %	35 %	P<0.01
Inactive	45 %	64 %	29 %	P<0.01
At least 10 glasses of alcohol consumed daily	20 %	34 %	9 %	P<0.01
Cannabis consumed every day	57 %	66 %	49 %	P<0.01
Heroin	48 %	50 %	46 %	
Cocaine	45 %	50 %	41 %	
BHD	43 %	44 %	42 %	
Just to get high	14 %	29 %	8 %	P<0.01
Methadone	19.5 %	19 %	20 %	
Just to get high	5 %	12 %	2 %	P<0.01
Morphine sulfate	20 %	23 %	16 %	
Just to get high	12 %	14 %	10 %	
Codeine	22 %	26 %	19 %	
Ecstasy	29.5 %	34 %	26 %	
BDZ	21 %	19 %	23 %	
Usual place of consumption:				
In the street	19 %	26 %	13 %	P<0.01
In a squat	18 %	33 %	5 %	P<0.01
HCV + (N=63 / N=76)	13 %	16 %	11 %	
HIV + (N=63 / N=71)	6.0 %	7.9 %	4.2 %	

Source: PRELUD 2006, OFDT

The accumulation of social handicaps can clearly be seen when we examine variables concerning the users' social situations. The homeless users are also those who frequently

possess no resources, no health cover, and whose educational and professional activity levels are the lowest. This group is characterised by high levels of alcohol consumption. The use of other substances during the last month did not appear to be significantly higher than for the rest of the sample attending risk reduction structures (this is partly due to the low number of people concerned) including for opioid substitute treatments (buprenorphine and methadone). However, when users are questioned concerning the intentional use of drugs, it becomes clear that the use of substitute medicines "to get high"[41] is clearly higher among young homeless people than among youngsters in a less precarious situation.

Although the data does not reveal an injection or material-sharing frequency which is significantly different among homeless or non-homeless people, the homeless are more inclined to consume drugs in at-risk situations. It is also possible (non significant difference) that they are more likely to be contaminated by the hepatitis C or HIV viruses.

Vulnerability traits

Two traits have been selected: the fact that the user has declared that he/she consumes high doses of buprenorphine purely with the goal of "getting high", and the fact that he/she consumes morphine sulfate. Although morphine sulfate is sometimes prescribed as part of an opioid substitution treatment despite the lack of a marketing authorisation for this purpose, these prescriptions are generally not issued to users under the age of 25. Consequently, we may consider the very use of morphine sulfate as a "problem use" trait.

The consumption of high doses of buprenorphine during the last month to "get high".

We note a high degree of social precariousness of users under the age of 25 consuming buprenorphine with the sole aim of "getting high" (n=36 only). Of these, 83% lived in unstable or precarious accommodation. Some 42% claim to be homeless, with almost 20% living in a squat (not included among the homeless) and less than 6% living with the family on a regular basis. 2/3 these (69%) have not been to secondary school (secondary level or professional vocational training certificate level) and an equal number are listed as inactive. None are in continuous paid employment. A similar percentage (67%) have no resources. More than a quarter (28%) have no social insurance and 39% rely on the free, universal health insurance system (CMU). Their consumption profile during the previous month varies from that of the group as a whole, chiefly concerning alcohol (36% of them consume at least 10 glasses a day vs 18%) and substances related to the "party" environment (ecstasy: 44% vs 21%).

The use of morphine sulfate

This level of precariousness can also be seen among young people who consumed morphine sulfate during the previous month (n=48): 79% of them live in unstable or precarious accommodation, among whom 40% (of the total number) are homeless, with 17% living in squats, vans or mobile homes. Only 10% of them still live with their families. Four out of five (83%) have not been to secondary school (secondary level or professional vocational training certificate level), 67% are inactive and 10% are unemployed. Some 59% have no resources. A third (31%) have no social cover and 42% are covered by the CMU.

These two groups only partially intersect (11 people) and unlike the previous group among young drug users having consumed morphine sulfate during the previous month we find an excessive consumption of substances (heroin 59 % vs 45 % for those who do not use morphine sulfate, cocaine 63 % vs 40 %, BHD 65 % vs 38 %, and methadone 39 % vs 25 % etc.). This group's consumption of medicines is also fairly specific, including: benzodiazepines 41 % vs 16 % of which flunitrazepam accounts for 14 % vs 2 % of the total number, and Artane 4 % vs 0 %.

[41] The reply stated: "To get high, including handing the effects of "coming down" after a drugs trip or handling the craving". The other proposed replies were: "To stop using heroin or another opioid or to get treatment" and "Both

Curiously, none of these users feel that they are in worse physical or mental condition than other users of the same age.

We should also note that the daily alcohol intake, with at least 10 glasses a day is related to unfavourable socio-economic indicators, without any specific characteristics in the usage profiles being apparent, with the exception of a high use of buprenorphine and ecstasy.

II.2.2. The most vulnerable groups of users: a qualitative approach.

Currently, two social groups combine particularly high levels of vulnerability and frequent at-risk behaviour in France. The increasing levels of at-risk behaviour (whether this concerns the substances consumed or the consumption methods among the most precarious groups of users) appears to be a marked trend over recent years. Intensive and daily consumption of a range of substances, a resurgence of heroin, heightened buprenorphine and morphine sulfate abuse and above all the increasing popularity of injection are all factors increasingly seen among these particular groups. (Cadet-Taïrou, Gandilhon et al. 2007).

Disaffiliated youngsters

Since the year 2002, the TREND monitoring scheme has focused on the higher visibility of an increasingly young and itinerant social group, characterised by generally precarious living conditions, often consuming a combination of drugs in a somewhat chaotic manner, and making use of the emergency services provided by the health and social establishments on an occasional, "as needs" basis (Bello, Toufik et al. 2005). This group of young drug users (who are usually under the age of 25) has been referred to as the "wanderers" by Bello et coll. who provide an in-depth description of this group in a TREND report (Bello, Toufik et al. 2005). Unlike a social group described as "nomadic", comprising young people belonging to a counterculture with a collective and even communal structure, who (despite their relatively precarious living conditions) have a certain amount of control over their travels, their income and their use of psychotropic substances, the "wanderers" are characterised by their enforced marginality. Indeed, whereas the "nomads" tend to wear their marginality as a badge, and see it as a lifestyle choice, most of the younger "wanderers" are cut off from their families and have dropped out of the educational system, finding themselves drawn into a process of "disaffiliation" (Castel 1999) which leads them into a state of social marginality far more quickly as they do not have access to benefits. Their mobility is actually quite limited, being restricted to travelling throughout an urban area, and their wanderings are purely opportunistic, being linked to their day to day needs and the availability of drugs[42].

Other than for "counter-culture" users, the psychotropic substances consumed are first and foremost those associated with the "party" environment: ecstasy and cocaine. However, they are also particularly characterised by the use of natural hallucinogenic substances (Salvia, cactus, mushrooms, Datura), buprenorphine and morphine sulfate, particularly in Paris in circles frequented by punks and travellers. The consumption of multiple drug varieties is the norm, with combined drug taking carried out according to the opportunities presenting themselves and with consumption taking a particularly chaotic form among the most disaffiliated groups. We should also mention the frequency of alcohol abuse.

Due to its continued negative image, injection is believed to be quite rare, particularly among the youngest addicts, but for several years now we have noted a progression towards injection has addicts get older. As opioid addiction sets in, alcohol abuse is the main cause of health problems for these young people. The damage to health resulting from a particularly precarious lifestyle is also highly visible (including traumatological skin infections, and violence, etc.).

[42] We find a description of these users and details of their drug use in the 2004 TREND report.

Their cohabitation with other users of risk reduction structures or treatment centres (where they attend these) often results in a climate of conflict (with people travelling around in groups and the presence of dogs, etc.). One of the defining features of the under 25 age group compared to older addicts is a heightened reticence to have any contact with health professionals or risk reduction schemes, and this group will only visit the relevant structures in order to meet their short term needs. Additionally, their wandering lifestyle makes any long-term work in this area impossible.

Finally, as noted at a quantitative level, the age limits applicable to the French social welfare system make it impossible for young people to obtain housing aid, benefits or social cover. Even though this group is largely male, in 2005 we have noted that female drug users were particularly present. We are seeing a feminisation of the disaffiliated subgroup in varying degrees, according to the urban area concerned, particularly among the youngest (18-22 years of age) whose extreme social precariousness can lead to prostitution and to a radical departure from traditionally feminine behaviour including the rapid adoption of high risk behaviour (injection).

New migrants from Eastern Europe.

The other group, which is essentially urban in nature, comprises individuals who also find themselves in a precarious situation, and who chiefly originate from Eastern Europe. Our knowledge of these users is based almost entirely upon ethnographic data, as the language barrier and their fear of being arrested by the police and the justice system prevent them from responding to surveys carried out by questionnaire[43].

Generally living in collective squats, this overwhelmingly male subgroup is varied in nature, and includes several different profiles, based among other things on the country of origin. Although these groups include people of all ages, a certain percentage of them are aged under 25. They have fled either traumatic family circumstances or persecution in the countries of origin, problems with the local police and authorities, or have come here to seek treatment for HIV or HCV, drugs substitution treatments or simply to pursue what they perceive as a better life in Western Europe however, their access to the labour market and to health care is extremely limited due to their illegal immigrant status on French Territory, and many of them suffer extremely poor health conditions due in particular to the harmful effects of drug injection. Once they are officially recognized as suffering from HIV or HCV, this can provide a "passport" to more general healthcare, but their treatment can be chaotic in view of their living conditions.

The consumption patterns reported for several years now are marked first and foremost by the ingestion of massive quantities of alcohol which, quite apart from the levels of violence which this generates, also makes the socialisation of these users very difficult. The use of other substances is restricted to their low levels of income and in France this chiefly concerns medicines: opioids, particularly morphine sulfate and buprenorphine (supplementing or following on from a heroin habit which often began back in their country of origin), and benzodiazepines, (particularly Valium®). Others also continue an amphetamine habit acquired back in their country of origin. As consumers of multiple substances, many have totally lost control of their drug consumption.

These products are chiefly consumed by injection. They are obtained either on the black market or by a prescription for the few that have access to the free CMU scheme, which also further boosts drug trafficking. Indeed, trafficking can often constitute a means of survival.

[43] This data is derived from the reports of the various TREND network sites having worked in 2005 on the theme of new migrants and drug use based on the network's continuous data collection tools including: ethnographic observations, interviews, focus groups and qualitative surveys. This involved the offices in Marseille, Paris and Rennes. This data will be summarised and published in late 2007.

The language barrier and the violence involved in their dealings make their socialisation a major problem, especially vis-à-vis other drug users. Added to their high levels of social precariousness, these factors make this a subgroup with very distinctive needs, and one which is particularly difficult to treat. Consequently, the increasing presence of these two user groups in front line schemes and treatment programmes raises the question of adaptation vis-à-vis a target group which is increasingly numerous, young, diverse, and for which the key challenge is one of resocialisation.

II.3.3. A diverse range of risks and practices in the "techno-party" environment.

A quantitative survey carried out in the "techno-party" environment in 2004 and 2005 based on an ethnographically structured sampling process made it possible to estimate not only the usage levels of psychotropic substances in the techno-party environment, but also the frequency of certain high risk practices (Reynaud-Maurupt 2007 awaiting publication). The quantitative phase of the study was preceded by an ethnographic research phase which made it possible to identify four distinct "affinity groups" (give or take occasional local variations) for all sites. Among the users surveyed, 829 were aged between 16 and 24.

One can observe that the four "affinity groups" present on the techno scene and identified during the ethnographic phase, are distinguished by distinct socio-demographic profiles, but also by differing levels of consumption (Table). Consequently, we find a sort of gradual progression when we consider the social situation and the practices of the users according to the group with which they associate by preference:

- The "Alternative" group (rave and free parties). Part of this group comprises counterculture enthusiasts.
- These are distinguished first and foremost by their fondness for music. Better integrated at a social level, this group includes a higher percentage of students.
- The "Clubbing" group (i.e. clubs playing electronic music). This group is chiefly comprised of hedonists, who devote a substantial budget to going out and to buying clothes. The "gay friendly" establishments investigated during the survey belong to this particular affinity group;
- or the "Select" group (invitation-only/sponsored entry clubs or bars requiring "smart dress")[44]. This is a sector of society with a living standard which is higher than found among the other groups, whose members cultivate an atmosphere of selectivity (Reynaud-Maurupt 2007 awaiting publication,).

Adepts of the "alternative" scene, who are generally younger, consume drugs at a higher frequency. They have a greater tendency to snort or even inject drugs. We should also add (data not provided) that they place the risk threshold related to the use of drugs at a higher level than for the other groups. At the same time, the educational level, income and levels of independence are often lower than for the other groups. However, although we observe high usage frequencies among young people moving in "alternative" circles, their level of social precariousness appears to be quantitatively limited.

For several years now, the ethnographic data collected as part of the trend programme has shown a slide into uncontrolled drug use for certain vulnerable users of drugs in a party environment.

[44] A description of these various groups is available in Reynaud-Maurupt, C. (2007 awaiting publication,). Les pratiques et les opinions liées aux usages des substances psychoactives dans l'espace festif "Musique Electronique". Etude de faisabilité d'une enquête "en population cachée" à partir d'un plan de sondage ethnographiquement raisonné, OFDT. (*Practices and opinions related to the use of psychoactive substances in "electro-music" festive environments. Feasibility study for a survey of a "hidden population group" based on an ethnographically structured survey plan*)

Table 12.4. Demographic and practical characteristics of the four "affinity groups" identified within the electro-party environment, 2004-2005.

	Alternative N = 337 %	Urban N = 228 %	Clubbing N = 184 %	Select N = 80 %
Socio-demographic data				
Males	65.6	64.5	51.1	52.5
Average age	21.0	21.3	21.2	22.1
Higher education after the baccalaureate	31.5	61.4	54.3	80.0
Accommodation: living with parents	37.1	35.3	38.8	39.5
Accommodation: living with friends, living precariously, or living in a institution	9.2	5.7	4.9	2.5
Paid work during the last 6 months (continuous, intermittent, paid training placement or casual employment)	71.5	71.5	72.8	65.1
Of which continuous paid employment	30.9	28.5	40.8	33.8
Student during the last six months	38.0	46.5	29.9	46.3
Unemployed	9.5	3.9	7.1	1.3
CMU (free health insurance scheme)	16.0	3.8	3.8	3.5
No social cover	1.5	1.3	0.0	0.0
Reasons for going out in the evening To take drugs (important / very important)	38.5	24.8	14.2	6.4
Used at least once during the month				
Ecstasy	54.3	26.3	20.7	7.5
Non-base cocaine	42.7	24.1	17.9	17.5
Crack or free base	12.2	4.4	1.6	0.0
Amphetamines	30.9	9.6	5.4	1.3
Hallucinogenic mushrooms	23.7	16.2	2.7	1.3
LSD	22.0	7.9	2.7	1.3
Heroin	13.4	2.2	1.1	1.3
Poppers	8.0	7.5	17.9	3.8
Ketamine	5.3	0.9	0.0	0.0
Cannabis (daily)	68.0	48.2	20.1	23.8
More than 10 glasses of alcohol on occasions	17.7	14.9	6.9	9.3
Average age the first time he/she got drunk	14.3	15.1	15.9	15.6
Mixing 3 substances during the same evenings (not counting tobacco) during the last 30 days among friends	69.2	40.8	23.9	18.8
Administration via injection				
Yes, at least once during his/her lifetime	3	1.8	0	1.3
Yes, at least once during the last month	0.3	0.0	0.0	0.0

Source: Quanti-festif 200'-2005, OFDT / GRVS (data from among the under-25s not published)

II.4. Discussion.

Population groups associated with a high prevalence and usage frequency of psychotropic substances are characterised by a level of social vulnerability significantly higher than that found in the general population of the same age. However, these groups are varied in nature and among them we can identify certain groups which are clearly more vulnerable than the others when considered at a socio-economic level, when considered with regard to substance abuse and in general concerning both of these aspects simultaneously. Moreover, it appears that among the most precarious groups, the use of illegal drugs or

illegally obtained medicines is linked to massive alcohol consumption which, for certain users, is actually the most problematic form of consumption.

The contribution made by qualitative data to our understanding of vulnerable groups.
When it comes to prevention, risk reduction, support or treatment, it is very important to be able to identify the vulnerable groups concerned sufficiently accurately, and to be able to determine their needs. To do so, our experience has shown that for these population groups who are already major consumers and who present varying degrees of precariousness, the contribution made by qualitative data is greater than that provided by quantitative data.

The comparison between homeless people (and/or those with precarious accommodation arrangements) and other users of frontline drug support structures shows that differences certainly exist where social precariousness is concerned, but the indicators reveal that when everything is taken into account, few differences exist between these two groups where usage is concerned (considering of the consumption levels of the complete population group with which we are working). We should be focusing on the reasons for using certain substances, and chiefly with opioid substitutes, in order to identify any differences or variations.

As part of this quest for traits, the quantity of data only confirms what the quality of data has already shown. The use of multivariate statistics based on larger samples may make it possible to more clearly identify vulnerable groups, but the indicators generally used lack the level of precision needed to describe fairly complex situations (including culture, relationships with the family, and past history, etc.). Furthermore, part of the vulnerable section of the population in France with regard to their "at risk" practices, and social situations do not speak French, and are often living here illegally. Consequently they are extremely reluctant to take part in any kind of survey. Only a more comprehensive approach, possibly involving a translator, will enable us to get nearer to these people. Qualitative data also makes it possible to build up typologies which are far closer to the reality of the situation, and therefore more useful when it comes to targeting precise population groups and identifying their needs. Conversely, when typologies have been drawn up based on ethnographic data, the quantitative approach makes it possible to identify and describe phenomena with greater certainty, as shown by the results for the "Quanti-festif" survey.

The role played by the social dimension of vulnerability
Without wishing to enter into a debate concerning the causal link between social precariousness and drug use, it appears that social difficulties among the majority of young users observed have not arisen because of drug use, but rather coexist with it. Above all, social vulnerability appears to be a major handicap when it comes to supporting and treating the addict including: a lack of access to health care, social exclusion which limits relationship building to the addict's peer group, and a lack of geographical stability making it impossible to carry treatment and social or psychological monitoring programmes through to a satisfactory conclusion. However trivial this statement may appear, due to its obvious nature, it is clear that the socio-economic aspect must be taken into account when treating problematic drug use.

III. A description of young people under the age of 25 treated in the specialised treatment centres (CSSTs).

The results presented below are taken from the RECAP survey (Recueil commun sur les addictions et les prises en charge/*Joint Report on Drug Addiction and Drug Treatment*) carried out for the very first time at a national level in 2005. The main objective of RECAP is to monitor the number and characteristics of those people treated in France for addiction problems by the Specialist Drug Addiction Treatment Centres (*Centres de soins spécialisés*

pour toxicomanes or CSSTs) and the Alcohol Ambulatory Treatment Centres (*Centres de cure ambulatoire en alcoologie or CCAAs*). A secondary objective for RECAP is to supply information to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as per the European protocol for the recording of treatment applications that all of the European states have agreed to observe [1]. Establishments specializing in alcohol abuse are not currently included within the perimeter of the EMCDDA's activities. The data used here therefore concerns patients under the age of 25, treated by the CSSTs for their problems related to drug use. They may have been dealt with either via the CSSTs standard processing activities or via the "young addicts consultation" organised under the auspices of the CSSTs. However, based on the 2005 RECAP data, it is not possible to distinguish those patients seen as part of a "young addicts consultations" from the rest. The term "CSST" will therefore refer indifferently to both processing methods.

The objective is to present the socio-demographic characteristics and drug usage practices of young patients visiting the CSSTs presenting certain vulnerability criteria, and to highlight their special characteristics. The vulnerable groups defined in advance are the homeless, young people living in institutions, "delinquents" and those with a psychiatric case history. The results of the analysis of all patients dealt with in the CSSTs [2] and those of a separate survey carried out among those welcomed at the "young addicts consultations" [3] make it possible to distinguish three groups of patients in order to describe their drug usage characteristics: those patients whose reason for treatment concerns cannabis consumption, those received for their difficulties with opioids and/or cocaine, and those whose problems are related to the use of other substances. These groups have been created taking full account of the information concerning the product causing the most problems for the user, consumed during the last 30 days, the product having generated a request for treatment and the existence or otherwise of substitution treatments.[45].

In 2005, approximately 15,200 patients aged under 25 received in 95 separate ambulatory CSSTs, 15 residential treatment centres and 2 CSSTs located in penal establishments. This number accounts for 34% of the total numbers of people processed by the above mentioned structures [2]. The response rate for the outpatients, just like the number of structures, is close to 50%.

We will begin by presenting several vulnerability indicators observed among patients under the age of 25 received by the CSSTs. Among these indicators, a number have been chosen in order to create four groups of patients (the "vulnerable groups") who are successively described and compared with "non-vulnerable" young patients, belonging to none of the predefined vulnerable groups.

III.2.1. Vulnerability criteria

The average profile of patients under the age of 25 processed by the CSSTs is that of a young man aged 20.3 years, living in a relatively stable socio-economic environment, living with his parents (65%) in long term accommodation (81%), and who is being referred to the CSST by the courts (40%) or by a family member (15%) as a result of cannabis abuse (63%).

However, these average results should not lead us to ignore the particularly difficult conditions experienced by a number of users, concerning their social, economic and health-related aspects, or the contact with the justice system and/or the security forces. Indeed, we should note that almost a quarter of young people under the age of 25 processed by the CSSTs face financial difficulties, with 17% possessing no resources of their own, and 6% living off benefits. Some 22% of young patients drop out of the educational system early,

[45] A patient treated for his difficulties with cannabis but who also receives a substitution treatment (former heroin addicts for example) will be included in the opioids/cocaine group).

with their educational levels not exceeding the BEPC (secondary school certificate). Precariousness or other accommodation-related difficulties are experienced by 19% of patients, a number of whom live in institutions (5%) or penal establishments (2%), in provisional accommodation (9%) or are simply homeless (2%). When information is available[46], we see that a non-negligible proportion have already been hospitalised in order to receive psychiatric care (15%) or have previously attempted suicide (13%). More than one young person in 10 (12%) has already spent time in prison.

Even though they constitute a minority, a number of young patients live in conditions of extreme vulnerability. It would certainly be a good idea to describe them in greater detail, vis-à-vis both their socio-demographic situation and their drug use, in order to be able to highlight their specific characteristics. Improved knowledge of these groups will make it possible to adapt and improve both preventive and therapeutic strategies in order to be better able to meet their particular needs.

The various vulnerability indicators are sometimes closely related, and often concentrated on the same individuals. This is the case for example concerning those who leave the educational system early, a factor which naturally results in both professional and financial precariousness. The vulnerable groups selected in principle are comprised based on various indicators concerning where they live, the existence of any acts of delinquency and the presence of psychiatric problems. The result is a succession of descriptions of homeless patients, young people living in institutions, those having served time in prison and/or placed in a penal environment, and those patients having a history of psychiatric hospitalization an/or suicide attempts. For each vulnerable group, the situation of the patients concerned is compared with that of those processed by the programmes who have none of the vulnerability characteristics studied here. Occasionally, the four vulnerable groups overlap, and the same person may feature several vulnerability factors. Of all of the patients aged under the age of 25 processed by the CSSTs, 21.4% possess at least one vulnerability characteristic related to the place in which they live (homeless or living in an institution), to acts of delinquency and/or to past psychiatric history. Among the vulnerable patients, the majority feature only a single characteristic (86%) but a non-negligible proportion feature two characteristics (14%) or even three (1.2%).

Table 12.5. Breakdown of young patients received by the CSSTs in 2005 according to their vulnerability criteria

	Number	%
Homeless patients	316	2.4
Patients living in institutions	692	5.2
”Delinquent” patients	1277	11.9
Patients with a history of psychiatric problems	1476	20.2
Patients displaying at least one vulnerability criterion	3256	21.4
Patients displaying no vulnerability criteria	11932	78.6
All patients	15188	100.0

Source: RECAP 2005, OFDT

III.2.2. Homeless youngsters

The group of patients declaring themselves homeless tend to be younger than the “non-vulnerable” patients (with an average age of 21.7 years vs 20.1 years) and to contain a higher proportion of females (26% vs 19%). Chiefly out of work (inactive or unemployed)

[46] The response rate to questions concerning hospitalisation and suicide attemps case history were 46 % and 42 % respectively

(84% vs 25%) and without resources (54% vs 15%), the homeless patients treated by the CSSTs mostly live alone (64.5% vs 12%) or with their partner or friends (18% vs 12%). Their level of education is also lower (Table 12.6). They have often been referred to the CSST by another social/health-related body (41% vs 15%) or at the user's own request (40% vs 21%). Given the high percentage of individuals having already injected drugs among homeless youngsters (42% vs 10%) it should come as no surprise to note that among the homeless, we observe a higher declared prevalence of HCV among the injectors (12.5% vs 2.9%). A third of homeless youngsters have already spent time in prison. Certain young homeless people also have a history of psychiatric problems: 36% have already been hospitalised on psychiatric grounds other than for detoxification, and 29% have already attempted suicide.

Table 12.6. Breakdown of young patients received by the CSSTs in 2005 according to their educational level.

	Homeless		"Non-Vulnerable"	
	Number	%	Number	%
Failed to complete primary education	2	1.0	19	0.2
Level: primary education	18	9.3	187	2.2
Level: School certificate (4 years' secondary education)	59	30.4	1429	16.8
Level: secondary school level vocational certificates	89	45.9	3748	44.1
Level: baccalaureate (A-level/High School Diploma)	22	11.3	2351	27.6
Level: two years' higher education	3	1.5	500	5.9
Level: More than two years' higher education level	1	0.5	269	3.2
Total patients	194	100.0	8503	100.0

Source: RECAP 2005, OFDT

We possess substance-related information for 282 homeless young people. More than half of them were treated by the CSSTs for difficulties with opioids and/or cocaine (55% vs 23%), while a quarter were treated exclusively for cannabis (24% vs 68%) and roughly one user in five was treated for problems with another substance (21% vs 9%).

Homeless users of opioids/cocaine are characterised by more frequent "at risk" behaviour. Injection is the most popular usage method (47% vs 14% among "non-vulnerable" users of opioids/cocaine), followed by snorting (23% vs 58%). Two out of three users of opioids/cocaine consumed these drugs on a daily basis, with the majority being addicted (78%), and two thirds receive substitution treatment.

Young homeless people treated by the CSSTs for their problems related to cannabis use can be distinguished from other "non-vulnerable" cannabis users due to their level of use, which is significantly more pronounced. Cases of addiction are more frequent among the homeless than among "non-vulnerable" patients receiving treatment for cannabis (73 % vs 41 %) and "at risk" practices are relatively less numerous (13 % vs 36 %).

Homeless young people attending a CSST for a consultation for other substances, most frequently mentioned problems with crack (7% vs 0.2% among the "non-vulnerables" attending the CSSTs for the use of other substances) and less often with cannabis[47] (7 % vs 18 %). They generally started their drug use at a younger age (14.9 vs 16.7 years old) and report higher usage levels (73% vs 47% using the substances on a daily basis).

[47] These users are not part of the "cannabis" group as the product which eventually led to them seeking treatment at the CSST was a product other than cannabis

III.3. Young people living in institutions

Young patients living in institutions can be distinguished from other patients possessing none of the four vulnerability characteristics, due to the means by which they had been brought in contact with the various treatments available. They are chiefly referred to the CSSTs by an institution, a social services department or another social/health-related body, and less frequently by the courts or the legal apparatus (Table 12.7). Mostly inactive or unemployed (49% vs 25%) they are usually without resources of their own (32% vs 15%) and more rarely receive benefits (16% vs 34%). A higher proportion of this group dropped out of education at primary school (9 % vs 2 %) or did not get beyond secondary school (42 % vs 19 %). Just as with the homeless, the proportion of individuals having already injected drugs is higher among young people living in institutions (20% vs 10%). However, the variation between this group and the "non-vulnerables" is less pronounced than for the homeless. Among the injectors, HCV infection was declared in 10.5% of cases (vs 2.9%). Where their mental health is concerned, a third have a history of hospitalization on psychiatric grounds and 27% have already attempted suicide.

We possess substance-related information for 650 young people living in institutions (i.e. 94%). Most of them are being treated for cannabis use, but are treated less frequently for this problem than is the case for "non-vulnerable" patients (54% vs 68%). Applications for treatment for problems related to the use of substances other than opioids/cocaine and cannabis are more frequent for youngsters living in institutions (18.5% vs 9%).

Compared to "non-vulnerable" patients who are users of cannabis, young people living in institutions and treated by the CSSTs for their difficulties with cannabis are more likely to declare that they take the drug on a daily basis (63% vs 46%) frequently as a result of addiction (54% vs 41%) or harmful use (28 % vs 23 %). They have also started taking drugs at an earlier age (14.4 vs 15.4 years old).

Young users of opioids/cocaine living in institutions receive substitution treatments more frequently than users of opioids/cocaine who do not belong to vulnerable groups (74% vs 66%). The most common usage method is snorting (42% vs 58%) followed by intravenous use (30% and 14%).

Young people in institutions are characterised by a higher proportion of consultations with the CSSTs for problems related to other hallucinogenic substances (32% vs 5%) and to a lesser extent regarding treatment for the use of cannabis (12% vs 18%), tobacco (3% vs 16%) and MDMA (4% vs 9%). Consumption, which is genuinely regular (daily use for 49% and consumption several times a week for 19%) is categorised as addiction in 42% of cases.

Table 12.7. Breakdown of young patients received by the CSSTs in 2005 according to the source of their referrals.

	Living in institutions		"Non-vulnerable"	
	Number	%	Number	%
The patient himself	159	24,1	2253	21,2
Friends and family	26	3,9	1726	16,2
Local doctor (GP)	16	2,4	523	4,9
CSST or similar	32	4,9	170	1,6
Risk reduction structures	13	2,0	151	1,4
Structures specialising in alcohol abuse	8	1,2	98	0,9
Liaison teams	19	2,9	29	0,3
Other hospital/health establishment	45	6,8	245	2,3
Social services and institutions	183	27,8	333	3,1
Obligation to go through medical care	35	5,3	837	7,9
Treatment order	26	3,9	912	8,6
Courts: case closure with guidance	21	3,2	1384	13,0
Other legal or administrative measures	50	7,6	1577	14,8
School/university	13	2,0	249	2,3
Other	13	2,0	145	1,4
Total patients	659	100,0	10632	100,0

Source: RECAP 2005, OFDT

III.4. Young "delinquents"

The "delinquents" group is comprised of young patients who declared that they have already been imprisoned at least once and/or placed in a penal environment. Compared to the "non-vulnerable" patients seen by the CSSTs, the "delinquents" tend to be older (21.9 years old vs 20.1) and characterised by a smaller percentage of girls (7.0% vs 19%). They have a tendency to contact the CSSTs themselves (28% vs 21%) or following an order to receive treatment (23% vs 8%) and are less often referred to the CSSTs by other parts of the legal apparatus (16% vs 36%). They can be distinguished from the other "non-vulnerable" patients by the fact that this group contains a higher proportion of unemployed and inactive individuals, and a lower proportion of students (please see the table below). A higher percentage of this group has already taken drugs intravenously (21% vs 10%). Compared to the homeless and to youngsters living in institutions, the percentage of younger "delinquents" having a psychiatric case history is somewhat lower: 22% have already been hospitalised and 18.5% have already attempted suicide.

Table 12.8. Breakdown of young patients received by the CSSTs in 2005 according to their professional situation.

	"Delinquents"		"Non-vulnerable"	
	Number	%	Number	%
No continuous paid activity	161	14.7	1946	19.9
Intermittent paid activity	168	15.3	1538	15.8
Unemployed	321	29.3	1402	14.4
Student, pupil, unpaid training placement	82	7.5	3789	38.9
Inactive (other)	363	33.2	1067	10.9
Total patients	1095	100.0	9742	100.0

Source: RECAP 2005, OFDT

The information concerning the products consumed, which is available for 1108 young "delinquents" demonstrates that the main substance for which they are most frequently treated usually falls within the opioids/cocaine group (46% vs 23% for young "non-vulnerable" patients) but that the percentage for cannabis is also reasonably close to this figure (40% vs 68%). The percentage of users experiencing difficulties with other products is higher among the young "delinquents" (15% vs 9%).

The younger "delinquents" experiencing difficulties with opioids/cocaine display usage patterns similar to those of young "non-vulnerable" patients treated for opioid/cocaine use. Generally daily users (71%), they suffer from addiction (81%) and their preferred consumption method is snorting (54%) or smoking/inhaling (22%).

When receiving treatment from the CSSTs for their cannabis problems, the consumption levels are found to be higher among the "delinquents" than among the "non-vulnerable" category: the daily use of cannabis is more frequent (65% vs 46%) and cases of addiction (53% vs 41%) more numerous in comparison with other "non-vulnerable" patients treated for cannabis.

The young "delinquents" seen by the CSSTs for problems related to the use of substances other than cannabis and opioids/cocaine display consumption levels in excess of those of "non-vulnerable" young users of other products: 55% (vs 45%) are addicts and 59% are daily users (vs 47%).

III.5. Young people with a history of psychiatric problems

Among the young people under the age of 25 received by the CSSTs, 1476 people (i.e. 20%) had a history of psychiatric problems. Among these, 44% have already been hospitalised on psychiatric grounds, for reasons other than detoxification, while 31% have already attempted suicide, and 25% mention both. The patients with a psychiatric case history are on average slightly older (21.1 years old vs 20.1) and include a significantly higher proportion of women (35% vs 19%) than those young patients displaying none of the predefined vulnerability characteristics. These young people are more likely to live alone (23% vs 12%), without their parents (50% vs 28%). They also more frequently mentioned that they were living in provisional accommodation (15% vs 9%), with 4.5% of them being homeless and 10% living in institutions. This group is characterised by the high proportion of people receiving disabled adults' allowance or income support (Table 12.9). Compared to the "non-vulnerable" group of patients, visitors to the CSSTs with a psychiatric case history are more likely to have been referred to the CSST by professionals in the social/health-related fields (34% vs 15%) or came along of their own accord (32% vs 21%) and are less likely to have been referred there by the courts (14% vs 44%). Among the young people displaying a history of psychiatric problems, 16% have already been imprisoned. More than one in four

patients with a history of psychiatric problems has experimented with injection (27% vs 10%) and the declared prevalence of HCV among those stating that they have used injection is higher (8.4% vs 2.9%).

Patients displaying psychiatric vulnerabilities compared to other "non-vulnerable" patients are more often treated by the CSSTs for difficulties involving opioids/cocaine (46% vs 23%) and other substances (15% vs 9%) than for problems related to cannabis (38% vs 68%).

Table 12.9. Breakdown of young patients received by the CSSTs in 2005.

	Those with a history of psychiatric problems		"Non-vulnerable"	
	Number	%	Number	%
Income from employment	299	22.9	3171	35.5
ASSEDIC (unemployment benefit)	119	9.1	729	8.2
RMI (income support)	34	2.6	72	0.8
AAH (disabled adults' allowance)	65	5.0	74	0.8
Other social welfare benefits	66	5.1	321	3.6
Income from a third party/parties	415	31.8	3260	36.5
Other resources (including without income)	306	23.5	1308	14.6
Total patients	1304	100.0	8935	100.0

Source: RECAP 2005, OFDT

Patients treated for their problems with opioids/cocaine differ from "non-vulnerable" users of opioids/cocaine due to a higher prevalence of "at risk" behaviour: intravenous consumption is more frequently used by patients with a history of psychiatric problems (24% vs 14%) to the detriment of snorting (44% vs 58%). More than half of opioid/cocaine users with a history of psychiatric difficulties has already experimented with injection (47% vs 28%) even if the percentage of patients receiving substitute treatments is no different (69% compared to 66% among the "non-vulnerable" opioid/cocaine users), the prevalence of methadone as part of the substitution treatments is higher among patients with a psychiatric case history (43% vs 34%) The opposite applies when we consider BHD (55% vs 63%).

Young people with a psychiatric case history treated for cannabis use began using the drug at a younger age than other young cannabis users (14.8 years old vs 15.5). They are more frequent consumers (69% vs 46% of daily users) and have a greater tendency to be addicts (62% vs 41%).

The significant prevalence of alcohol regarding the treatment for young people with a history of psychiatric problems is higher (41% vs 31%) and the percentage accounted for by tobacco and other hallucinogenic substances is lower (6% vs 16% and 1% vs 6%). Young people with a history of psychiatric problems also begin consumption at an earlier age (15.8 years old vs 16.7 years).

III.6. Discussion.

The homeless stand out from the other vulnerable groups as a result of their more pronounced socio-economic and health problems. This is the group most affected by unemployment/inactivity, most often lacking resources, living alone and receiving no help or support from those they know. The use of intravenous consumption and the declared prevalence of HCV among homeless "injectors" are also higher. They are more likely to be

concerned by problems of past psychiatric history than young people living in institutions or young "delinquents".

Those living in institutions tend to be younger than the patients belonging to the other vulnerable groups, and their situation is slightly better than that of the homeless. Most of this group received treatment for their difficulties with cannabis, and report high usage levels which are nevertheless lower than those of the home is patient's treated for cannabis abuse. Opioid/cocaine users living in institutions practice "at risk" behaviour somewhat less frequently than the homeless, and are more likely to by receiving substitution treatment.

The subgroup comprising "delinquent" young people tends to be older and to contain a higher percentage of males. This group can be distinguished from the other vulnerable groups by the fact that these individuals often seek treatment after being ordered to do so. The health indicators are less worrying for the "delinquents" than for patients belonging to the other vulnerable groups: fewer of them have a case history of psychiatric problems, their level of experimentation with intravenous drug taking is lower, as is the declared prevalence of HCV. The "delinquents" are received by the CSSTs for their difficulties with opioids/cocaine or cannabis in fairly similar proportions.

Of all the vulnerable groups, the subgroup comprising users with a case history of psychiatric problems is the subgroup containing the highest proportion of females. These individuals received by the CSST usually receive support from their inner circle (family and friends) in addition to welfare benefits. They are treated by the CSSTs for high drug usage levels and high risk consumption practices. After the homeless patients, this is the group displaying the highest prevalence of opioid/cocaine use, intravenous drug taking and HCV.

Regardless of the vulnerability factor concerned, vulnerable patients possess a number of common socio-economic and health-related characteristics when compared to "non-vulnerable" patients, including lower educational levels, a precarious or non-existent professional situation, scarce resources, a higher prevalence of "at risk" behaviour and a higher prevalence of HCV. On the other hand, they can be distinguished by the differing means and circumstances via which they seek or are referred to treatment.

Regardless of the vulnerable group involved, the percentage of patients treated for opioids/cocaine and other substances is higher and the proportion of cases concerning cannabis lower when compared to "non-vulnerable" patients. Vulnerable users of opioids/cocaine begin drug taking earlier in life and engage in high risk activity more frequently when compared to "non-vulnerable" patients. Those treated for cannabis abuse have higher levels of consumption and more serious usage diagnoses than "non-vulnerable" cannabis users.

The result of this analysis suggests that links exist between socio-economic vulnerability and drug usage practices. When we consider all patients under the age of 25 welcomed by the CSSTs, we also note that the weight of all vulnerability factors is higher among users of opioids/cocaine and other substances than among the young people treated for cannabis use. Additional studies need to be carried out in order to further examine the link between socio-economic vulnerability and drug use, and to focus in particular on the causal relationship between the two.

IV. General conclusion

Over and above the discussion focusing on the concept and its practical implementation, it is the very relevance of this notion of vulnerability as an analytical reference which may be questioned. Thanks to the contribution made by sociology in the field of inequality and social marginalisation, we are today aware that the most vulnerable individuals and social groups are also the least visible, as the present work generally demonstrates. Any examination of the issue based on the identification of vulnerabilities must by definition be incomplete given

that the most vulnerable and marginal population groups are not taken into account, either in public policies or in the statistical data collection systems describing them (Beaud, Confavreux et al. 2006). Consequently, it is difficult to measure the effectiveness of these targeting strategies as the addicts least likely to reply to a questionnaire are often those targeted by the specific aid packages.

This work should not lead us to believe that the socio-demographic factors identified in the description of drug-using sub-groups can replace an explanation of usage behaviour patterns, which should be accounted for via exogenous sociological psychological theories that are not deployed here. What are the reasons which lead a person to consume cannabis or other drugs in an abusive manner? This is a key point, due to the intrinsic political dimension associated with this type of epidemiological analysis. Whether directly or otherwise, the main activities presented here involve "classifying" the individuals and sub-groups involved, and ranking them vis-à-vis a predetermined problem according to the information requirements of the public authorities, or to scientific interests. The strategy for identifying risk factors concerning illnesses or health-impairing individual behaviour is certainly a public health issue, but theoretically it is also likely to "target' all forms of deviant or undesirable behaviour. Finally, an observation of drug use behaviour is based on a public intervention policy which it fuels in return by legitimising it. As such, it contributes to a form of social control and behaviour normalisation.

With this in mind, we should bear in mind the complexity and the intricacy of the links between the individual factors identified as part of this work, and the occasionally contradictory influence that they can have on drug use. This result is supported by other studies which also invite us to consider drug use independently of social vulnerability, which is considered to be synonymous with precariousness in the professional or family environment, etc. Regardless of the operational definition that we choose to use, vulnerability does not appear to be a *sine qua non* condition for drug consumption as a number of studies demonstrate that it is quite possible to be a regular user of drugs such as cocaine or heroin while at the same time being well integrated socially, having stable employment and being part of a stable couple (Fontaine 2006). The social insertion factors may even constitute a factor in encouraging controlled use (including drug use in festive/party environments, at weekends, use by white collar staff and stock market traders, etc.). In other words, it can be said that the usage method may matter more than the substance concerned.

13. Drug related research in Europe - Organisation, news, and perspectives concerning research into drugs and addiction phenomena in France

1. The general organization of drug research in France.

1-1. The place occupied by drug research as part of French public policy in the fight against drugs and drug addiction.

Faced with the rapidly changing situation observed in France during recent years where the use of both legal and illegal drugs are concerned (particularly among teenagers and young adults, but also in a number of specific subgroups, for example those with highly precarious lifestyles and living conditions) the government has noted that the usable research potential in addition to the available knowledge and assessment tools are still insufficiently developed to enable the public authorities to take the right decisions in sufficient time. At the same time, key players operating in the field with responsibility for preventing drug addiction and treating addicts have issued warnings to the political establishment concerning the limited scientific resources available to them (in terms of both expertise and evaluation) needed to face up to the challenges and difficulties involved in their daily work. For this reason, since 1998 the development of a system designed to monitor and research drugs, consumption patterns and addiction phenomena has become a key priority as part of the pluriannual plans drawn up by the French public authorities.

In view of the scale and diversity of the needs expressed by the various players and contributors where drug policy is concerned (government departments, treatment organisations, associations, professionals and civil society) vis-à-vis scientific circles, the decision has been taken to begin by encouraging the development of all aspects of drug research, including the neurosciences and clinical research in the biomedical field, in addition to research in the human and social sciences and in public health with regard to public policy making. From among these various areas, the public authorities have highlighted a number of priority areas in their action plans, including (recently) the critical question of boosting the effectiveness of treatment protocols for addicts or the delicate matter of the relationship between drug consumption, violence and delinquency.

1.2. The key characteristics of the potential for drug research in France.

Since the early 1980s, France has used a central structure to coordinate government action in the drugs field, i.e. the Interministerial Mission for the Fight against Drugs and Drug Addiction (Mission Interministérielle de Lutte contre les Drogues et les Toxicomanies or "MILDT"). Since 1995, this mission has reported to the prime minister. Originally a modest initiative, the mission's scientific organization role has developed over the years, and today constitutes a major activity for the MILDT. The central role given to the MILDT since 1998 in organizing and coordinating research is a result of two characteristics specific to the French situation in the field of drug research.

1.2.1. First characteristic: the complexity of the challenges facing public policy in the drugs field, with regard to the available scientific resources.

Although research into the field of drugs and drug addictions has come a long way in the last 20 years, the knowledge currently available to us still remains insufficient when we consider the diversity of the needs expressed by the key public players and professionals in this field, concerning the implementation and assessment of their activities.

Firstly, the public players require descriptive knowledge: who is consuming what, what sort of changes in consumption patterns are we witnessing, who is producing the drugs and who is selling them? This requirement for descriptive data upstream of statistics measuring the activities of the state's different departments (including statistics on drug seizures or arrests for drug use) led to the establishment of the French Monitoring centre for Drugs and Drug Addiction (OFDT) between 1993 and 1996. The OFDT is linked both institutionally and via its budget to the MILDT. This observatory works on a regular basis with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as part of the REITOX network. Here, the focus is on descriptive knowledge, drawing upon the various statistical and epidemiological disciplines, in addition to socio-anthropological skills.

Secondly, both the public players and the drugs treatment/prevention professionals need to have access to knowledge concerning the mechanisms and underlying logic where behaviour related to drug use, abuse, and addiction is concerned, this has been vital in order to make headway when it comes to identifying and understanding individual, family, social and cultural factors related to drugs consumption, including their biological substrate. This explanation of underlying mechanisms involves carrying out fundamental research, both in the field of the neurosciences and human/social sciences. Here, we begin to enter fields in which direct outside control (in the form of a restrictive research programme dictated from outside by the public authorities) is neither possible nor desirable. On the other hand, an approach aimed at encouraging consensus among the scientific community concerning the areas for research to be explored as a priority is seen as a useful course of action, which the MILDT makes use of via its scientific seminars. As an example, in spring 2006 the MILDT organized a meeting of French and international specialists to discuss the issue of cocaine. This seminar made it possible to identify a number of research areas concerning effective treatments for addiction to cocaine, the use of which is rising in France.

Thirdly, professionals and public players need to be able to draw upon the resources of evaluative research in order to measure the effects and results of the actions and policies introduced (prevention systems based on the provision of information or education, legal tools and regulations, treatment and addict-assistance schemes, risk reduction schemes, etc.). At a central level, this evaluative research involves three separate areas of research: clinical research for the "treatment" aspect, public health research for prevention through the provision of information and education, risk reduction and health indicator definition aspects, and research via an assessment of public policies requiring combined assistance in the fields of sociology, law and the political sciences, criminology (which is not particularly well developed in France) and public economics.

1.2.2. Second characteristic: the varied and fragmentary nature of the various participants engaged in drug research in France.

France has developed no particular targeted scientific strategy in this research field since the 1960s. Consequently, the various parts of the scientific world involved in research into the fields of drugs and the phenomena of drug abuse and addiction are relatively fragmented in nature.

In the field of the neurosciences, the research potential is divided among the laboratories of two public research bodies (the National Institute of Health and Medical Research / Institut National de la Santé et de la Recherche Médicale [INSERM] and the National Centre for Scientific Research / Centre National de la Recherche Scientifique [CNRS]) to which should be added several university laboratories or those linked to the Grandes Ecoles (advanced universities). This fragmentation does not particularly restrict the dynamism of the drug research sector. This is a highly active research environment, closely linked to major trends in international research.

The situation is far less encouraging for the Human and Social Sciences (HSS). The research teams in the field of the HSS are chiefly located either in the universities or at the CNRS (Department of Human and Social Sciences) with a significant number of laboratories and research groups "associated" with the universities, or at the National Institute for Agricultural Research (Institut National de la Recherche Agronomique - the economics and sociology of food consumption), at the Institute of Research for Development – (Institut de Recherche sur le Développement - the geography, economics and sociology of development), at the School for Advanced Studies in the Social Sciences (Ecole des Hautes Etudes en Sciences Sociales) and to an extent at the various associations. This fragmentation of research teams is combined with a wide spread of research issues being pursued. This situation hampers dialogue and discussion, which remain far more sporadic and limited in the HSS then in the area of biomedical research. We should also note that the research teams are less open to international research and the European dimension of research in this area.

Concerning the research potential in public health, the teams concerned are divided among the above mentioned OFDT , the INSERM (epidemiology, biostatistics), the university hospital centres possessing public health departments and/or drug monitoring or toxicant monitoring programmes, the Regional Health Observatories (Observatoires Régionaux de la Santé or "ORS"), the health agencies (the Health Monitoring institute / Institut de Veille Sanitaire and the Institute for Prevention and Health Education / Institut de Prévention et d'Education à la Santé), not forgetting the various associations and their field staff.

Finally, concerning clinical research into the treatment of addiction, the teams operating in this field are divided among the psychiatric departments of the university hospitals, pharmacology departments, centres specializing in the treatment of addicts, which (in France) are usually based outside the hospitals, not forgetting the preclinical and clinical research teams working for medicine manufacturers (in particular concerning nicotine or opioid substitutes).

The current structure of the French system for organising and coordinating drug research.

Faced with an increase in the consumption of tobacco, cannabis and synthetic drugs among teenagers and young adults, in addition to the rapid spread of the aids epidemic among opioid injectors, it appeared unrealistic to totally abandon the vital research effort into these issues, purely at the researchers' initiative. For this reason, the choice was made in France to have this coordination function managed by the MILDT, which is a governmental organisation.

1.3.1. The MILDT's areas of activity in the research field.

The MILDT is particularly keen to stimulate research into drugs and drug addiction in two major and complementary areas.

First area: an active policy aimed at encouraging the development of new knowledge.

This initial objective has resulted in a number of activities being undertaken.

Firstly, the MILDT covers virtually all of the financial requirements related to the activities carried out by the French Observatory for Drugs and Drug Addiction (OFDT) in order to guarantee among other things the long-term future of the observation scheme which includes epidemiological surveys among the general population concerning consumption levels and their changes, in addition to the alert and monitoring system for new trends in the field of drug use (the Trend-Sintes scheme). Each year, this support totals some €3.4 million, making a total of €24.5 million over the period 2000-2007. Additionally, the MILDT also

provides regular financial support to a French network of Drug Addiction Evaluation and Information Centres (Centres d'Evaluation de la Pharmacodépendance or "CEIP") in partnership with the Agence Française du Médicament (the AFSSAPS, the French Health Products Safety Agency). This support totals some €300,000 per year, i.e. approximately €2.1 million for the period 2000-2007. These centres play a drug monitoring and toxicant monitoring role concerning the consumption of psychoactive substances or medicines used illegally, and organises studies into the potential for drug abuse and addiction of these substances.

Next, since 1999, the MILDT has introduced a system aimed at encouraging research, and which involves the launch each year of a multi-themed tender (in the biomedical, public health, human/social and political science fields) in order to encourage work on addictions of all kinds. As part of this scheme, the MILDT works with two other partners: the INSERM and the National Cancer Institute, a recently created research and assessment organisation. Via this tender-based programme, the MILDT and its partners encourage initiatives in the field of fundamental research aimed at understanding action mechanisms as well as application research, whether this concerns the fields of treatment, prevention or the assessment of public policies. Finally, the tender-based system also encourages researchers to work on a number of disciplinary interfaces (neuroscience/clinical disciplines, clinical disciplines/human and social sciences, etc.) in order to promote a comprehensive understanding of the problems of drug consumption and addiction.

In total, over the 1999-2006 period, the tender scheme has made it possible to finance more than 100 research contracts, approximately half or which are today completed. This financial support represents an overall financial package of €6.3 million for the whole period, equal to roughly 800,000 to €1 million per year, with the average aid package per project being roughly €60,000 paid over two years. A scientific committee at the MILDT, comprising top level experts from the various disciplines concerned, carries out a rigorous assessment and selection process for the projects to be financed.

Approximately 20% of the supported research concerns projects in the field of the neurosciences, a further 20% concerns clinical projects and the remaining 60% concerns projects in the areas of the human and social sciences and/or public health. This decision to provide the bulk of the funding to the HSS area is a deliberate strategy. The MILDT and its partners aim to build up and stabilize the research potential in this area, which today still remains somewhat fragile.

Over time, while protecting the open nature of its tender process, the MILDT has nevertheless highlighted a limited number of research priorities in keeping with public action requirements. As an example, these priorities include the question of a sudden cessation of consumption (with no therapeutic treatment involved, which the Anglo-Saxons referred to as "change without treatment"), which raises major questions concerning the methods and limitations applicable to treating addictive behaviour, that of innovation in the prevention and clinical processing field, or that of the recent development of addictions in which no drug is involved, such as addictions to games or to the Internet.

Accompanying these initiatives, since 2001, in collaboration with the French Ministry for Research and the Universities, the MILDT has also financed thesis grants for students studying for a doctorate, who have chosen to focus their doctorate on the field of drugs and addiction research.

In addition to the MILDT, a number of other French public or private institutions are involved in financing drug-related research. Firstly, we find the Ministry for Health, which finances several clinical projects in some years, concerning protocols for the treatment of addicts as part of a national scheme for the financing of research carried out in the French hospitals: the

Clinical Research Hospital Programme (Programme Hospitalier de Recherche Clinique or "PHRC"). The Ministry of Health also finances several field studies into specific groups of drug users. Moreover, two specialised public agencies, the Agence Nationale de Recherche sur le Sida (National Agency for AIDS Research) and the Institut de Veille Sanitaire (National Institute for Public Health Surveillance) regularly support surveys and research projects examining the relationship between intravenous drug consumption and transmissible illnesses (mainly HIV and HCV). Finally, numerous associations and private foundations representing either the professionals concerned, or the users, or the companies related to this area in various ways (distributors of alcoholic drinks, tobacco manufacturers or pharmaceutical firms) finance surveys and research work with varying degrees of regularity.

Second area: the policy of summarising and making available the newly acquired scientific knowledge.

In addition to the actions aimed at encouraging new knowledge creation, the MILDT also works to put this available scientific knowledge at the disposal of the public authorities and key players in the fields, to help them to better focus their activities.

Firstly, the MILDT regularly organises colloquiums intended to present and to make best possible use of the results obtained from the research supported by it as part of its tender programme. The most recent colloquium of this type was held in February 2005 in Paris. The next is scheduled for August 2007. Additionally, the MILDT regularly asks the INSERM to carry out collective assessments at its request, which cannot be described as studies in the strict sense of the word, but are rather critical analyses of available knowledge, carried out by a multidisciplinary scientific team assembled by the INSERM, which is given the task of analysing and summarising the published literature for a given subject over a period of months. Typically, this activity involves assessing knowledge based on research. In view of the conflicting views always inherent to public intervention in the drugs field, this collective assessment provides the French authorities with two distinct benefits: drawing up an objective overview of approved knowledge concerning subjects which usually result in conflicting and contradictory opinions, thereby encouraging the emergence of shared viewpoints, and secondly to allow for the scheduling of the relevant programme of research, highlighting any gaps in our knowledge of a given issue.

Since the year 2000, four collective assessments have been carried out by the INSERM at the MILDT's request. The first, concerning "The benefits and risks of alcohol consumption for health" was completed in July 2001 and its results made public in September 2001. The second concerning "the effects of the consumption of cannabis upon health and behaviour" was completed in September 2001 and its results circulated in November 2001. Two other assessments have also been carried out, one into "The individual risks and social harm associated with alcohol consumption" the results for which were circulated during the second half of 2002, and the other into the question of "Tobacco addiction: origins, solutions, and factors associated with the success and failure of attempts to stop smoking" the conclusions for which were made public in 2003.

The performance of these assessments is not only intended to generate shared viewpoints faced with the uncertainty surrounding certain aspects of the questions examined. Action to circulate the results of these critical summaries based on this work was carried out subsequently, aimed at the public authorities and professionals, as well as at civil society. Consequently, the drafting of drug prevention documents regularly published by the MILDT and aimed at the general public, beginning with the recently updated reference book "Better knowledge means fewer risks" which is now entitled "Drugs and addiction, your information guide", is directly based on the approved data assembled via the four above-mentioned assessments. More generally, the mission works closely with the INSERM in order to ensure the extensive circulation of the conclusions of these assessments, thereby contributing to

ensuring that public and private bodies speak with a single voice on issues which ultimately concern the daily lives of us all. Indeed, nothing is more counterproductive than a "fragmented" public message concerning the question of drug use, as this often results in uncertainty, which is a factor severely hampering key players in the field.

The relationship between "drug research" and "public policymaking" in France.

Where the French situation is concerned, relationships between "research" and "public action" are forged fairly easily in the field of descriptive research and the epidemiological observation of consumption trends. The various players involved in drugs policies (authorities, professionals, experts and associations, etc.) use the data regularly produced by the French Observatory for Drugs and Drug Addiction. Similarly, the clinicians who treat patients suffering from addiction have fully understood the need to regularly keep informed about the latest research results pertaining to their speciality fields. For particularly complex questions, clinical psychologists' associations have also taken the initiative of organizing clinical consensus conferences working with the specialised agency in France which organises this type of event (the National Agency for Health Accreditation and Evaluation / Agence Nationale d'Accréditation et d'Evaluation en Santé or "ANAES"). Two consensus conferences were held in recent years in France, one focusing on strategies for treating alcoholic patients, and the other on therapeutic strategies for opioid addicts.

Additionally, the Ministry of Health supervises the activities of committees of experts aimed at providing a greater understanding of the scientific dimension of those problems to which the authorities need to provide responses in the form of new legislation and regulations. Where the drugs field is concerned, this is particularly the case for the National Commission on Narcotics and Psychotropic Substances (Commission Nationale des Stupéfiants et des Substances Psychotropes), which supplies the French authorities with its justified opinion concerning the appropriateness of classifying certain substances as narcotics, when their usage increases or changes. This is also the case with a new, recently established "addictions" committee which is intended to assist the health authorities to take suitable decisions concerning the treatment of addicts based on available scientific data.

On the other hand, in those areas covered by fundamental research, the relationship between "research breakthroughs" and "public action" are far more problematic. This is due to the fact that the benchmarks for fundamental research are by their very nature very different from the benchmarks used for decision-making and action by the public policy decision makers. Moreover, very few players in the field of drugs policy have a scientific background, enabling them to directly understand the progress made by fundamental research. It was precisely in order to tackle such obstacles that an organisation such is the INSERM developed its collective expertise system, which the MILDT uses in its own particular field.

Another difficulty concerns the fact that in France we are trailing when it comes to assessing implemented public policies, compared to the system generally used in the Anglo-Saxon countries. This is due to several factors: the fact that evaluative research is a fairly young discipline in France, whether this involves assessing policies or assessing drug prevention or rehabilitation schemes, the absence of an "assessment culture" among many key players, and finally the insufficient circulation of assessment methods and tools. This is a major area to be tackled in the years to come, in which the MILDT is heavily committed.

CURRENT TRENDS AND OUTLOOKS IN THE FIELD OF DRUG AND ADDICTION RESEARCH IN FRANCE.

2.1. Neuroscientific research themes in the addiction field

The French teams specializing in the neurosciences are chiefly concentrating their investigations on three main research themes, closely allied with the main topics of international research.

An in-depth understanding of the neurobiological action mechanisms involved in the creation and continuation of drug addiction.

Achieving such an understanding involves analysing interactions taking place at a cellular and molecular level between the various neuronal systems involved, particularly when the user moves from controlled consumption to compulsive consumption. Although each of the systems is currently fairly well known for its overall operation and its potential contribution to triggering and/or maintaining addictive processes (beginning with the key system of dopaminergic neurons), the question of interdependence and reciprocal interaction remains a subject meriting greater attention. With this in mind, the MILDT supports a number of research projects participating in this forward looking approach, including a project focusing on the role of cannabinoidergic and serotoninergic systems in alcohol dependency with the aid of genetically modified murine models (Laurence LANFUMEY –INSERM Unit U. 288 - Paris). Another concerns the interaction between dopaminergic and noradrenergic systems in opioid addiction (François GEORGES – UMR CNRS 5541 – Bordeaux), while a third concerns the interaction between the dopaminergic system and the hypotalamo-hypophyso-adrenal axis (glucocorticoid hormones) in the modulation of the addictive effects of cocaine and other psychostimulants (Pier Vincenzo PIAZZA –INSERM Unit U.588 – Bordeaux).

2.1.2. The exploration of biological factors influencing vulnerability to drug addiction

Not all drug takers become addicts. In other words, not all drugs users fall into a compulsive consumption pattern of a product which they continue to take despite its harmful consequences. Only a minority of them (between 5 and 15% of users according to the drug concerned) actually go on to become addicts. This raises the question of the differential factors which explain this inter-individual variability where vulnerability to addiction is concerned. This area for research is currently being explored by a fairly large number of teams, as it represents a major challenge with the potential to help improve the way we treat addiction through greater awareness of the biological substrate of individual vulnerabilities. The MILDT is supporting work carried out by several research groups currently involved in examining vulnerability factors such as in utero alcoholism, perinatal stress, genetic mutations affecting certain receptors activated by drug consumption, interactions between genes and their environment, or the phenomena of hypersensitivity to glucocorticoids.

2.1.3. Research in the field of neuroimaging.

The differentiation of cerebral reactions between occasional drug takers and drug addicts is one of the key areas of progress achieved in recent neuroimaging work. Focusing on substances as varied as heroin, tobacco or alcohol, the studies carried out have highlighted the fact that addicts react differently from occasional users during the reward pathway whether in terms of their level of neuronal activation or in the number of cerebral structures activated. The MILDT is supporting work carried out by numerous French research teams working on pre-clinical and clinical studies on numerous factors concerning addiction to tobacco, opioids and cannabis-based on neuroimaging techniques. Among these, we should mention the work coordinated by Jean-Luc MARTINOT and Christian TRICHARD (a

combined INSERM – CEA unit at Orsay) on the inhibition of certain cerebral locations among regular tobacco smokers.

2.2. Areas for clinical research into addictions.

The increased dialogue between the various specialities involved in the field of addiction treatment over the last eight years (alcohologists, tobaccologists and specialists in illegal drugs) has created an environment which is favourable for the expansion of clinical research into the treatment of addictive behaviour. By comparing their practices, the clinical psychologists have even been able to identify common and recurrent problems in the performance of treatment such as the question of craving (an irresistible urge to take the substance under the effect of external stimuli and in the absence of any detoxification syndrome) which remains a key factor in preventing addicts from kicking their drugs habit, the regulation of the misuse of drugs (subutex injections, a return to normal smoking habits despite wearing a nicotine patch, or simply a move from one form of drug addiction to another, etc.) not forgetting the question of how related psychiatric problems should be dealt with. Concerning the various aspects of the treatments, current clinical research in addictology is essentially being focused on four main areas

2.2.1. The explanation of cognitive, emotional and affective processes involved in the reinforcement of addictive behaviour by the addict.

This first area for research is handled by clinical psychologists and psychiatrists involved in treating addicts. The challenge of the work undertaken is to highlight the affects, emotions and cognitive processes experienced and employed by patients in maintaining their addictive behaviour, and which constitute obstacles to helping them to distance themselves from the drug and to regain their freedom of choice. The MILDT supports several clinical research teams participating in this work, dealing with themes as diverse as emotional regulation and the quest for sensations among tobacco addicts or alcoholics (Solange CARTON – University of Paris 5), the cognitive dissonance upstream of addicted tobacco smokers (Patrick GOSLIN – CNRS – University of Paris 10 - Nanterre), the capacity to deal with the stress of abstinence among alcoholic patients or the specific impact of psychophysiological reactivity among opioid addicts (Marc AURIACOMBE – University of Bordeaux 2).

The analysis of psychiatric comorbidity.

The MILDT supports a number of research contracts in topical themes such as the relationship between schizophrenia and cannabis consumption or the analysis of the interactivity between psychopathological problems and specific personality traits before addiction sets in (involving samples of non-clinical population groups).

The analysis of the neuropsychological and somatic consequences of addictive behaviour and the side effects of treatment.

In this field too, the MILDT makes a point of participating in this key aspect of clinical research by supporting research groups working on themes as diverse as the measurement of neuropsychological changes brought about by alcohol addiction (Michel REYNAUD –Paul Brousse Hospital – Villejuif), the biophysiological mechanisms involved in myocardial dysfunctions caused by cocaine consumption (Christelle MONTEIL –INSERM Unit U.644 – Rouen) or the mechanisms involved in the respiratory problems which may be provoked by the combination of a Subutex treatment with the concomitant prescription of benzodiazepines (Frédéric BAUD –Fernand Widal Hospital– Paris).

2.2.4. The construction and assessment of clinical protocols for "new" addictions

Over the last 10 years, French clinical psychologists have had to deal with a rapid increase in requests for treatment for relatively new forms of addiction such as the intensive consumption of cannabis or the addictive and sometimes exclusive use of cocaine and/or crack. What has made it all the more difficult for the clinical psychologists to treat these new types of patient is that there are currently no effective benchmark treatments, whether for cocaine addiction or for cannabis addiction. For this reason, the MILDT has taken the initiative of supporting two major research operations. The first is a European multicentre clinical research protocol entitled the INCANT Study: INternational CAnnabis Need of Treatment, the purpose of which is to assess a multidimensional family therapy protocol (the MDFT method) for intensive younger users of cannabis. The INCANT study seeks to test the transposability of the MDFT method, developed by clinical psychologists in Miami, in European treatment environments, in addition to assessing its effectiveness compared to usual therapeutic approaches. Five countries are participating in this forward looking study which is to be extended until 2009: France, Holland, Belgium, Germany and Switzerland. The MILDT provides financial support for the two French teams participating in this European multicentre trial, namely the team run by Olivier PHAN (Institut Mutualiste Montsouris – INSERM Unit 669 – Paris) and that of Jean-Pierre COUTERON (CEDAT – Mantes la Jolie). In total, this financial support from the MILDT represents a budget of €890,000 for the period 2005-2009. The total budget for the INCANT totals almost €4.5 million for the five countries concerned over the same period. The second clinical research protocol supported by the MILDT is the first part of a study concerning the treatment of cocaine addicts. This involves testing the contribution made by a modafinil treatment in order to improve the detoxification of patients hospitalised for cocaine addictions. This clinical trial is based both on recent hypotheses derived from neuroscientific research into the role of the dopamine transporter (DAT) in the triggering and deepening of cocaine addiction, and on high resolution medical imaging techniques. This ongoing project is managed by Michel REYNAUD and Laurent KARILA from the Paul Brousse Hospital in Villejuif.

2-3. Areas for research in the human or social sciences and in the field of public health.

2.3.1. An analysis of professional practices concerning their interaction with the attitudes and characteristics of patients.

This initial research contract is managed by the teams working in the fields of quantitative sociology, professional sociology and medical anthropology. We have long known that the effectiveness of treatments is not only dependent upon the pharmacological characteristics of the medicines prescribed and/or the treatment techniques used by the treatment provider (psychotherapeutic or behaviour therapy). The context and the quality of the relationship established in the treatment environment also play a decisive role, particularly regarding the patient's observance of his own treatment. A wide variety of factors are involved in building up this relationship, including the culture and professional practices of the treatment providers, the patient's history, the imaginary and symbolic aspects which the latter attaches to aspects of his treatment (particularly his relationship to the medicine), his beliefs, values and views, not forgetting the social or family-related characteristics which have helped shape his identity and which influence his relationship with the medical institution. The MILDT supports a number of research projects in this area. Two research contracts, which have today been completed, have focused on the question of prescription practices for psychotropic medicines in relation to the characteristics of the doctors and of the people receiving treatment, including their symbolic relationship with the medicine concerned (Philippe LE MOIGNE – Cesames INSERM Unit U.611 – Paris ; Anne LOVELL – Diasporas – University of Toulouse Le Mirail). Another research project deals with the issue of factors

concerning the heterogeneousness of general practitioners' medical practices in the field of opioid substitution treatments (Isabelle FERONI – INSERM Unit U.379 - Marseille). Another also focuses on general practice, in order to be able to describe the various practices used by general practitioners concerning the detection and treatment of tobacco addiction among their patients (Valérie SCHWOEBEL – GRES Médiation Santé – Toulouse).

2.3.2. The relationship between drug consumption, acts of violence and delinquency.

French researchers are only now beginning to explore this area for research. The MILDT contributes to financing an epidemiological survey into violence against women in New Caledonia (the ENVEF survey), which includes a subsection dealing with the relationship between this violence and the consumption of alcohol or illegal drugs by the aggressor, but also by the victim. (Marcel GOLDBERG –INSERM Unit U.88 – Saint Maurice). Two research contracts focus on legal issues and the penal treatment of violence and road accidents related to recurrent drunk driving (Claudine PEREZ – DIAZ, Cesames INSERM Unit U. 611 – Paris ; Jean-François LAE, Source – University of Paris 8).

2.3.3. The analysis and evaluation of public policies in the field of drugs.

From the outset, via its tendering programme, the MILDT has been keen to encourage research into (and the assessment of) changes in sensitive public policies over the last 15 years. It has assembled teams of legal experts, legal sociologists, and specialists in political science. Currently, several research projects are being supported, focusing on various themes such as the issue of relationships and dialogue between the associations and the public authorities with regard to drug prevention schemes (Didier TAVERNE – Sciences, Regions and Societies – University of Montpellier), changes in the specialised addict-care sector (Benoit BASTARD – CNRS – Centre for Organisational Sociology – Paris), the economic and commercial challenges of the international classification of drugs (François-Xavier DUDOUET – CNRS ESA 7026 – Nanterre), or a European comparison of public policies aimed at reducing smoking or the excessive consumption of alcohol such as those being carried out in four countries: Sweden, Finland, Germany and France (Arnaud RAYNOUARD – Faculty of Law - Toulouse).

2.4. A number of perspectives.

With the support of the INSERM, the MILDT seeks to initiate research projects which develop operational interfaces between disciplines. Two projects in particular demonstrate the potential offered by such interfaces. The first concerns the phenomenon of cannabis consumption by heroin users involving a substitution treatment using high dosage buprenorphine or methadone. The protocol develops the neuroscience-clinical research interface as it includes a preclinical neurobiology aspect devoted to studying the interactions between cannabinoid and opioid systems on animal models and a clinical aspect which will describe the usage methods of cannabis by a sample of patients undergoing substitution treatment in addition to clinical variables associated with their dependency upon this product. The aim is to be better able to understand the interaction between the two systems generated by the use of cannabis and to assess the clinical impact among patients with a major opioid addiction (Jean-Pierre LEPINE and Jean-Michel SCHERRMANN – Combined laboratory: INSERM U. 705 – CNRS UMR 7157 – Paris). The second project illustrates the potential concerning the interface between clinical disciplines and human and social sciences. It focuses on the possible impact of a clinical consensus conference organized in 1999 by the French Society of Alcohology (Société Française d'Alcoologie) concerning "Methods and recommendations for the detoxification of alcohol addicts" in the professional environment concerned, namely alcohologists operating in specialised centres and general practitioners (Martine BUNGENER – Combined laboratory: INSERM U. 502 – CNRS UMR 8559 – Paris)..

2.5. Articles published by French researchers in international journals.

2.5.1. Published articles in the field of addiction neuroscience

Between 2004 and 2006, four French research groups, the first based in Bordeaux (François Magendie Neuroscience Institute – INSERM Unit U.588 "Behavioural Physiology Laboratory" –Victor Segalen University), the second and third in Paris (Institut Pasteur – CNRS URA 2182 "Receptors and Cognition" unit; Collège de France – INSERM Unit U.114 "Pharmacological neurobiology"), and the last in Marseille (Combined unit: CNRS/University of Provence - "The Neurobiology of cognition) produced five major articles published respectively in the following journals: Science, Nature, Proceeding of the National Academy of Science USA (PNAS) and in Nature Neuroscience.

Deroche-Gamonet; V., Belin, D., Piazza, PV., "Evidence for addiction-like behaviour in the rat", Science. 2004 Aug 13;305(5686):1014-7.

Maskos, U., Molles, BE., Pons, S., Besson, M., Guiard, BP., Guilloux, JP., Evrard, A., Cazala, P., Mameli-Engvall, M.? Dufour, N., Cloëz-Tayarani, I.? Bemelsmans, AP., Mallet, J., Gardier, AM., David, V., Faure, P., Granon, S., Changeux, JP., "Nicotine reinforcement and cognition restored by targeted expression of nicotinic receptors", Nature. 2005 Jul 7; 436(7047):103-7.

Salomon, L., Lanteri, C., Glowinski, j., Tassin, JP., "Behavioral sensitization to amphetamine results from an uncoupling between noradrenergic and serotonergic neurons", Proc Natl Acad Sci USA. 2006 May 9;103(19):7476-81.

Gutkin, BS., Dehaene, S., Changeux, JP., "A neurocomputational hypothesis for nicotine addiction", Proc Natl Acad Sci USA. 2006 Jan 24;103(4):1106-11.

Baunez, C., Dias, C.? Cador, M., Amalric, M., "The subthalamioc nucleus exerts opposite control on cocaine and natural rewards", Nat Neurosci. 2005 Apr;8(4):484-9.

Additionally, over the last 18 months (2006 and the first half of 2007), the French teams working on addiction neurosciences have produced 26 articles in international journals with review committees, such as the Journal of Neuroscience, Neuropsychopharmacology, Neuroscience, the European Journal of Neuroscience, Neuropharmacology, Psychopharmacology , the British Journal of Pharmacology , the Journal of Neurochemistry, Chemical Research in Toxicology, etc. In appendix one you will find a list of these 26 articles in alphabetical order based on the name of the first author.

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

Laumon, B. et al., (2005). Cannabis intoxication and fatal road crashes in France: population based case-control study. British Medical Journal (331) 1371-4.

See also National Report 2006 for more details.

2.5.2. The publication of articles in the clinical research field.

Over the period spanning 2004 to the first half of 2007 (3 ½ years), 19 articles were published by French clinical teams in international journals with review committees and covering various aspects in the treatment of addicts. These articles have been published in internationally renowned journals, including Addiction, the American Journal on Addictology, Critical Care, European Addiction Research, Drug and Alcohol Dependence, European Psychiatry, Psychiatry Research, Substance Abuse Treatment Prevention and Policy, Toxicology Review, Substance Use and Misuse, or Psychopathology, etc..

2.5.3. The publication of articles in the field of the human and social sciences, and public health.

Over the period from 2003 to the first half of 2007, 15 articles were published by French research teams working the field of the human and social sciences and/or public health, in international journals with review committees. These articles chiefly concern four areas: epidemiology, the monitoring of road accident data related to drug consumption, heath economics and health sociology. These articles have been published in a wide range of international journals with an excellent standing, including Addiction, Health Economics, Journal of Health Economics, Addictive Behaviors, Journal of Addictive Disorders, British Medical Journal, Drug and Alcohol Dependence, Substance Use and Misuse, Social Science and Medicine, etc. In appendix three you will find a list of these 12 articles in alphabetical order based on the name of the first author.

The circulation of observational data and research results.

3.1. The circulation of observational data produced by the French Observatory for Drugs and Drug Addiction (Observatoire Français des Drogues et des Toxicomanies).

The OFDT's mission as defined by its constitution is twofold. Firstly, it is intended to meet the need for information expressed in the public field, by field operatives or by private individuals. The second is the production and circulation of information in a number of forms: through the production of articles, by the publication of periodicals (and in particular the fortnightly journal "Tendance"), via the publication and participation in the drafting of various works (with an example being the collective work on cannabis published in July 2007).
The circulation of information produced by the OEDT is also one of the OFDT's responsibilities and can also be considered as something of a focal point.

3.2. The circulation of research results via national scientific journals

In France, there are three scientific journals with review committees specifically dedicated to the issue of drugs and clinical research into addiction.

The most important of these is the journal "Alcoologie et addictologie" which is published on a quarterly basis. It is aimed at clinical psychologists treating various types of addictions (alcohol, tobacco, illegal drugs, and "product-free" addictions, etc.). The articles cover both the somatic and mental aspects of treating addicts. The journal is managed by an editorial committee supported by a scientific committee and a review committee. The publication criteria for the articles are the usual international criteria. The articles are drafted in French but include a resume in English. The authors are mainly French but the journal also regularly includes work from contributors throughout the French speaking world (Quebec, Switzerland, Belgium, and French speaking Africa).

The second journal is the journal "Psychotropes", including the subheading "Revue internationale des toxicomanies et des addictions" (the international journal for drug abuse

and addictions). This was founded by clinical psychologists, psychoanalysts and psychiatrists specializing in the treatment of patients suffering from addiction. This initial mission continues to dominate where the selection of scientific articles is concerned, but the journal is also very open to contributions from other disciplines including epidemiology, anthropology or health sociology. It is published on a quarterly basis and is managed by a scientific committee supported by a review committee. The publication criteria for the articles are the usual international criteria. The journal has a network of French speaking correspondents (Belgium, Senegal, Lebanon) and from Mediterranean Europe (Spain, Portugal, Italy, Greece) giving it an international dimension where the choice of authors is concerned. The articles are drafted in French with a resume in English.

The third review is far more specific as it focuses on the toxicological aspects of drug taking. This is the "Annales de Toxicologie Analytique" which is produced by the French Society of Analytical Toxicology (Société Française de Toxicologie Analytique or SFTA). The articles deal with the question of screening for drugs in various biological environments, and include details of case studies related to fatal intoxications following the consumption of psychoactive substances, also covering certain forms of psychotropic medicine misuse. A certain percentage of the articles deal with toxicological issues outside the drugs field. The journal also contains transcriptions of verbal information and laboratory notes. The articles are mostly drafted in French and include a resume in English. Several articles are published in English. The journal is managed by the SFTA's executive board supported by an editorial committee. The publication criteria for "long" articles are the usual international criteria. The journal is published on a quarterly basis.

Apart from these three journals focusing on the question of drugs, several general scientific journals in France also regularly publish articles dealing with the field of addictions. For researchers in epidemiology and public health, there is the "Revue d'Epidémiologie et de Santé Publique" published by Elsevier, the articles for which are written in French or English (published on a monthly basis). For researchers in the fields of the human and social sciences, the leading French journal is "Sciences sociales et santé" (a quarterly journal published by Libbey Eurotext). For researchers in legal sociology and political science working more specifically on the consequences of drug consumption upon public order, the leading French journal is "Déviance et société" (a quarterly journal published by the CNRS). Finally, researchers in addiction neurosciences should opt for the major international journals in this field. They are also to be found in numerous French scientific journals written more with the layman in mind, as civil society is relatively interested in progress with the neurosciences. In France we find a large number of professional journals covering the field of addictions. These professional journals play a non-negligible role in the circulation of scientific results outside the scientific community, i.e. aimed at various field operatives working in the area of drug addiction, whether these are health professionals, social workers or associations representing drug users.

PART C: BIBLIOGRAPHY AND ANNEXES

14. Bibliography

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15. Annexes.

15.1. Table index.

15.2. Graph index.

15.3. Abbreviations.

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

	(OFDT)
ESPAD	European School survey Project on Alcohol and other Drugs (INSERM- OFDT-MJENR)
ESSAD	Equipe de soins spécialisés à domicile
FFA	Fédération française d'addictologie
FNAILS	Fichier national des infractions à la législation sur les stupéfiants (OCRTIS)
FNES	Fédération nationale des comités d'éducation pour la santé
FRAD	Formateurs relais antidrogues (Gradés de la gendarmerie nationale)
GECA	Groupe d'étude grossesse et addiction
GIP	Groupement d'intérêt public
IC	Intervalle de confiance
ILS	Infraction à la législation sur les stupéfiants
INPES	Institut national de prévention et d'éducation pour la santé (ancien CFES)
INRETS	Institut national de recherche sur les transports et leur sécurité
INSERM	Institut national de la santé et de la recherche médicale
INVS	Institut national de veille sanitaire
IST	Infections sexuellement transmissibles
IT	Injonction thérapeutique
IVG	Interruption volontaire de grossesse
JAP	Juge d'application des peines
JAPD	Journée d'appel de préparation à la défense
JO	Journal officiel
LOLF	Loi organique relative aux lois de finances
M€	Million(s) d'euros
MILAD	Mission interministérielle de lutte antidrogue (ministère de l'Intérieur)
MILC	Mission interministérielle de lutte contre le cancer
MILDT	Mission interministérielle de lutte contre la drogue et la toxicomanie
MST	Maladies sexuellement transmissibles
OCRTIS	Office central pour la répression du trafic de stupéfiants
OEDT	Observatoire européen des drogues et des toxicomanies
OFDT	Observatoire français des drogues et des toxicomanies
OMS	Organisation mondiale de la santé
OPPIDUM	Observation des produits détournés de leur utilisation médicamenteuse (CEIP)
OR	Odd ratio (risque relatif ; rapport de cote)
PA	personne année
PAEJ	Points d'accueil et d'écoute jeunes
PES	Programme d'échange de seringues
PFAD	Policier formateur antidrogue
PRAPS	Programmes régionaux d'accès à la prévention et aux soins
PRS	Programmes régionaux de santé
PRSP	Programmes régionaux de santé publique
RDR	Réduction des risques (politique de)
RECAP	Recueil commun sur les addictions et les prises en charge (OFDT)
RMI	Revenu minimum d'insertion
RSM	Ratio standardisé de mortalité
SAM	Enquête "stupéfiants et accidents mortel de la circulation routière" (DGS/OFDT/INRETS)
SFA	Société française d'alcoologie
SIAMOIS	Système d'information sur l'accessibilité au matériel d'injection et de produits de substitution (InVs)
SINTES	Système d'identification national des toxiques et des substances (OFDT)
SMPR	Services médico-psychologiques régionaux hospitaliers
SPIP	Service pénitentiaire d'insertion et de probation
TDI	Indicateur de demande de traitement [Treatment demand indicator]
THC	Tétrahydrocannabinol
TREND	Tendances récentes et nouvelles drogues (OFDT)
UCSA	Unité de consultations et de soins ambulatoires
UDC	Unité de coordination maternité et situations à risques
UDVI	usage(ers) de drogues par voie intraveineuse (ou injectable)
UPS	Unité de soins pour sortants
VHB	Virus de l'hépatite B