ANNUAL REPORT ON THE STATE OF THE DRUGS PROBLEM IN THE EUROPEAN UNION

France

MARCH 1997

INTRODUCTION 4

PART I : NATIONAL POLICIES: LEGAL & ORGANISATIONAL FRAMEWORK 5

CHAPTER 1.OVERVIEW OF DRUG POLICY 5
CHAPTER 2.SUMMARY OF RELEVANT LEGISLATION AND PENALTIES 6
CHAPTER 3.KEY ADMINISTRATIVE AND ORGANISATIONAL ACTORS 6
3.1_Key actors, their roles and relationships between them 6
3.2_Budgets and funding arrangements 8
3.3_International cooperation 8
CHAPTER 4.NEW DEVELOPMENTS IN THE REPORTING YEAR (1996) 11
4.1_Changes in policy or legislation 11
4.2_Administrative and organisational changes 12
4.3_New information requirements regarding drug policy 12

PART II : DRUG MONITORING SYSTEMS AND SOURCES OF INFORMATION 14

CHAPTER 5.NATIONAL MONITORING AND INFORMATION SYSTEMS 14
The existing system 14
CHAPTER 6.DESCRIPTION OF NATIONAL FOCAL POINT(S) 15
6.1_Organisation and operation 15
6.2_Legal basis, rules and procedures, staffing, financing 15
6.3_Network of partners of the Focal Point 16
6.4_Relationship to national monitoring and information systems 17
6.5_Use of Focal Points within the country 18
CHAPTER 7.TYPES AND SOURCES OF INFORMATION AVAILABLE 18
7.1_Epidemiology 18
7.2_Demand reduction 19
7.3_Documentation centres 20
CHAPTER 8.ARRANGEMENTS FOR REPORTING TO OTHER INTERNATIONAL ORGANISATIONS 21
National report produced by the co-operative group for the fight against drug use and trafficking (Pompidou Group) 23
Epidemiological sub-groups (Pompidou Group) 23
CHAPTER 9.NEW DEVELOPMENTS IN THE REPORTING YEAR (1996) 23
9.1_Changes in national monitoring systems 23
9.2_Changes within the Focal Point 23
9.3_New data gathering priorities 23

PART III EPIDEMIOLOGICAL SITUATION 24

CHAPTER 10.HISTORICAL DEVELOPMENT OF DRUG USE AND ADDICTION (1960S - 1980S) 24
CHAPTER 11.CURRENT SITUATION OF DRUG USE AND DRUG ADDICTION (PREVALENCE, DIFFERENT DRUGS, PATTERNS, CHARACTERISTICS, TRENDS) 24
11.1_DRUG CONSUMPTION IN THE POPULATION (SURVEYS ETC.) 24
A. Drug consumption among adults 24
B. Drug consumption among adolescents 26
11.2_Problematic drug use (estimates, indirect indicators) 28
A. Drug users and drug addicts : estimations of prevalence 28
B. Drug addicts under treatment in health and social institutions 30
11.3_Patterns of use and characteristics of users 31
A. Age 32
B. Gender, nationality, professional integration, and health coverage 33
C. Ethnographic approach to cannabis consumption in France 35
Epidemiological monitoring of patients on methadone 37
11.4_Risk behaviours (e.g. injecting, sharing) 39
A. Administration intraveineuse 39
B. The attitudes and pratices of drug users who are confronted wiyh the risk of being contaminated by aids and hepatitis viruses 40
11.5_Risk and protective factors 43
A. Drug consumption among adolescents 43
B. Getting over drug addiction 43
C. Alcohol, tobacco, and various illicit drugs use among young people 45
11.6_Different drug profile 46
A. Substances taken 46
B. Polydrug consumption and intravenous administration 48
CHAPTER 12.SOCIAL AND CULTURAL ASPECTS 50
12.1_Social processes, cultural context 50

12.2_Attitudes and public opinion *50*
CHAPTER 13.DRUG-RELATED PROBLEMS AND CONSEQUENCES 50
13.1_Mortality *50*
13.2_Morbidity *52*
13.3_Social problems : professionnal activity and social insurance *54*
13.4_Legal problems *55*
A. Arrests for illicit drug use *55*
B. Convictions and incarcerations for drug use *57*
CHAPTER 14.AVAILABILITY AND SUPPLY 59
14.1_Sources of supply and trafficking patterns in the country *59*
A. Drug-related money laundering *59*
B. Arrets, sentencing, and improsonment for supplying and trafficking drugs *61*
14.2_Illicit drug market indicators : drug seizures (number and quantity) *63*
CHAPTER 15.DISCUSSION 64
15.1-15.2_Main trends and new developments in drug use and consequences *64*
15.3-15.4_Methodological limitations and evaluation of data quality *66*
15.5-15.6_ New information needs, gaps, and priorities for future work. *67*

PART IV : DEMAND REDUCTION INTERVENTIONS 68

CHAPTER 16.POLICY DIMENSION 68
CHAPTER 17.THEMATIC DIMENSION - OUTLINE OF DEMAND REDUCTION 69
17.1_First childhood intervention *69*
17.2_School programmes *69*
17.3 _Youth programmes outside schools *71*
17.4_Mass media campaigns *72*
17.5_Telephone help lines *72*
17.6_Community programmes *72*
17.7_Groups experimenting with drugs *73*
17.8_Outreach work *73*
17.9_Low threshold services *73*
17.10_Prevention of HIV infection among drug users *74*
17.11_Substitution programmes/Maintenance programmes *74*
17.12_Detoxification *75*
17.13_Outpatient treatment *75*
17.14_Inpatient treatment *76*
17.15_Self help groups *76*
17.16_General health care *77*
17.17_Harm reduction *78*
17.18_After-care *79*
17.19_Gender-specific issues *79*
17.20_Parenthood and drug use - children of drug users *79*
17.21_Parents of drug users *79*
17.22_Drug use in prisons *79*
17.23_Drug use at the workplace *80*
17.24_Other activities : documentation *81*
CHAPTER 18.EVALUATION, RESEARCH AND TRAINING 81
18.1_Evaluation *81*
18.2_Research *83*
18.3_Training *85*
CHAPTER 19.DEVELOPMENTS AND INFORMATION NEEDS 87

CONCLUSIONS 88

ANNEXES 89

MOBILIZED NETWORK 90
CONTRIBUTIONS TO THIS REPORT 91
Director of Publication *91*
Supervision and Writing *91*
Thanks for their participation *91*
GENERAL BIBLIOGRAPHY 92
ACRONYMS 93

INTRODUCTION

This report, prepared by the National Focal Point, is France's contribution to the European Monitoring Centre for Drugs and Drug Addiction's annual report, according to the work programme established by the European Information Network on Drugs and Drug Addiction (REITOX).

The framework provided by the EMCDDA was respected, but it was necessary to make certain adaptations. Some chapters were thus combined, or titles were adapted, to better fit with national cultural reality. In short, it was not possible to consider developing each chapter in depth, because of both the amount of work required to do so, and the needed means to carry it out. Consequently, some chapters have been developed more than others, and some were not developed at all because the time allotted was insufficient to produce quality work. It seemed preferable to use this solution in order to protect the « spirit » with which this report was developed. It is the fruit of working collectively, and not simply an « expert's » report.

Periodically drawing up a report on the state of the drugs and drug addiction phenomenon in France, is part of the national mission endowed upon the French Observatory which published a report titled « Drugs and Drug Addiction, Indicators and Trends, 1996 edition » in December, 1996. Part 2 of this present report is entirely made up of extracts from this publication which is described in the appendices.

PART I : NATIONAL POLICIES: LEGAL & ORGANISATIONAL FRAMEWORK

Chapter 1.Overview of Drug Policy

The French policy on fighting drugs and drug addiction fits into a legal framework essentially resulting from a law enacted on December 31, 1970. This law had three objectives:

- to establish the principle of prohibiting drug use, while proposing court ordered treatment programmes at the same time
- to severely repress trafficking,
- to ensure free and anonymous treatment for drug addicts who are willing to go through the detoxification process.

1970's law establishes drug addiction as harmful to individuals, and therefore harmful to society in general. It introduces the concept of prohibiting drug use in private, one which had not been previously dealt with in former laws. The law enacted on July 2, 1916, only prohibited drug use in public places.

Public action, which has fit into this framework since the law was enacted, has been designed to eradicate drugs and drug use by finding support in two additional principles: abstinence, and detoxification (for those who have become addicted). It is structured around two main concerns: public security and public health. The public health field has experienced growing importance over time, particularly since the apparition of AIDS in the 1980's.

Since 1970, several important steps may be noted in the field of public action:

1977 A circular letter from the Ministère de la Justice (Ministry of Justice) was sent out. This letter made no distinction between hard or soft drugs, and recommended a differentiated approach depending upon the nature of the substance.

1978 An initial public report on the « drugs and drug addiction » phenomenon (Pelletier Report) recommended directions to be taken. Implementing these directions in the following years enabled the development and consolidation of the specialised prevention and care system.

1982 An interministerial committee was established. This was organised in accordance with regulations under the authority of the Prime Minister.

1983 A law, relative to decentralisation, was enacted on July 22, 1983 making the State responsible for expenses involved in applying 1970's law. In one respect, this enabled the State to actively direct the development and advancement of drug addiction treatment, but also led to the semi-autonomous regions relinquishing this responsibility.

1987 On May 13, 1987, a decree was made authorising the unrestricted sale of syringes. This was the first important text of a new « harm reduction » policy.

1990 The Trautmann Report, a second public report on « drugs and drug addiction », was published. It recommended developing a policy which would balance out supply and demand reduction, and improving treatment for drug addicts.

1993 A triennial governmental plan on fighting drugs and drug addiction was adopted in September, 1993. It contained a series of short and long-term measures in the fields of international action, fighting trafficking, court ordered treatment programmes and improving the treatment and prevention system. Much more than in the past, it committed France to a policy of reducing the harm caused by drug addiction. Substitute treatments, which were nearly non-existant, were developed.

1994 The think tank which was set up by 1993's governmental plan, made public the Henrion Report, which focused on the need of giving greater importance to prevention and breaking the exclusion of drug addicts. Although the committee

was divided on the question of decriminalising drug use, it unanimously supported reforming 1970's law. The majority of these members (9 out of 17) was in favour of decriminalising the possession and use of small amounts of cannabis, with certain regulations.

Current policy is based upon the will to maintain an equilibrium between repression, prevention, treatment and reintegration. From a health standpoint, continuing the harm reduction policy fits in with the concept of globally treating drug addicts. Global treatment simultaneously targets preventing and treating their infectious pathologies, as well as favouring access to treatment. The prescription of substitute treatments (Methadone and Subutex) has strongly grown.

Chapter 2.Summary of Relevant Legislation and Penalties

The legislative framework in the area of drugs and drug addiction essentially results from a law enacted on December 31, 1970.

The fight against alcoholism fits into a different framework. A related decree was made on July 28, 1955 (measures concerning dangerous alcoholics), and a law was enacted on January 10, 1991 (measures concerning advertising for alcohol). The treatment system for alcoholics is completely separate from the drug addiction treatment system (with the occasional exception).

The following may be found in the appendices:

- a chart summarising legal texts related to the repression of drug-related offences
- a list of legal texts related to the health and social treatment of drug addicts.

Chapter 3.Key Administrative and Organisational Actors

The fight against drugs and drug addiction is a State mission in France. The government is in charge of providing general orientations, and the budget needed to carry them out.

Actions undertaken by the public authorities fit into the framework of an interministerial policy which has been defined by a committee composed of the different competent ministries, presided over by the Prime Minister. The current policy was developed from the two latest action plans: the triennial plan (September 21, 1993) completed by the plan established on September 14, 1995.

This policy is designed to maintain complementarity and balance in all the fields of action, prevention, treatment, integration and repression on all levels: local, national and international.

3.1_Key actors, their roles and relationships between them

Actors in the prevention field

Many partners are involved in primary prevention: Ministère des affaires sociales (Direction de l'action sociale)- (Ministry of Social Affaires (Department of Social Action)), Ministère de l'éducation nationale - (Ministry of National Education), Ministère de la défense nationale - (Ministry of Defence), Ministère de l'intérieur - (Ministry of the Interior), non-specialised youth associations from the social sector, specialised structures such as « Fondation Toxicomanies Prévention Jeunesse » - (« Youth Drug Addiction Prevention Foundation »), local communities, professionals (doctors, teachers), volunteers.

These partners participate in several types of actions:

- training professionals and volunteers working in this sector,

- field actions among young people (through sports, culture, leisure activities, humanitary actions, environment)
- informative and preventive actions carried out among young people in schools,
- listening areas for young people and parents,
- actions designed to inform and increase awareness among young people and adults, drawing up and disseminating pedagogical materials

Actors in the treatment field

In France, the treatment system is based upon two principles: it is both free and anonymous.

It functions using funds which are administered by the Direction générale de la santé (DGS) - (General Health Department, at the Ministry of Health).

Health policies are described in chapter 16.

Actors in the integration field

Drop-in centres, open during the day, and structures which provide housing at night, are available for the most deprived drug addicts. They are designed to deal with emergency situations, provide elementary treatment, and to orient individuals towards the health system.

The Ministère des affaires sociales (Direction de l'action sociale) - (Ministry of Social Affaires (Department of Social Action)), contributes towards co-ordinating actions in the integration field.

The specialised sector is quite diversified, taking care of needs ranging from withdrawal to re-integration.

The legal administration develops programmes which are designed to prepare individuals for leaving prison. These programmes take the drug addiction dimension into account.

Actors in the repression field

The main departments responsible for repressing drug trafficking are:

- la mission de lutte anti-drogue MILAD (Ministère de l'intérieur) - (The Mission for the Fight against Drugs (Ministry of the Interior)), co-ordinating organisation between the different active departments of the National Police.
- l'Office Central pour la Répression du Trafic Illicite de Stupéfiants OCRTIS (Ministère de l'intérieur), - (Central Office for the Repression of Drug-Related Offences (Ministry of the Interior)) national department, international and operational involvement, interministerial organisation.
- l'Office Central pour la Répression de la Grande Délinquance Financière (Ministère de l'intérieur) - (Central Office for the Repression of Grand Financial Delinquency (Ministry of the Interior)), operational department which opposes money laundering,
- la Gendarmerie Nationale (Ministère de la Défense) - (National Gendarmerie (Ministry of Defence)), operates in rural and peri-urban areas, as well as on the sea for the Maritime Gendarmerie,
- la Douane (Ministère du Budget) - (Customs Department, Ministry of the Budget)), fights drugs and psychotropic substances from entering and remaining in France.

- le TRACFIN (Ministère du Budget) - (TRACFIN (Ministry of the Budget), department where notifications of suspicion of money laundering-related offences are received and processed.
- La Mission nationale de contrôle des précurseurs chimiques (MNCPC) - (The National Mission for Controlling Chemical Precursors) associates police officers, customs officials and representatives from the Ministère de L'Industrie (Ministry of Industry), for monitoring and implementing regulations on precursor substances.
- Legal authorities ensure both the development of court-ordered treatment programmes through their public prosecutorís departments in relation with the health and social departments, and the repression of drug trafficking and drug-related money laundering through the magistrate's courts and their assizes.

co-ordinating the fight against drugs and drug addiction

The interministerial committee, presided over by the Prime Minister, brings together representatives of the main ministries which are concerned by this problem. La Mission Interministerielle de Lutte contre la Drogue et la Drug addiction (Interministerial Mission for the Fight against Drugs and Drug Addiction) (MILDT) prepares the interministerial committee's resolutions and sees that they are carried out. It also runs and co-ordinates the actions of competent ministries particularly in the areas of observing and preventing drug addiction, receiving, treating and re-integrating drug addicts, training field workers and conducting research. A co-ordination committee, made up of representatives from each of these ministries, meets periodically.

The MILDT, an interministerial organisation, does not take action in the place of State services, but rather works with and for them. Each ministry implements policies which are decided upon by a council of ministers or an interministerial committee. The MILDT has an intervention budget used in order to support government actions. In 1996, this budget was around 230 MF (35 M ecus). It doesn't spend these funds itself, but rather distributes them among the different ministries which are responsible for carrying out a commonly decided programme at the beginning of each year. Therefore, the various administrations are budgeted finances to complete their own actions or speed up their projects. This is done in conformity with the directions given by the interministerial committee. The MILDT supports two public interest groups with these funds:

- The national telephone helpline « Drug Information Services »
- The French Observatory of Drugs and Drug Addiction.
- The Prefect, who represents the State in each department, assisted by a project leader, directs and runs a system which is based upon co-ordinating State services in contact with legal authorities, as well as co-operating with local communities and associations.

3.2_Budgets and funding arrangements

This chapter may not be developed because of insufficient information. A double approach enabling this field to be understood is in progress: a report from the national audit office on the field of drugs and drug addiction is being produced, and a macro-economic study on the social and public costs of drugs in France is being conducted.

3.3_International cooperation

France has signed all of the international conventions related to the fight against drugs:

- Convention on narcotics (**1961**)
- Convention on psychotropic substances (**1971**)
- United Nations Convention against the Illicit Trafficking of Drugs and Psychotropic Substances (**1988**)

United Nations and International Organisations

The main French participation in international action for the fight against drugs and drug addiction is listed below:

UNITED NATIONS	
- Drug Commission	*MILDT, Ministère des Affaires Etrangères - (Ministry of Foreign Affairs)*
- International Drug Control Organisation	*Ministère des Affaires Etrangères - (Ministry of Foreign Affairs)*
- United Nations International Drug Control Program	*Ministère des Affaires Etrangères, MILDT - (Ministry of Foreign Affairs)*
WHO	*Ministère des Affaires Etrangères, Ministère de la Santé, MILDT - (Ministry of Foreign Affairs, Ministry of Health)*
OICP - INTERPOL	*Ministère de l'Intérieur - (Ministry of the Interior)*
OMD	*Ministère du Budget (Douanes) - (Ministry of the Budget (Customs))*
DUBLIN GROUP	*Ministère des Affaires Etrangères, MILDT- (Ministry of Foreign Affairs)*
INTERNATIONAL FINANCIAL ACTION GROUP (GAFI)	*Ministère de l'Economie (Trésor), Ministère de la Justice, Ministère de l'Intérieur, "Commission Bancaire", Banque de France, MILDT - (Ministry of the Economy, Ministry of Justice, « Bank Commission », Banque de France, MILDT)*

An enlarged Europe

Concerning the Council of Europe, the Pompidou Group and its thematic subgroups, organised conferences and mandated reports within these frameworks (ex: the multi-city reports), French contribution to this work has been provided through the participation of various groups described below. This participation was co-ordinated by the MILDT. The main French participation is listed below:

COUNCIL OF EUROPE	
Pompidou Group	
Permanent Correspondent	*MILDT, Ministère des Affaires Etrangères - (MILDT, Ministry of Foreign Affairs)*
Airport Group	*MILDT, Ministère de l'Intérieur, Ministère du*

	Budget (Douanes), Ministère de la Défense (Gendarmerie). - (MILDT, Ministry of the Interior (Customs), Ministry of Defence (Gendarmerie))
Epidemiological Group	*OFDT, MILDT*
Precursor Group	*MILDT, Ministère de l'Industrie (MNCPC), Ministère de l'Intérieur, Ministère du Budget (Douanes) - (MILDT, Ministry of Industry (MNCPC), Ministry of the Interior, Ministry of the Budget (Customs)*
Other Groups	*MILDT + Ministères concernés (MILDT + ministries concerned)*

The European Union

The General Secretariat of the Interministerial Committee on Issues of European Economic Co-ordination, ensures that the positions of the different French ministerial departments are co-ordinated on issues falling under the scope of the European Union.

A list (not all inclusive) of the main European Union work groups in which France participates has been established below. The ministry, or head department has been put in bold characters.

Horizontal Drug Group	- **National Drug Expert** (SGCI)
° 1st pillar	
- Health Group	**- Ministère des Affaires Sociales - (Ministry of Social Affairs)**, Ministère de la Santé (Ministry of Health), MILDT
- Committee of Experts article 10	- MILDT, MNCPC, Ministère de l'Intérieur, Ministère du Budget (Douane) - (Ministry of the Interior, Ministry of the Budget (Customs))
° 2nd pillar -	
- PESC Drug Group	**- Ministère des Affaires Etrangères - (Ministry of Foreign Affairs)**
° 3rd pillar	
- K4 Co-ordinators Group	**- Coordonnateur national -** (SGCI) (**National Co-ordinator** (SGCI))
- « Drug and Organised Crime » Group	**- Ministère de l'Intérieur**, **MILDT** (selon ordre du jour) Ministère de la Défense (Gendarmerie), Ministère du Budget (Douane), Ministère de la Justice - (**Ministry of the Interior**, MILDT, (per agenda) Ministry of Defence (Gendarmerie), Ministry of the Budget (Customs), Ministry of Justice, MILDT)

- Police Co-operation Group (Technical and Scientific Police, Training)	- **Ministère de l'Intérieur**, Ministère de la Défense (Gendarmerie), Ministère du Budget (Douane) - (**Ministry of the Interior**, Ministry of Defence (Gendarmerie), Ministry of the Budget (Customs))
- « Europol » Group	- **Ministère de l'Intérieur**, Ministère de la Défense (Gendarmerie), Ministère du Budget (Douane), Ministère de la Justice - (**Ministry of the Interior**, Ministry of Defence (Gendarmerie), Ministry of the Budget (Customs), Ministry of Justice)
- Customs Co-operation Group	- **Ministère du Budget (Douane)**, Ministère de l'Intérieur - (**Ministry of the Budget (Customs)**, Ministry of the Interior)
- « International Organised Crime » Group	- **Ministère de la Justice**, Ministère de l'Intérieur, Ministère des Affaires étrangères - (Ministry of Justice, Ministry of Foreign Affairs)

Chapter 4.New Developments in the Reporting Year (1996)

4.1_Changes in policy or legislation

Supply reduction

France enacted a law on April 29, 1996, making its internal legislation conform with the measures found in article 17 of the 1988 Vienna Convention. This law confers new powers upon State services in order to more efficiently fight drug trafficking on the high seas. It henceforth authorises them to intervene outside of territorial waters to inspect all ships - French, foreign (subject to the approval of the flag State) or without a nationality - which are suspected of being involved in drug trafficking. This law also establishes French jurisdiction for prosecuting and judging those (and their accomplices) who commit offences on the high seas aboard foreign ships.

France enacted a law on February 21, 1996 ratifying the Council of Europe's November 8, 1990 Convention on laundering, tracking down, seizing and confiscating criminal products. A law enacted on May 13, 1996, brought French legislation into conformity with this international convention by creating a general offence for laundering products of all crimes or offences, and by instituting an international co-operative procedure aimed at tracking down, seizing and confiscating criminal products.

France enacted a law on June 19, 1996 bringing its internal legislation into conformity with the measures found in article 12 of the Vienna Convention. It also finished transposing **European Community** rules and directives on controlling the exchange of EU and non-EU precursor substances. This law adds administrative penalties to a series of obligations based upon the approval and registration of operators, marking products, ... and requires that all suspicious or unusual operations be notified.

treating drug addicts

(see part IV)

4.2_Administrative and organisational changes

On April 24, 1996, the Mission Interministerielle de Lutte contre la Drogue et la Toxicomanie (MILDT) (Interministerial Mission for the Fight against Drugs and Drug Addiction) was created by decree. It was joined directly to the Prime Minister in replacement of the Délégation Générale à la Lutte contre la drogue et la Drug addiction (DGLDT) (General Delegation for the Fight against Drugs and Drug Addiction) which was joined to the Ministère des affaires sociales et de la santé (Ministry of Health and Social Affairs).

A circular letter sent out on July 9, 1996, stated that a project leader, responsible for co-ordinating prevention, treatment, and integration actions, would be established for each Prefect in each department.

4.3_New information requirements regarding drug policy

Masson Report (Senate, March, 96)

Senator Masson's report to the Prime Minister on the convention for applying the Schengen agreements, proposes measures of internal or international order and adjustments in the convention, mentions the special case of the Netherlands, and presents thoughts on the evolution of the security policy in Europe.

Ghysel Report (National Assembly, March, 96)

In March, 1996, Deputy Ghysel presented an informative report on the Netherlands' drug addiction policy. It was submitted by the commission on cultural, family and social affairs.

Gentilini Report

Upon a request made by the Minister of Justice and the Minister of Health, Professor Gentilini conducted a study mission on HIV infections, the hepatitis viruses, drug addiction in prisons, and progress made in applying a law enacted on January 18, 1994 which reorganised medical treatment in prisons. The report, which was published in November, 1996, makes proposals aimed at improving the application of the above-mentioned law.

- health and social treatment for individuals who have HIV or hepatitis viruses, and for drug users, during imprisonment,
- preparing individuals for getting out of prison and re-integration,
- alternative measures to being imprisoned, the rapport between society and « its » prison

Report produced by the Inspectorate for judicial services

Upon a request by the Minister of Justice, the Inspectorate for judicial services created a work group designed to improve the treatment of imprisoned drug addicts and to fight against drugs being brought into prisons. It was lead by JP Jean. The report, which was submitted in July, 1996, ascertains that because of the increasing number of imprisoned drug addicts, there is a high demand for illicit substances which circulate within the prison system: It proposes specific measures designed to:

- reduce the amount of drugs being brought into prisons,

- reduce drug demand by improving available treatment, while at the same time limiting the health risks which are related to viral contamination,
- make global treatment possible within the sentence,
- implement a pluridisciplinary way of managing drug addiction-related questions in prisons.

PART II : DRUG MONITORING SYSTEMS AND SOURCES OF INFORMATION

Chapter 5.National Monitoring and Information Systems

There are four large information fields:

substances, their classifications, their status and effects, the state of the market (price, purity...), economic and monetary flows generated by trafficking and their social consequences;

users, their number, description of the populations involved and their problems, particularly with morbidity and mortality;

uses, the links established between substances, users and their environment, the dynamics of drug use and drug addiction (when started, developments, when stopped), itineraries, harm factors;

actions undertaken by the various institutions and structures whose mission is fighting drugs and drug addiction, systems, their activities, means used, the evaluation of: systems with regard to activities produced, activities with regard to means granted, systems with regard to « demand »...

The existing system

With regard to the main categories of needed information defined above, the existing information system is particularly incomplete in the fields of measuring the economy of drugs and evaluating actions.

Concerning **substances**, there are two different observational systems. The first is based upon recording drug seizures carried out by the different departments operating in this area, and possibly analysing the seized substances. The second is based upon the centre d'étude et d'information sur les pharmacodépendances (CEIP) (network of study and information centres on drug-dependence), and on the pharmacovigilance network.

Concerning **use and drug users**, the majority of data is provided by administrative sources which simultaneously reflect part of the drug addiction phenomenon and the institutional action toward it. These information sources are particularly valuable because of their permanence and regularity, although their production mainly answers the information needs of institutions which enables them to carry out their actions.

The French statistical system on drugs and drug addiction is based upon two key types of institutional sources, health and social institutions and legal institutions, completed with studies on particular populations and general population studies.

- **Health and Social Institutional Approach**. The observed population is that of drug addicts undergoing treatment in the health and social system.
- **Legal Institutional Approach**. Legal institutions enable both use (demand) and supply to be approached. Approaching demand is oriented by the illicit character of the behaviour, or substance being taken. In comparison with the health and social system, where heroin is the predominant substance, cannabis users are most often noted by legal institutions. There is not as much knowledge about supply as there is about demand. When looking at the evolution of an indicator, it is particularly difficult in this field to distinguish which part is relative to the modification of the phenomenon and which part is the result of efforts or progress made in taking legal action.
- **Studies of particular populations**. These sources are designed to describe target populations of drug addicts. This is done using institutional criteria (for example:

clients in specialised centres), or non-institutional criteria (targeting groups which are at risk).

- **General Population Surveys**. These sources, which are rather rare in France, are designed to measure the global population's behaviours and attitudes towards drugs based upon a representative sample.

Chapter 6.Description of National Focal Point(s)

6.1_Organisation and operation

The French Observatory of Drugs and Drug Addiction is the French focal point for the REITOX network. Its creation met a national need: to set up a system designed to observe and distribute information on drugs and drug addiction to decision makers and scientists.

The Observatory's mission is in line with the constitutional agreement for a public interest group: « observing drugs and drug addiction, collecting, analysing, synthesising and distributing data, improving these data both quantitatively and qualitatively; gathering distributing and improving knowledge and analysis in all disciplinary fields interested in drugs and drug addiction; assessing and organising research performed in these areas ».

The decision to provide the French Observatory with a Public Interest Group status was made after much debate and discussion, lasting over a three year period. This status allows the Observatory to have autonomy in performing its mission of « observation » in comparison with areas of co-ordination and action falling under the responsibility of the Mission Interministérielle de Lutte contre la Drogue et la Drug addiction (MILDT) (Interministerial Mission for the Fight against Drugs and Drug Addiction). It also enables it to be endowed with an autonomous legal status operating within public accounting rules and subject to the National Audit Office.

6.2_Legal basis, rules and procedures, staffing, financing

The legal basis of the OFDT comes from a decree made on March 3, 1993, and its constitutional agreement, which created a public interest group. Its actual implementation followed a decision made by the interministerial committee on September 14, 1995.

Management Board

The observatory is directed by a management board made up of :

- the **State** represented by:

• le Ministère du travail et des affaires sociales (Ministry of Labour and Social Affairs)

• le Secrétariat d'Etat à la santé et à la sécurité sociale (Ministry of Health and Social Security)

• le Ministère de la justice (Ministry of Justice)

• le Ministère de la défense (Ministry of Defence)

• le Ministère de l'intérieur (Ministry of the Interior)

• le Ministère des affaires étrangères (Ministry of Foreign Affairs)

• le Ministère du budget (Ministry of the Budget)

• le Ministère de la ville et de l'intégration (Ministry of City Development and Integration)

- le Ministère de la jeunesse et des sports (Ministry of Youth and Sports)
- le Ministère de l'éducation nationale, de l'enseignement supérieur et de la recherche (Ministry of National Education, Upper Education and Research)
- la Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT) (Interministerial Mission for the Fight against Drugs and Drug Addiction)

- and those representing public or private rights :

- la fédération nationale des observatoires régionaux de la santé (the International Federation of Regional Health Observatories)
- le réseau national de documentation sur les pharmacodépendances "Toxibase" (the National Network of Documentation on Drug Dependencies « Toxibase »)

Scientific College

Upon a proposal made by the president of the management board, a scientific college was designated for a three year period. It is made up of 17 members with a renewable mandate. 7 members represent the INSERM (National Institute for Health and Medical Research), the SESI (Department of Statistics, Studies, and Information Systems), the OCRTIS (Central Office for the Repression of Drug-Related Offences), the Military Health Department, the CESDIP (Centre d'Etudes Sociologiques sur le droit et les Institutions Pénales) (Sociological Study Centre on Law and Criminal Institutions), the INSEE (National Institute for Statistics and Economic Studies), and the DGDDI (customs). In addition, ten other specialists from fields related to areas fitting into the group's interests are personally appointed. These people do not represent the institutions from which they come.

The scientific college provides counsel on projects which are a part of the group's work programme. It formulates advice on these projects, their organisation, and their results.

Personnel

The Observatory's work is performed by a small permanent team of 8-10 people (recruited or sent out by the group). If need be, specialists are brought in from outside of the group.

Budget

The main parts of the Observatory's budget are the following :

Interministerial subsidies "fight against drugs and drug addiction"	10,4 MF
Other subsidies or State support	1,0 MF
European subsidies	0,2 MF
Total	11,7 MF

6.3_Network of partners of the Focal Point

The Observatory implemented a drugs and drug addiction information system (REITOX-France) to help increase the analytical capacity of those working in this sector. This was done by facilitating the circulation of information and offering them a global viewpoint enabling them to put the phenomenon back into its context.

A first circle of partners working with statistics, studies, documentation and information has been connected, or are is in the process of being connected to REITOX-France (see appendices) within the framework of the following pilot projects:

- - supporting « statistical project groups », made up of geographically dispersed persons, by providing them with tools like message services, forums, and document exchanges;
- - implementing a group of experts which can be quickly drawn together to give its opinion on controversial information or pending questions;
- - implementing a complementary monitoring system designed to measure recent drug use trends through networking (for those who are able to return and analyse information);
- - consolidating a French documentary distribution network, structured around TOXIBASE, the existing national network;
- - maintaining the electronic bulletin, accessible on Internet, containing basic information on drugs and drug addiction as well as current headlines that are regularly updated.

The REITOX project takes into account the Observatory's end goal - to provide better information to those in charge of the fight against drugs and drug addiction. On one side, this implies enabling those working directly in the field to access REITOX, and on the other side proposing tools developed by REITOX when they can support implemented policies, especially within the framework of the governmental plan adopted on September 14, 1995.

Developing a national network also takes into account orientations that the European Observatory sets for the REITOX programme.

6.4_Relationship to national monitoring and information systems

To successfully carry out its mission, the Observatory defines its activities on the basis of a cartography of information sources which respects the various roles and responsibilities of each individual. Around this basis, drawing up reliable indicators, reports, and carrying out study programmes are organised. Its action fits into a co-operative network of actors relying upon computerised network techniques:

The following work programme was approved by the management board:

- - perfecting reliable drug addiction evolution indicators in France;
- - implementing a complementary system for monitoring recent trends in drug use;
- - studying and possibly launching a global operation (perhaps in the form of a general population study) for observing drug consumption and behaviour towards drugs;
- - publishing an annual report on the state of the drugs and drug addiction phenomenon in France, and contributing to the annual report for the European Observatory;
- - defining a triennial study programme, particularly considering the need of developing tools for evaluating the various implemented programmes of action;
- - extending the drugs and drug addiction information network (REITOX-France) in order to improve the analytical capacity of those working this sector by facilitating the circulation of information and offering them a global viewpoint enabling them to place the phenomenon back into its context;

- - participating in projects undertaken within the framework of the European Observatory.

6.5_Use of Focal Points within the country

Chapter 7.Types and Sources of Information Available

7.1_Epidemiology

The statistical and epidemiological sources which are available on a regular basis in France have remained the same since version 1 of Information Map was drawn up. Thus, the same sources were described in a slightly different framework in version II of Information Map. They are divided up into the following categories:

Health Institutional Sources :

- Enquête toxicomanie dite de novembre (November Drug Addiction Survey) drug addicts undergoing treatment in health and social structures
- Infection à VIH chez les résidents des centres de soins spécialisés pour toxicomanes avec hébergement (HIV Infection among Residents of Specialised Inpatient Drug Addiction Treatment Centres)
- Base de données en toxicomanie (Drug Addiction Database)
- Toxicomanes incarcérés vus dans les antennes toxicomanie (Imprisoned Drug Addicts seen in Prison Drug Addiction Treatment Centres)
- Dossier médical de l'immunodéficience humaine (DMI2) (Medical File on Human Immunodeficiency)
- Déclaration obligatoire des cas de SIDA (Mandatory Declarations of AIDS Cases)

Legal institutional sources:

- Fichier national des auteurs d'infractions à la législation sur les stupéfiants (National File of Perpetrators of Drug-related Offences)
- Casier judiciaire national (National Police Record)
- Fichier national des détenus (National Prisoner File)

General Population Surveys:

- Baromètre Santé 1993-1994 (Health Barometer 1993-1994)
- Suivi épidémiologique des conduites toxicophiles dans les centres de sélection des armées (Epidemiological Monitoring of « Toxicophile » Behaviour in Military Recruiting Centres)
- Enquête Santé des adolescents (Adolescent Health Survey)
- Bilan d'activité de Drogues Info Service (Activity Report for Drug Information Services - telephone help line)

Ethnographic surveys:

- La consommation de cocaïne à Paris (Cocaine Consumption in Paris)

- Travail sexuel, toxicomanie et VIH à Paris (Sexual Work, Drug Addiction and HIV in Paris)
- Les travailleurs sexuels et la consommation de crack (Sexual Workers and Crack Consumption)

Other ethnographic surveys have been fully conducted since version II of Information Map was drawn up in November, 1996. These new sources, as well as other ad-hoc surveys have been described in full detail in the « Repertoire des sources statistiques sur les drogues et les toxicomanies » which is currently being updated and will be published by the OFDT in March, 1997.

Technical comments on Information Map version II

It seems important to us to draw attention to the fact that the two types of statistical coverage mentioned in the descriptive sheets of Information Map version II were not easy to fill out. On one hand, information on the subject is rarely available. On the other hand, the concepts inferred by the two questions on covering the source, are hard to comprehend and should be clarified in the next manual.

7.2_Demand reduction

The repertory of resource individuals working in the area of demand reduction enabled the French Observatory of Drugs and Drug Addiction to begin working on the subject.

The choice of those who were questioned was established in order to initially have a global and national vision of actions carried out in France in the field of demand reduction. It seemed important to us to precisely describe the various actions undertaken by the resource individuals. It is quite clear that it will be necessary to research locations on a finer scale: regional, local.

15 individuals answered the questionnaire from section I of Information Map version II :

- - Madame F. Moyen - MILDT,
- - Monsieur G. Cagni - FFT,
- - Madame D. Billet - Ministère de la Jeunesse et des Sports - Mission « Environnement social des jeunes » (Ministry of Youth and Sports - « Social Environment Mission for Young People »),
- - Monsieur A. Tourre - Ministère de l'Intérieur (Ministry of the Interior) - MILAD,
- - Monsieur J.F. Rioufol - DGS - (General Health Department) Aids Division,
- - Madame N. Frydman - MILDT,
- - Madame M.P. Joly - Ministère de l'Aménagement du Territoire, de la Ville et de l'Intégration (Ministry of National and City Development and Integration) and Ministère du Travail et des Affaires Sociales - Direction de l'Action Sociale (Ministry of Labour and Social Affairs - Department of Social Action),
- - Madame N. Neulat - Ministère de l'Education Nationale, de l'Enseignement Supérieur et de la Recherche (Ministry of National Education, Upper Education and Research) - Direction des Lycées et Collèges, (Administration of Lycées and Collèges),
- - Madame N. du Saussois - Ministère de l'Education Nationale, de l'Enseignement Supérieur et de la Recherche (Ministry of National Education, Upper Education and Research) Direction des Lycées et Collèges, (Administration of Lycées and Collèges),
- - Monsieur J.M. Devevey - MILDT,

- - Madame C. de Peretti - Ministère de l'Education Nationale, de l'Enseignement Supérieur et de la Recherche Recherche (Ministry of National Education, Upper Education and Research) - Institut National de Recherche Pédagogique (National Institute for Pedagogical Research),
- - Monsieur B. Cohen - Drogues Info Service (Drug Information Services),
- - Monsieur P. Rio - Ministère de la Défense (Ministry of Defence) - Gendarmerie Nationale (National Gendarmerie),
- - Madame O. Sampeur - Ministère de la Justice (Ministry of Justice) - Direction de l'Administration Pénitentiaire (Department of Penitentiary Administration),
- - Madame D. Vasseur - Comité Français d'Education pour la Santé (French Committee for Health Education).

The OFDT was unable to question all of the selected individuals because of a lack of time :

- - Monsieur Benaiche - Délégation Interministérielle à la Ville (DIV) (Interministerial City Delegation),
- - Madame Freire - Délégation Interministérielle à l'Insertion des Jeunes (DIIJ) (Interministerial Delegation on Integrating Young People),
- - Changement d'interlocuteur - Ministère de la Justice (Ministry of Justice) - Direction de la Protection Judiciaire de la Jeunesse (PJJ) (Department of Legal Protection for Young People),
- - Monsieur Bourdillon - Direction des hôpitaux (Hospital Administration)- Mission Sida (AIDS Mission),
- - Monsieur Tonnelet- Association Nationale des Intervenants en Drug addiction (National Association of Drug Addiction Field Workers),
- - Monsieur Binder - Association Nationale Généralistes & Toxicomanies (National Association of General Practitioners and Drug Addictions).

Other individuals did not wish to answer the questionnaire. They considered that the French situation could not be integrated into the list because of its specific characteristics.

The SP3 office at the General Health Department wanted to write a text describing the French approach to demand reduction. This text has been integrated into chapters 16 and 17.

From the angle of perpetuating new motivations, it would be desirable for the EMCDDA to establish a feedback system between resource individuals and itself.

7.3_Documentation centres

Sources of documentation have not changed from the last version of Information Map version I 1995. Therefore, the questionnaire in section III of Information Map II was filled out by the following documentation centres:

- - Le centre coordonnateur (The co-ordinating centre) : TOXIBASE Lyon
- - Associated centres :
- - AMPT (Marseille)
- - CAST (Reims)
- - CAS (Strasbourg)

- - DIDRO (Paris)
- - Marmottan (Paris)
- - PEPA - CRDT (Montpellier)
- - CEID-Pey-Berland (Bordeaux)
- - SEDAP (Dijon)
- - The MILDT documentation centre.

Since it was created in 1996, TOXIBASE has been fulfilling two objectives: developing information and documentation services in the field of drug-dependency, (documentary database, minitel and internet services, documentary magazines, press reviews, etc.) and providing access to specialised documentation through a network of associated centres.

TOXIBASE is made up of a network of 9 associated documentation centres spread out in different regions :

- - Paris : DIDRO centre, Marmottan centre
- - Reims : CAST
- - Dijon : SEDAP
- - Strasbourg : CAS
- - Marseille : AMPT
- - Bordeaux : CEID-Pey-Berland
- - Montpellier : PEPA - CRDT

The majority of these centres is located in counselling and after-care centres for drug addicts. This is a fundamental point since they are thus directly and closely linked to clinical priorities in the field.

Each associated documentation centre has developed its own documentary base from which information may be obtained on-site, through the Internet, or by Minitel.

The database is fed by the different centres through computerised files which are directly transmitted to the co-ordinating centre. They also participate in developing other products or services.

Some of the associated centres have developed a specific documentary approach in function with the centres wherein they are located: prevention actions (DIDRO), research (Marmottan), psycho-analysis (Reims), liaison with the Council of Europe (Strasbourg) etc.

Thus, to a large extent, the great wealth of fulfilmentís and interventions undertaken by the different TOXIBASE associated documentation centres, have gone beyond the simple documentary framework enabling documentation on prevention and information actions on a global level to actually be used

Chapter 8.Arrangements for Reporting to other International Organisations

When international organisations need quantitative information, whose supply is generally controlled within the framework of international conventions, it comes directly from operational institutions. This is the case whether the reports sent out by these institutions are addressed to the international organisations, or the institutions are answering questionnaires coming from international organisations.

The main French institutions cited as sources or correspondents in international reports are:

La Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie - (Interministerial Mission for the Fight against Drugs and Drug Addiction) (MILDT), for a global vision of public action, 8 avenue de Ségur, 75350 Paris 07 SP, T:33 1-40566000, F:33 1-40567210,

Office Central pour la Répression du Trafic Illicite des Stupéfiants - (Central Office for the Repression of Drug-Related Offences) (OCRTIS), for anything concerning controls and investigations, 101 rue des Trois Fontanot 92000 Nanterre, France T:33 1-40978033, F:33 1-47210320,

Direction Générale des Douanes et des Droits Indirects - (General Customs and Indirect Duty Department) (DGDDI), customs actions, statistical report, 23 bis, rue de l'Université 75700 PARIS 07 SP

Direction Nationale du Renseignement et des Enquêtes Douanières - (National Department of Information and Customs Surveys) (DNRED), controls and investigations, 18-22 rue de Charonne, 75528 Paris Cedex 11, France, T:33 1-49233636, F:33 1-49233622,

Ministère de l'Industrie, Mission Nationale de Contrôle des Précurseurs Chimiques - (Ministry of Industry, National Mission for Controlling Chemical Precursors (MNCPP), approval and recording of operators, application of regulations, international exchanges, 3-5 rue Barbet de Jouy, 75353 Paris Cedex 07, France, T:33 1-43192261, F:33 1-43192334,

Agence du Médicament, Direction de l'évaluation du médicament, Unité stupéfiants et psychotropes - (Medicine Agency, Department of Medicine Evaluations, narcotics and psychotropic substances unit), for monitoring psychotropic molecules, 143/145, boulevard Anatole France, 93200 Saint Denis, France, T/33 1-48132291, F:33 1-48132003,

Ministère de la Justice, Service des Affaires européennes et internationales, Bureau du droit pénal international et de l'entraide répressive internationale - (Ministry of Justice, European and International Affairs Department, International Criminal Law and Repressive Co-operation Office), for the impact on French legislation, 13 place Vendôme, 75042 Paris, France, T:33 1-44861434, F:33 1-44861441,

Ministère des Affaires étrangères, Direction des français à l'étranger et des étrangers en France, Division des conventions judiciaires et de la nationalité - (Ministry of Foreign Affairs, Department of French Citizens abroad and Foreigners in France, Judiciary and Nationality Conventions Division), for co-ordinating participation in international conventions, 23 rue La Pérouse, 75016 Paris, France, T:33 1-40667105, F:33 1-40666450,

Ministère des Affaires étrangères, Direction des affaires stratégiques de sécurité et du désarmement - Ministry of Foreign Affairs, Department of Strategic Affairs for Security and Disarmament (DASSD), sous direction de la sécurité - (Sub-Department for Security) (SEC), 37 quai d'Orsay 75007 PARIS, T : 33 1 -43174551, F : 33 1-43175896

Secrétariat général du comité interministériel pour les questions de coopération économique européenne - General Secretariat of the Interministerial Committee on Issues of European Economic Co-operation (SGCI) interministerial structure for issues falling under the domain of the European Union, 2, boulevard Diderot, 75012 PARIS, T:33 1-44871717, F:33 1-44871119.

Ministère du travail et des affaires sociales, Service des études, des statistiques et des systèmes d'information - (Ministry of Labour and Social Affaires Department of Statistics, Studies, and Information Systems) (SESI), 7, boulevard des cinq Martyrs du Lycée Buffon, 75015 PARIS, France, T:33 1-44369000, F:33 1-44369110

Work concerning qualitative aspects, which are generally specialised by theme, leads to the implementation of networks of participants which generally include:

co-ordination, often carried out by the Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie (Interministerial Mission for the Fight against Drugs and Drug Addiction),

nearly systematic participation on the part of services which are responsible for internally co-ordinating the fight against drugs and/or statistics within operational services,

participation of particular specialists according to the field.

National report produced by the co-operative group for the fight against drug use and trafficking (Pompidou Group)

The French National Report is prepared by the permanent representative at the Council of Europe which summarises the situation using information obtained from institutional sources and comments provided by other MILDT representatives. This is done for the pan-European ministerial conference.

Epidemiological sub-groups (Pompidou Group)

The French Observatory of Drugs and Drug Addiction has co-ordinated France's contribution to this group over the last three years. The French partners include: the OFDT, IREP, DGS, INSERM, SESI, and OCRTIS. Synthesising tasks has been distributed among the partners in the following way:

- « tour de table » report from the Spring session: written by the OFDT and validated by the other partners
    - updating multi-city reports: the OFDT centralises updating the charts, the IREP writes the comments, and the other partners validate the work.

Chapter 9.New Developments in the Reporting Year (1996)

9.1_Changes in national monitoring systems

The November Drug Addiction Survey, from the statistics department at the Ministère des affaires sociales (SESI) (Ministry of Social Affairs), which describes drug addicts undergoing treatment in health and social institutions, is one of the key pillars in the drug addiction field. It has existed in its current form since 1989 but after being thoroughly re-evaluated in 1996, it will be completely redone in 1998: the field of institutions and services to be surveyed, the survey's methodology and how it is conducted. Within the framework of these changes, the OFDT financed a study designed to evaluate the coverage and quality of information gathered during the survey using a representative sample of institutions in the northern regions and Ile-de-France.

9.2_Changes within the Focal Point

See chapter 6

9.3_New data gathering priorities

See the conclusions

PART III EPIDEMIOLOGICAL SITUATION

Chapter 10.Historical Development of Drug Use and Addiction (1960s - 1980s)

Drug use began to increase in France at the end of the 1960's. The most widely used substances at that time were cannabis and LSD. Heroin use was still marginal. Users were mainly secondary school students, as well as students from the more favoured social environments. Taking drugs was an alternative, anti-establishment, behaviour.

During the 1970's, and more particularly in the second half, heroin use and addiction began developing. LSD use dropped but heroin, barbiturates and amphetamine use spread into new less favoured social environments. Using syringes became quite frequent. Drugs themselves were an escape and an end. Money began to play a dominant role and the phenomenon of selling drugs in order to get drugs developed.

This phenomenon became more serious in the 1980's as drug use spread to all the social environments. New substances appeared (solvents, cocaine - which up to this time had mainly been used by small groups of socially well-integrated individuals, crack at the end of the 1980's). Polydrug abuse developed as alcohol and psychotropic substances became massively associated. The health consequences of drug addiction got worse: the number of overdose-related deaths exploded, and the AIDS crisis emerged.

Chapter 11.Current Situation of Drug Use and Drug Addiction (prevalence, different drugs, patterns, characteristics, trends)

The indicators mentioned in each part come from statistical and epidemiological data sources which cover the national territory in general. Information for them is produced on a regular basis. These statistics could not alone cover all drugs and drug addiction trends and for this reason it seemed important for us to include written texts which cite selective surveys conducted among more specific drug addiction populations.

11.1_Drug consumption in the population (surveys etc.)

A. Drug consumption among adults

« Baromètre Santé 95 » survey

According to the Baromètre Santé 95 survey, 22% of all adults between the ages of 18 to 75 years have been offered drugs at least once, with men being approached more often than women. Cannabis was the drug offered in 93% of the cases. In 1992, cocaine was offered in 6% of the cases, but increased to 12% in 1995.

In 1995, 16% of those surveyed reported having taken some drug during their lifetime, up from 12% in 1992. This increase may be explained by the fact that drug use has become more commonplace, particularly among young people. This leads to a better notification rate. Another possible hypothesis is that older generations which never or rarely experimented with drugs are passing away, being replaced by generations for which drug use is less rare. This hypothesis would especially enable an

explanation to be made for the increase in the rate of experimenters or users over the age of 45 between 1992 and 1995.

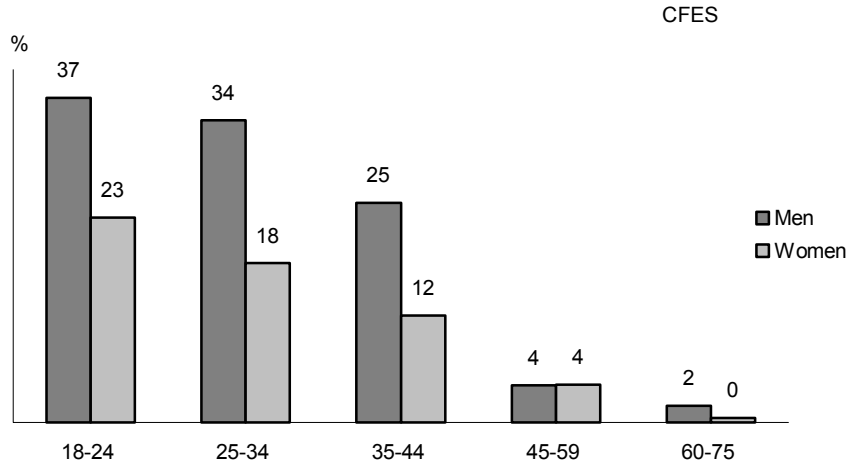
Drug consumption by substance (%), 1995

CFES

Drug use ...	lifetime (%)	past year (%)
Cannabis	15,2	4,4
Hallucinogenic substances	1,5	0,2
Medicine	1,1	0
Cocaine	1,1	0,1
Glues and solvents	0,8	0,1
Ecstasy, amphetamines	0,7	0,3
Heroin	0,4	0
Other drug	0,5	0,1
All drugs	15,8	4,4

Drug experimentation over a lifetime is highly linked to gender and age. Men, who are approached more often, account for 21% of all users (at least once) compared to 11% for women. In addition, the survey showed that the number of persons experimenting with drugs decreased as population age increased - from 32% for the 18 - 24 age bracket to 1.5% for the 60 - 75 age bracket.

Lifetime cannabis consumption, by gender and age, 1995



In 1995, as in 1992, 4% of all people surveyed had taken some drug over the last 12 months (6% of men and 3% of women). Cannabis was involved in more than 90% of the cases, as was the case with lifetime drug consumption. Drug use over the last 12 months was particularly more frequent among single people and students/conscripts, with 13% and 17% respectively.

Survey in selection center for young men

In 1995, a survey was conducted among young men summoned to army selection centers (mainly between 18 and 22 years of age). It provided information about drug consumption over the last three months, following an appointment conducted by a doctor. Opiates and cocaine consumption within the preceding three days, as well as cannabis consumption within the preceding week, could be detected from urine analysis.

"Toxicophile" behaviour among young men in recruiting centers, 1995

DCSSA

Drug use over the past three months (%)	
Cannabis	19,1
Cocaine	0,7
Heroin	0,6
Ecstasy	0,5
LSD	0,4
Mushrooms	0,2
Amphetamines	0,2
Codeine	0,1
Inhalants	0,1

Cannabis was the product most often used: 19% of those surveyed in these centers reported having consumed cannabis over the preceding three months.

Methodological References

- **Baromètre Santé, 1995, CFES**

  Representative sample of the population aging from 18 - 75 years (n = 1993) consulted in December 1995

  Individuals who report having consumed an illicit drug, or misused a toxic product are counted in this report: (over the last 12 months, over a lifetime).

  Cited substances: cannabis, medicine used to drug oneself, sedatives, barbiturates, uppers, hallucinogenics, LSD, hallucinogenic mushrooms, cocaine, inhaled products (ether, poppers, glues) - ecstasy, amphetamines, heroin.

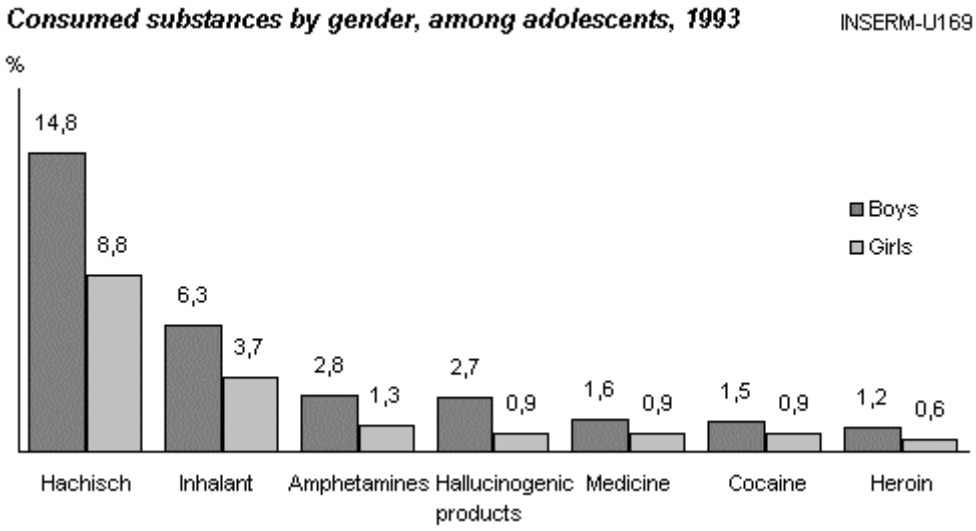
- **Enquête sur les conduites toxicophiles dans les centres de, 1995 », DCSSA**

  A random sample taken through a two degree drawing system. This was done in each selection center for young men summoned to the centers during the first quarter 1995 (n = 10, 870). These were young men who presented themselves in one of the 10 selection centers in metropolitan France, but who were not candidates for enlistment. The survey consisted of a) a urine sample to be analyzed for cannabis metabolites, opiates and cocaine (for the last two, confirmation was made through a chromatography in liquid gas and a mass spectrometry), and b) an appointment conducted by a doctor on consumption over the preceding three months.

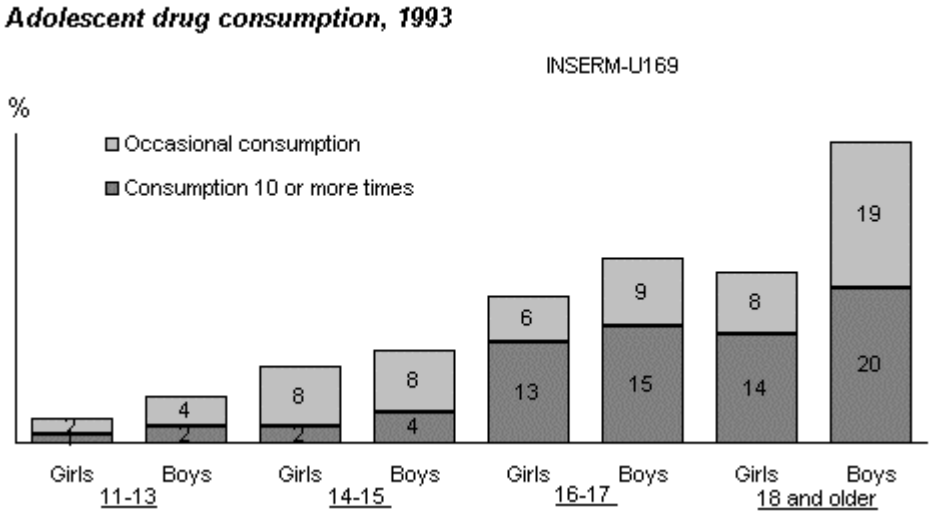
B. Drug consumption among adolescents

Different surveys show that over a 20 year period, experimenting with illicit drugs spread among adolescent students.

In 1993, 85% of all 11 - 19 year olds had never tried drugs, and 5% had already taken drugs more than ten times. Hashish was the drug most commonly experimented with: 12% of all adolescents had already smoked it. Inhalants (which are not illicit) follow up hashish, concerning 5% of all adolescents. There was very little cocaine and heroin consumption: around 1% of all 11 - 19 year olds had tried cocaine or heroin at least once. The survey cannot take into account information on ecstasy and amphetamines use because it is a recent phenomenon that is rapidly growing. However, it seems as though a noticeable share of young people who participate in rave parties, consume ecstasy or amphetamines during the party. This goes for LSD as well, but in lower quantities.



As with alcohol, drugs are more often consumed by boys. From 11 - 19 years of age, 18% of them have already experimented with an illicit drug, compared to 12% for girls (who consume more psychotropic medicine). Furthermore, if consumption tends to increase with age, more noticeably for boys, it also becomes more and more frequent. By 18 years of age, 19% of all boys and 8% of all girls have taken a drug at least 10 times in their lifetime.



Polydrug users are also frequent. 92% of those having experimented with an illicit drug also drink alcohol or smoke tobacco either regularly or daily, in the majority of the cases. Regular use of one of these products clearly increases the risk of also experimenting with an illicit drug. If the number of alcohol, tobacco, and drug users increases with age, so does the number of occasional or regular polydrug users (of these three products) going from 1.2% among 11 - 13 year olds to 21% among those 18 and older.

No links have been highlighted between drug use in adolescent students and their social and academic situation. However, the older ones, who « go out » (street, cafés, nightclubs,...) and those who express general dissatisfaction, are more clearly at risk than the others. Addiction to smoking, alcohol consumption, truancy, psychological problems, and violence, are indicators of risks that are frequently associated with repeated drug consumption.

Methodological References

- **Enquête Santé des Adolescents, INSERM-U169**

This is a representative sample taken on a national level, of young students in the secondary cycle in public schools (junior high and high schools) from 11 - 19 years of age (n = 12,391). The rate of unanswered questions is between 1% and 3% for drug consumption.

This is for lifetime consumption of seven classes of substances: hashish, cocaine, heroin, amphetamines, inhalants, hallucinogenic, medicine used to drug oneself.

11.2_Problematic drug use (estimates, indirect indicators)

A. Drug users and drug addicts : estimations of prevalence

One of the Observatory's prioritary tasks is to develop methods of estimating the prevalence of drug use, especially methods using indirect indicators which are produced by regular institutional sources. This is to indicate to the authorities the size of the phenomenon which is facing them. In fact, from the point of view of reducing infectious risks, which is one of the current priorities in fighting drug addiction, questioning more specifically revolves around intravenous drug addicts who are mostly heroin addicts.

It is impossible, and always will be, to specifically answer the following question: How many drug addicts are there? It is only conceivable to estimate the scale of the problem, and this requires taking into account several hypothesis whose stability is relative. The macro-demographic method of estimating the number of heroin addicts, presented in the preceding report, was also used for this report. A different evaluation, focusing on the number of occasional drug users has also been presented. It does seem important to put these two measurements into perspective in order to clearly mark the difference between drug users and drug addicts. This can be distinguished by considerable differences. But, quite often under the term of « drug addict », many facts are brought up that may not be compared.

Experimenters, Cannabis

In France, there are no general surveys on drug use. Nevertheless, some sources exist in partial fields. By drawing them together, we can get an idea of the scale of drug use.

Thus, by considering the notions of « drug use over a lifetime , or over the past year », which were used in the two main sources we have concerning this matter, we are able to estimate that around 7 million in France have consumed some drug at least once in their lifetime, and around 2 million have consumed a drug within the past year. In 90% of the cases, hashish was the drug consumed.

Heroin Addicts

By using a demographic model, we can estimate that there are about 160,000 heroin addicts. These are people who have mainly consumed heroin on a regular and prolonged basis over the last few months, and who have turned to the health and social system because of their practices. The most serious forms of heroin use have been focused upon. This estimation does not take into account occasional or heavy use by people who have not been seen in the health and social system because of their practices.

If the same model were used to estimate the number of intravenous drug users, the results would be identical. If the SESI survey results are considered, the number of cases indicating heroin as the main drug is noticeably the same as the number of cases for which intravenous drug use is mentioned. In fact, some people who use other substances, may also use the intravenous administration mode, or consume heroin intravenously as an associated product.

This estimation must be considered very cautiously because of the hypothesis used in making it. It should be matched up with other calculations determined by using different models. Thus,

extrapolating the results of the « capture-recapture » method recently applied in Toulouse and its suburbs, on a national level, would yield a noticeably different number. But this method cannot be considered strong in its present state of development. However, this type of parallel which is still unperfected, will be gone into more deeply. The reality of the situation, which is difficult to quantify, can only be approached by using several indicators.

Actions Taken, Work Prospects

Producing reliable estimations of prevalence requires considerable amounts of time. Therefore, beyond these estimations, investigating this subject followed a more global approach. Over the past year, the Observatory:

- - supported using a « capture-recapture » method of estimation in Toulouse and its suburbs;
- - inventoried different methods of estimation used abroad.

A seminary on the subject of prevalence was organized by the European Observatory and the Pompidou Group in June, 1996. It was agreed that **no single method may be considered as « the » method par excellence**, or be directly applied on a national level. It is preferable to move towards studies which experiment with different methods on a local level, and in various geographical areas, in order to eventually extrapolate to all of a national territory.

By drawing conclusions from these recommendations, the broad lines of our future work should be the following:

- - applying different methods and cross validating them on a local level in Paris and Toulouse, for estimating the prevalence of heroin addicts (and crack users, in Paris);
- - participating in developing a dynamic model with other countries to be used in estimating the prevalence of heroin addicts on a national level;
- - applying a technique called « nominative designation » on a local level in Paris and Lille for estimating the prevalence of ecstasy users.

Methodological References

- **Heroin addicts**

Demographic method: 160,000 heroin addicts

- The number of persons who mainly consume heroin on a regular and prolonged basis, having turned to the health and social system for help over the past few months.

- Hypothesis: annual entry flow estimated at 20,000 (SESI survey in November, 1993), average length of drug addiction estimated at 8 years.

« Capture-recapture » method used in Toulouse.

- The « capture-recapture » method is based upon using and matching several independent recording sources for cases. Each source constitutes a list of individuals considered to be a sample of the total population. Individuals may appear on several lists. By analyzing the composition of different lists, especially duplicated information, it is possible to estimate the « hidden population » and therefore evaluate the total population by mathematical modelling.

- The prevalence rate of opiate users (15 - 44 years) estimated in Toulouse: 3,5%

- **Drug experimenters**

Lifetime consumption: all drugs (7 million), hashish (6,2 million)

- rate for 11 - 17 year olds (11%): source INSERM-U169 1993 survey

- rate for 18 - 75 year olds (16%): source CFES, Baromètre Santé - « Health Barometer », 1995

- ratio of use in the past year compared to lifetime use (28%): source CFES, Baromètre Santé - « Health Barometer »

B. Drug addicts under treatment in health and social institutions

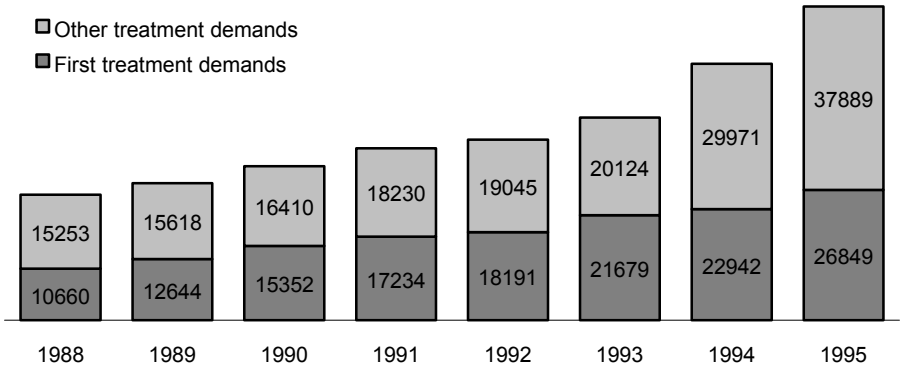
Drug addicts undergoing treatment in the health and social system are counted differently, depending upon the establishment surveyed. Only specialized treatment centers have a system enabling the number of these addicts to be calculated per year. In hospitals and social centers, only drug addicts treated during November are counted.

Above all, the number of addicts undergoing treatment may be used as an indicator of the amount of demand for care. However, certain limits arise such as: the selection of patients, the latent period between when the addiction to drugs begins and the first contact with a treatment center is made, and a variation between healthcare needs and care offered.

The number of drug addicts treated by the health and social system is growing from year to year (doubling in five years), but this trend was even more noticeable in specialized centers in 1994 and 1995. Indeed, in 1994 and 1995, they recorded a 20% increase in the number of drug addicts seeking treatment during the month of November, and a 22% increase during the year. This growth may be the combined reflection of an increasing number of drug addicts, changes in treatment practices, more frequent recourse to treatment, or even the sign of increased morbidity. The relatively stable numbers observed in hospitals and non-specialized social centers may be partially linked to fluctuations in the number of establishments who responded, and are therefore difficult to interpret.

Number of treatment demands in specialized centers, 1988-1995

SESI



Health and social services , and drug addicts treated in november 1995

SESI

Type of establishment	Number of establishments	Number of drug addicts
Specialized centers	**229**	**11114**
Hospitals	**526**	**7026**
Regional hospitals	54	1763
Hospitals	278	2323
Specialized psychiatric hospitals and private psychiatric hospitals	112	2619
Psychiatric clinics	82	321
Social establishments :	**554**	**4763**
Inpatient centers for social rehabilitation	316	1472
Prevention team	238	3291

64,738 drug addicts underwent treatment in specialized centers during 1995. For 41% of them, it was the first time they had been treated in this type of structure. In November, 1995, 11,114 drug addicts were treated in specialized centers, 7,026 in hospitals, and 4,763 in social centers. Some of the drug addicts treated in hospitals and social centers in November, reported that they were also being treated in a specialized center. When these double-counts are taken into consideration, it may be estimated that around 20,300 drug addicts were treated in the health and social system during the month of November, 1995. More than one fourth of them were treated in Ile-de-France.

Methodological References

- **November Drug Addiction Survey, SESI**

In this survey, drug addicts who are undergoing treatment in the health and social system (specialized drug addiction centers, hospitals, health centers which are not specialized in drug addiction (CHRS, clubs and prevention teams)) are recorded. This is done in spite of whether or not the treatment began before or during the observation period (during the year, or the month of November).

Drug addicts undergoing treatment are regular users of illicit substances, or misused licit substances. A particular drug addict may be treated several times in the same or different establishments, or sometimes even simultaneously.

The capacity of different types of establishments to determine that a person is addicted to drugs varies. This is particularly the case in hospitals and social centers which are not by nature specialized in this type of treatment, as compared to specialized drug addiction treatment centers. In addition, a drug addict may seek help from these structures for reasons which are not linked to drug addiction.

The survey field fluctuates in hospitals and social centers even if it remains constant in specialized centers. This makes calculating the survey's coverage rate in these establishments inaccurate.

The number of drug addicts treated in specialized centers during the year, is probably over-estimated. There are double-counts (being treated in the same center several times during the year) and in some cases it appears that the recourse (occurrence) and not the drug addicts (people) are being counted.

Rate of unanswered questions: 2% concerning the nature of treatment administered.

11.3_Patterns of use and characteristics of users

A. Age

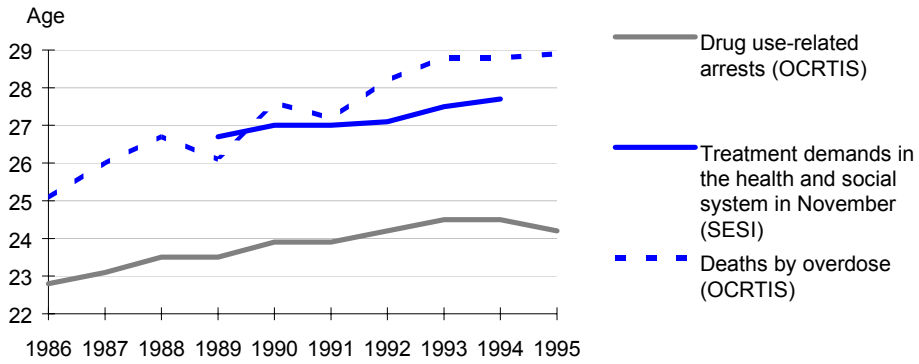
As is the case of licit psychotropic drug consumption, drug use and drug addiction are closely linked to age. This has proven true for all institutions that detect persons using illicit drugs. A large majority of them are strongly concentrated in the 20 - 35 year age group.

From year to year, the average ages of drug users are continuously increasing. This aging trend has been observed in arrested drug users (+ two years in 10 years), in drug addicts undergoing treatment in the health and social system (+ one year in six years), or even in persons having died from a drug overdose reported on by police or gendarmerie departments. The strongest age increase has been in overdose victims (+ four years). Several hypothesis have been advanced in order to explain this aging trend. It is hard to verify them, but the answer could probably be found by combining them all:

- - Increased tolerance towards drug addicts on the part of family and friends, increased socialization of the problem - hindering them from being detected by institutions (arrests, being treated later) even if the age for becoming addicted to drugs has remained stable
- - Variation in the ages for becoming addicted to, or getting off drugs - becoming addicted and/or getting off drugs later in life, or becoming addicted younger and getting off drugs later in life
- - Partial non-renewal of the population - some of the same drug addicts are being seen every year
- - Appearance of new itineraries - for example, persons having quit taking drugs who start up again, or for example persons who become addicted after 35 years of age
-
-

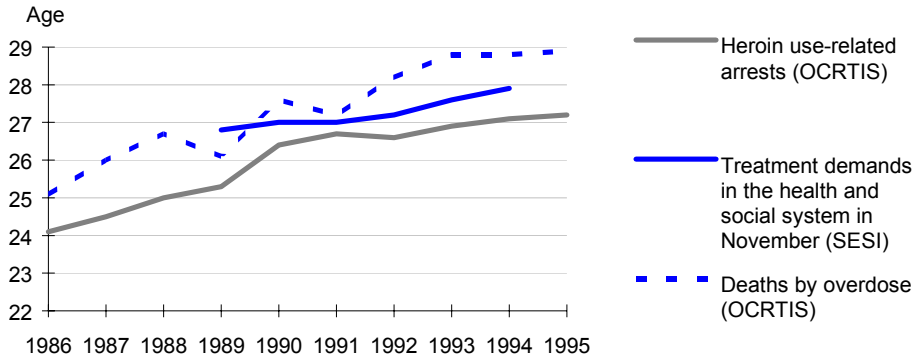
Average age of drug addicts treated, arrested and deceased by overdose, 1986-1995

OCRTIS, SESI



Average age of heroin addicts treated, arrested and deceased by overdose, 1986-1995

OCRTIS, SESI



Although the average age of arrested drug users is similar to that of drug addicts undergoing treatment, there is an average of three years difference in age. In 1995, the average age of arrested drug users was 24.2 years old, as opposed to an average of 27.7 years of age for drug addicts undergoing treatment in November, 1994. Comparing those who took heroin as a main substance, added to those who died from overdose (a result of taking heroin in 3/4 of the cases), reveals average ages which are very close: 27.2 years of age for arrests in 1995, 27.9 years of age for treatment in November, 1994, and 28.9 years of age for overdose-related deaths in 1995. Cannabis users, whose average age is 23 years, are strongly represented in arrest data while they constitute a minority in treatment data.

However, persons arrested for using crack are an exception to the aging trend in the drug addiction population. Indeed, they appear to be getting younger. Their average was 28.4 years in 1995.

Methodological References

- **November Drug Addiction Survey, SESI**

  In this survey, drug addicts who are undergoing treatment in the health and social system (specialized drug addiction centers, hospitals, non-specialized social centers) are recorded. This is done in spite of whether or not the treatment began before or during the month of November (n = 20,392)

  Drug addicts undergoing treatment are regular consumers of illicit products or misused licit products. A particular drug addict may be treated several times in the same establishment, or in different establishments, sometimes simultaneously.

- **National File of Perpetrators of Drug-related Offenses, OCRTIS**

  Arrests for illicit drug use during the year are listed in this file. All illicit toxic substances are concerned, whether they be used occasionally, or on a regular basis. Occurrences, and not people, are listed in this file. Some users may have been arrested several times over a one-year period.

  Overdose-related deaths are accidental deaths, reported on by police and gendarmerie departments, which are directly or indirectly linked to drug use.

In the health and social field, it is necessary to distinguish drug addicts by the type of establishment they are being treated in. The oldest are treated in hospitals - with an average age of 29.2 years. The youngest are treated in social centers that are not specialized in drug addiction - with an average age of 24.5 years. In addition to this, it has been observed that those who seek drug addiction treatment for the first time are a little bit younger.

B. Gender, nationality, professional integration, and health coverage

The masculine gender is by far the most highly represented among drug addicts, with the most pronounced difference being in the law enforcement field. 90% of arrested, convicted, or imprisoned drug users are men. 75% of all drug addicts undergoing treatment in health and social centers are of masculine gender.

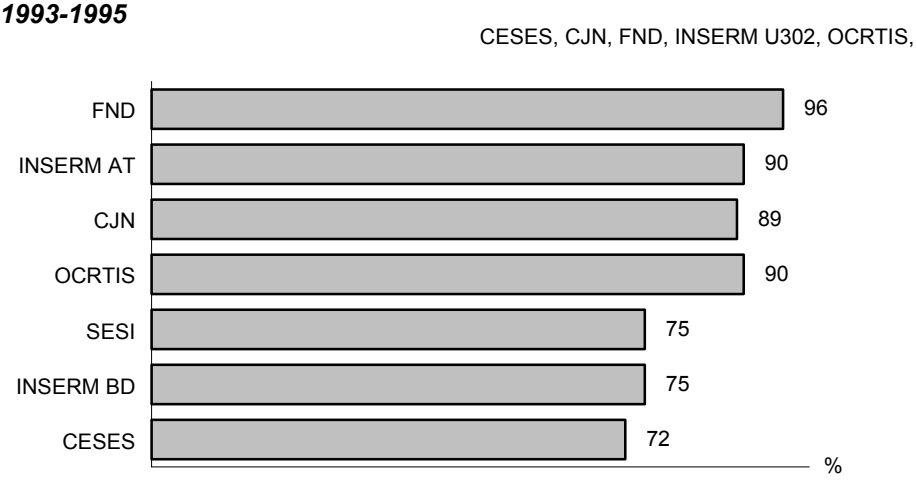
Drug addiction behavior is truly different between the genders. The ways in which risks are taken, and how the drug addiction is handled differ between the genders. Women taken fewer illicit drugs, turning more towards psychotropic medicine. There are also differences in institutional practices. Fewer women are arrested.

According to the sources, 70% to 90% of the drug addicts are French. The lowest rates are in the law enforcement field. On a national level, these proportions are smaller than those taken in the general population for the same age. If a more refined comparison is made on a regional level, the differences are lessened.

Information on professional activity and health coverage are only known for those drug addicts undergoing treatment in the health and social system during the month of November. It is therefore important to be careful when extrapolating results to the entire drug addiction population.

Integrating drug addicts into working life has not been highly successful. 72% of the drug addicts treated in November, 1994, had no professional activity, with 60% of them unemployed. In addition, those who did have jobs were in a precarious situation, because more than half of them only had a fixed-term contract. The highest percentage of non-working drug addicts was found in social centers, but those who were undergoing treatment there were generally younger.

Proportion of male drug users, by different sources, 1993-1995



Finally, although drug addicts declare that they have health insurance in nine out of ten cases, eight percent of them - most particularly those under 25 years of age - have no health coverage. One quarter of those drug addicts who are undergoing treatment receive RMI payments. The highest percentage of RMI beneficiaries are found among unemployed persons that have already had a job.

According to recent ethnographic studies (using a field approach) it seems that compared to previous years, drug addicts are experiencing intensifying poverty and unstable living conditions.

Methodological References

Foreigner: a person with a foreign nationality (EEC + outside of the EEC)

- **Sources**

CESES: Drug addicts treated in specialized inpatient centers, second quarter 1995.

DJN: Convictions for illicit drug use, 1993.

INSERM AT: Imprisoned drug addicts being treated in prison treatment units, 1994

INSERM BD: Drug addicts being treated in specialized centers, 1993-94

OCRTIS: Arrests for illicit drug use, 1995.

FND: Incarcerations for drug use as the main offense, 1995.

SESI: Drug addicts being treated in health and social structures in November, 1994.

- **November Drug Addiction Survey, SESI**

In this survey, drug addicts who are undergoing treatment in the health and social system (specialized drug addiction centers, hospitals, non-specialized social centers) are recorded. This is done in spite of whether or not the treatment began before or during the month of November (n = 20,392)

Drug addicts undergoing treatment are regular consumers of illicit products or misused licit products.

Rate of unanswered questions: 1.9% concerning professional activity, 12.9% concerning the RMI and 10.6% concerning health insurance.

C. Ethnographic approach to cannabis consumption in France

Dr. François-Rodolphe *Ingold

Mohamed **Toussirt

**Scientific Director at the IREP*

***Sociologist at the IREP*

32-36, rue Jean Cottin

75018, Paris, France

The object of this study was to apply ethnographic methods to cannabis consumption. This was done in order to explore the different ways of consuming this substance, the main social characteristics of its users, and possible health and social problems which may be associated with the different types of consumption. The paradoxical difficulty of this research consisted of exploring a phenomenon which is illicit, and at the same time commonplace and hidden. On account of the rarity of studies which have been conducted about this consumption, we opted to explore this phenomenon in the widest way possible, without a restrictive definition regarding frequency or quantities consumed. From a methodological point of view, we chose an approach which enables a vast amount of quantitative (from questionnaires) and qualitative (in the form of observations from the field and interviews) materials to be gathered and compared.

Method

Most of the information we have on cannabis consumption comes from administrative surveys, or studies which were conducted within particular institutional contexts (institutions where drug addicts are treated, the academic milieu, police data). This information does not claim to provide a complete picture of this type of consumption or its consumer. Therefore, it was interesting to conduct this study in a natural milieu, in order to obtain a less biased picture of cannabis consumers who are known to have relatively little contact with specialized medical-legal institutions.

The sample was constituted using the « snowball » method, which enables different environments and social networks to be explored. It also makes it possible to explore the great diversity in ways of consuming cannabis and its consumers' social situations. In spite of that, this method does not enable a representative sample to be constituted, but at least provides a guarantee that the sampling is diversified, or that the main scenarios are present. In practice, survey conductors were responsible for

starting from a known subject and then progressing from one person to the next until everyone in the chain had been surveyed.

The study itself was undertaken in several distinct geographical sites: Paris, the Parisian suburbs, Marseilles and the surrounding region, Rennes and the surrounding region, and two rural sites, the Lot and the Drome.

Main Results

Population: It is mainly a masculine population (71% men) which is clearly distinguished from that of drug users as seen in hospitals and prisons. The subjects average age is 28, but the age pyramid spreads out to include men and women over 50. Most of the subjects seem to be well integrated. Their educational level is high: 49% of them have achieved an upper educational level. On the whole, the parents social situation was not especially characterized by unemployment or family breakup.

Consumption: Most often, subjects report consuming cannabis every day, and several times per day (56%). In the other cases, there is a lower consumption frequency - once or several times per week (30%) or per month (14%). Therefore, on the whole, consumption is regular or relatively intense with minimal differences between men and women. Hashisch is the most frequently consumed substance (78%) although grass is preferred over resin (61%).

These different types of consumption are clearly distinguished from those known for drugs such as cocaine or heroin. Most often, there is a convivial and group dimension whether it be while consuming or purchasing. Let us point out the very clear existence of growing and sharing as ways of acquiring the drug.

Products which are consumed in association with cannabis are dominated by alcohol and tobacco. Other licit or illicit products with which consumers have experimented during their lifetime, are essentially heroin and cocaine for the oldest and ecstasy for the youngest. Cannabis consumption seems to be well controlled and rather stable on the whole. The majority of consumers do not or rarely call into question their use, and most often describe it as satisfactory. However, subjects are strongly preoccupied with the idea of dependency (61%). In respect to this, cannabis holds a special status. It is an illicit drug, not likely to lead to a state of dependency, and is even able to serve as a protection against dependency particularly with former alcoholics and drug addicts. The fact remains that a minority of users report being « addicted ».

Consumers and Consumption: The qualitative data gathered by interviewers through interviews and observations enable several points to be established. We will only summarize them here.

The circumstances around the first time a « joint » is used, are nothing spectacular. It most often occurs during parties or gatherings, and sometimes during the military service. Most often, there is no immediate effect or none at all. The effects which the consumer is looking for only appear later when the subject has begun to recognize the substance's psychotropic properties and begins to appreciate them. First, the subject discovers exhilarating properties, then learns to adapt his consumption. An entire learning process begins enabling the subject to master the substance's effects over time, making it possible to integrate this consumption into the his/her lifestyle.

Generations: Three distinct generations of users can be described. The oldest, over the age of 40, have essentially been consuming cannabis for a long time. Most often, they are well integrated socially although some have conserved a marginal or artistic lifestyle or activities.

The largest part of our sample is composed of subjects aging from 25 to 40. Many of them discovered cannabis in their neighborhood, lycée, or university. They function as a network and supply themselves as a group. Finally, those under the age of 25 often discovered cannabis quite young, at

the same time as their first cigarette, at a time when the drug in itself had become a sort of « playground » for many through movies and television. Among the latter, many consume ecstasy.

Conclusion

Our study confirms that cannabis is largely diffused on all social levels with no exception. As is the case for all psychotropics, cannabis consumption mainly concerns a population of young people and young adults, and seems to run out with age.

It also seems to confirm that cannabis consumption is little associated with severe health or social complications. This point puts cannabis in a very specific position compared to other drugs. However, we have also observed that certain consumption modes are very intensive, often associated with other licit or illicit drugs.

It appears to us that this so called « commonplace » phenomenon overshadows the place that cannabis has held as a powerful psychotropic.

Methodological References

This study was financed by the General Health Department and the French Monitoring Center for Drugs and Drug Addiction. It was conducted with contributions from: Catherine Flament (Marseille), Magguy Coulouarn (Rennes), Liliane Prévot (Cahors), Jean-Pierre Blanc (Montélimar) and Bernard Renucci (Paris and suburbs).

The global sample (N=1,087) was constituted from around one-hundred « snowballs », of different unequal size, some of which had gone beyond ten « waves » and others which had stopping after two or three. In addition, each survey conductor, was able to question around 10% of the subjects outside of this procedure in order not to exclude certain persons who were in specific situations or hard to access (those seeking treatment, AIDS patients, marginalized subjects).

The number of surveyed subjects per site is: 276 in Paris, 167 in the Parisian suburbs, 297 in Marseilles and its surrounding region, 153 in Rennes and its surrounding area, 50 in the Lot region and 51 in the Drome region. 31 survey conductors in all were recruited for this work, and were supervised by a coordinator in each site.

The pre-survey, started in December, 1995 was prolonged for several months. Gathering data was finished in April, 1996. Many difficulties were encountered, starting with getting access to the field and user's initially being distrusting.

Epidemiological monitoring of patients on methadone

Françoise *Facy

**Research Director at the INSERM U 302*

44, Chemin de Ronde

78110 Le Vesinet, France

The Context of the French Treatment System for Drug Addicts

Unlike other countries, France developed a specific treatment system for drug addicts starting in the 1970's. This system started with specialized state treatment centers whose main function was receiving drug addicts and/or their family and friends in order to provide them with medico-psychological, social, and educational treatment.

Since 1992, public authorities have encouraged these centers to prescribe methadone within the framework of global treatment (psychological, social, and medical) for those addicts having failed previous approaches. A consent-styled protocol governed how these centers functioned, in relation to a limited number of space and very precise selection criteria. Methadone has benefited from being put out on the market since 1995, and is being prescribed to patients by an increasing number of practitioners.

Preliminary Results

Preliminary results have shown large geographical diversity for subjects undergoing treatment, being more densely concentrated in areas which are already known for having AIDS and drug addiction problems.

On a toxicological and medical level, 95% of the addicts use heroin. It is the main substance taken by 85% of those being seen. 94% of them take (or have taken) it intravenously, an average of 24 injections per week. 37% of them used cocaine as an associated substance.

82% had previously undergone detoxification in an institution before starting the program. 47% of them had had an overdose, and 40% had attempted suicide.

An HIV serodiagnosis has been performed in 96% of the cases and shows positive for 29% of the subjects. 42% of them have an asymptomatic form, 34% have a minor clinical form and 12% a major clinical form.

On a socio-demographic level, the average age of admitted subjects is 32. It is higher than in other treatment centers.

It has been noted that women are slightly over-represented in comparison with other types of treatment (29%), and the majority of the subjects are French (94%). 48% of the patients are single, 38% live with someone, and 41% are parents.

The academic level is often higher than that of patients in other centers (27% have passed the « baccalauréat », or more). 69% of them are professionally qualified. 20% of the patients have a regular professional activity and 31% of them work intermittently. 20% benefit from the RMI.

On the level of those surrounding them, a strong family presence has been noticed (the presence of parents in 44% of the cases, of a spouse in 41% of the cases, and children in 28% of the cases). Only 12% live alone, 6% live in an institution, and 3% are homeless.

On a substitute level, 23% have already been included in a certified substitute program (out of 945 responses). 18% have taken methadone, and 43% have already taken buprenorphine.

On a level of monitoring patients, attitudes toward prevention have appreciably evolved. For risks of blood or sexual contamination 32% of the subjects have favorably evolved but 12% have unfavorably evolved.

In comparison with psychological data, 47% have favorably evolved and 17% have unfavorably evolved concerning anxiety. Patients with depression problems have shown improvement in 43% of the cases and have deteriorated in 17% of the cases.

Levels of family and social dissatisfaction have improved for 28% of the patients, but deteriorated for 11% of them.

Types of consumption are not always well discovered during treatment but the use of alcohol (n-54), opiates (n-74), benzodiazopines (n-35), and cocaine (n-11) were indicated.

Discussion

These results are temporary in comparison with a global treatment study which has been undertaken in centers with up to 5,000 patients where methadone is prescribed. However, some remarks may be formulated:

- On health and behavioral levels, there has been more favorable than unfavorable evolution.
- As with all types of treatment or prevention actions, there is a threshold of effectiveness which materializes by sub-groups of patients whose situation deteriorates on the level of becoming intoxicated or co-morbidity.

- A comparison with drug addicts from the same geographic areas without methadone provides indications about selection practices of subjects. These are marked by the seriousness of intoxicated behavior, relapses for treatment, and a high level of co-morbidity. On the other hand, a certain number of socio-cultural and professional characteristics seem more favorable and are known to be important factors in complying with treatment. They must be taken into account in order to assess how efficient the programs are.

Methodological References

Upon recommendation from the National Commission on Substitution Treatments, the Ministry of Health entrusted the INSERM with the task of conducting a national survey on patients undergoing treatment with methadone.

In a public health context, the evaluation objectives were:

-To quantitatively assess affected population groups.

-To characterize treated subjects and compare them with drug addicts who are usually seen in the treatment system.

-To research the existence of distinct sub-groups in comparison with monitoring treatment.

Questionnaires were established by the National Commission. Monitoring patients was organized according to questions asked when they began treatment, then asked every six months until they finished. 34 centers participated in this study from 1993 until September, 1995.

Descriptions of 1,077 subjects where made according to the grid established by the National Commission on Substitution Treatments.

11.4_Risk behaviours (e.g. injecting, sharing)

A. Administration intraveineuse

A. Intravenous Administration

Nearly 63% of the drug addicts undergoing treatment in the health and social system in November, 1994, had taken or were taking drugs intravenously. Among heroin addicts alone, this percentage goes up to 85%. Users who had or were currently taking drugs intravenously were older than the others. But, as noticed before, the most serious cases of drug addiction are found among the oldest subjects.

Methodological References

- ***November Drug Addiction Survey, SESI***

In this survey, drug addicts who are undergoing treatment in the health and social system (specialised drug addiction centres, hospitals, social centres which are not specialised in drug addiction) are recorded. This is done whether the treatment began before or during the month of November (n = 20, 392)

Drug addicts undergoing treatment are regular consumers of illicit products or misused licit products. The question of intravenous administration is independent of the main and associated products they have declared using.

Rate of unanswered questions : 12,4 % on intravenous drug use.

B. The attitudes and pratices of drug users who are confronted wiyh the risk of being contaminated by aids and hepatitis viruses

Dr. François-Rodolphe *Ingold, Mohamed **Toussirt

**Scientific Director at the IREP*

***Sociologist at the IREP*

32-36, rue Jean Cottin

75018 Paris, France

In this article, we present the preliminaries and main results of research that has been conducted on the behavior of drug addicts in two areas: injection and sexual practices. This research was performed using an ethnographic method in 5 sites throughout France: the Parisian suburbs, Lille, Marseilles, Metz, and Paris. It follows up on the first two related works which were carried out by the IREP in 1987-1988 and 1990-1991. These two research projects revealed rapid and progressive changes in drug addicts' behavior, and that risky practices have also persisted particularly concerning re-using syringes.

Population Description

The general characteristics of the 1,703 individuals surveyed are comparable to what is described in most samples of drug addicts, particularly the SESI's (drug addiction survey 1994 exercise). The average age of the subjects is 29, 72% are men and 28% are women.

It is significant that Lille is the city where the youngest subjects are found (both for boys and girls). This is probably due to the recent development of heroin use in Lille and the surrounding region.

The majority of subjects (52%) have a residence of their own, or live with their parents. This is the case in all of the sites except in Paris. It's in Paris that most of the unsettled subjects are found (47%). Conversely, subjects living in the suburbs have more stable living conditions. 76% of them report having a private or family residence.

In a very uniform manner, subjects are single (77%) and most often live alone (69%). Most often, they do not work and may or may not be on unemployment (69%). A large proportion of the subjects in our sample benefit from receiving the RMI (31%).

Aside from alcohol and medicine, the main substances taken are essentially heroin (99%), cannabis (72%), cocaine (66%), and crack (17%). These consumption patterns are identical in all of the sites except concerning crack which is usually found in Paris or the suburbs (respectively 43% and 18%). Its presence has also been reported in Lille (3%).

In a general manner, the frequencies for taking heroin are high (every day for 56% of the subjects). This enables discussion of a sample group which is dominated by very active, dependent users. Among subjects who reported taking a substitute product, Methadone and Moscontin were cited the most often. Other non-opiate substances such as Rohypnol were also cited.

Most of the subjects in all of the sites have been in prison at least once. The average number of times in prison varies from 3-4 depending upon the site, and the average total length of time spent in prison goes from 22-35 months.

Most of the subjects report having taken a cure in the past (an average of 2-4 times). The cure was most often administered in a specialized institution (33%), general hospital (26%), psychiatric hospital (25%), or by a general practitioner (18%).

Most of the subjects report having been tested for hepatitis B and C (72%) and AIDS (88%). This does not noticeably vary according to site.

Among those who have been tested, seroprevalence is globally 23% for hepatitis B, 47% for hepatitis C, and 20% for AIDS. The considerable proportion of HCV infected subjects is nearly identical in all of the sites. Differences are more varied for HIV seroprevalence: 6% in Metz, 5% in Lille, 36% in Marseilles, 26% in the Parisian suburbs, and 25% in Paris.

Injection Practices

Globally, 66% of the subjects surveyed report using a syringe to take their substance. 21% say that they have quit taking drugs intravenously, and 13% say they have never used a syringe.

Marseilles and Paris, are the two sites where the highest number of drug addicts take drugs intravenously. The lowest number is in Lille and Metz. However, Lille stands out as being very atypical compared to the other sites because heroin is mainly smoked instead of injected (51%).

Therefore, it is possible to say that a syringe is used in the global majority of cases in all of the sites, including Lille. However, other ways such as smoking and sniffing are currently being used in all of the sites except Marseilles.

Purchasing syringes in pharmacies has become the most common way of obtaining them. This is the case in all of the sites (from 90% - 97%), and we obtained identical results to those which were found in 1991. These purchases are described as systematic in the majority of cases (63%), although there are noticeable differences according to site.

Let us point out that purchasing syringes from Stériboxes is quite widespread, enabling users to have two syringes for the price of one. Purchasing and using Stériboxes was reported by a small majority of users (on average 59%), a bit less in Paris than in the other sites (37%). The two main sources from which users obtain syringes are pharmacies, and exchange programs. Users report using an average of 40 new syringes per week.

Re-using one's own syringe has remained the largest and most constant phenomenon since 1988. We obtained the same proportion of subjects declaring that they re-use their own syringes (75%). The only noticeable modification concerns the number of times they re-use the syringe. Syringes are currently used an average of two times (2-4 depending upon the site). Syringes were used an average of 4-5 times in 1988, and 3-4 times in 1991.

The question which was asked of users situated « sharing » within the context of other possible ways of « sharing », be it for injection materials, water, or the substance. Answers showed that a high number of users reported sharing all injection materials except syringes, as well as water and the substance itself. Syringes are the least shared objects (13%), whereas the substance, spoon, cotton, lemon, and water were described as being widely shared (from 54%-70%).

It is important to understand here that even if users have perfectly understood the importance of not sharing syringes, they are much less vigilant when it comes to the substance, spoon, cotton, lemon, and water.

We have gathered a certain number of elements concerning the last date of injection for users. Information about the last injection provides us with an instant image of drug user's practices starting with this unique, recent, and common event. In most of the cases, heroin was the injected substance (88%), which was more rarely the case for cocaine, crack, or medicine.

In most cases, the subjects used a new syringe (78%). A re-used syringe was used in 20% of the cases. There was no significant difference between sites. When syringes were re-used, in 86% of the cases they were personal syringes and non-personal in 14% of the cases. This data alone illustrates the association between re-using and « sharing » syringes quite well.

In most of the cases, re-used syringes were cleaned (79%), or more rarely disinfected (32%) before use. It should be highlighted that users distinguished between « cleaning » and « disinfecting ». In most cases where syringes were disinfected, bleach was the most commonly cited product (61%).

Sexual practices

This will just be a brief summary. Over three-fourths of the subjects said they had had at least one sexual partner during the year. This was the case in all of the sites for both men and women. The results gathered here were comparable to results gathered in previous studies.

The last sexual partner was described as being the usual partner in most of the cases, especially for women. These were rarely partners of the same sex, 2%-3% among men, and 2%-10% among women according to the site. In 35% of the cases they used injectable drugs, a comparable proportion to that which was found in 1990-91.

Let us point out that there was a clear difference between men and women at this level. Mens' partners were much less often injectable drug users than womens'. For men, in 25%-37% of the cases the last sexual partner was addicted to drugs. For women, the last sexual partner was addicted to drugs in 41%-60% of the cases according to the site.

The use of condoms, is certainly an elements that has greatly evolved since the mid 1980's. In 1987, using condoms concerned 22% of our sample, and concerned 45% of our global sample three years later in 1990/91. Half of them (23%) said they used a condom on a regular basis. We noticed that using condoms was strongly associated with serological status. 43% of the seropositive, or ill, subjects said they used them compared to 15% for seronegative subjects. This confirmed that there is an altruistic management of contamination risks among drug addicts. However, the qualitative data gathered underlined a certain discrepancy between risk management depending upon syringes and sexual life.

A small majority of the subjects reported having used a condom over the last 12 months (an average of 58%). This proportion was slightly superior to what was found in 1990/91 (45%). In a little more than one-half of these cases, using condoms was described as systematic (34%).

Sexual Work

An average of 12% of our subjects reported doing or having done sexual work. This proportion was comparable, although slightly weaker, to what we found in 1990/91 (17%), and varied little according to the site (from 5% in Metz to 17% in Marseille and Paris). In approximately half of the cases, this work was described as « regular » (55%), and mostly concerned women. Using condoms was reported in 76% of the cases.

Conclusion

The data we have, which have just been briefly touched upon here, show that risky practices remain dominated by re-using syringes, and that this is in a context where sharing other injection materials (cotton, spoon, water) has little evolved.

The rapid and recent increase in the proportion of subjects who were contaminated by the hepatitis C virus, should be interpreted as the result of these partial changes in user's behavior.

We observed that drug addicts were relatively little informed about the risks involved in re-using syringes and sharing injection materials. This was the same for the hepatitis viruses. Current prevention and communication strategies should be rapidly adapted to this situation.

Methodological References

This research was jointly financed by the General Health Department and the National Agency for AIDS Research. It was performed with contributions from Taoufik Adohane (Parisian suburbs), Jean Harbonnier (Lille), Daniel Barraud (Marseille), and Philippe Milburn (Metz). Claude Jacob

(CHS Jury-les-Metz), and Hugues Lagrange (CNRS) who contributed in defining the methodological protocol. The statistical processing of data was done by Azzedine Boumghar.

From a methodological point of view, subjects were selected using the « snowball » method on the street level, and according to a random protocol on the level of treatment institutions. The main criterion retained was the consumption of injectable drugs, whether they be injected or not. As a result, and unlike previous studies, our sample included a small number of subjects who no longer used, or had never used a syringe.

Our sample was made up of 1,703 subjects, 841 of whom were recruited on the street level, and 862 on the level of treatment centers or prevention structures (syringe exchange bus, and boutiques). Therefore, our sample was partially made up of subjects from the street and partially from institutions (at least globally). Data gathering (June, 1995-January, 1996) was conducted using a double approach: quantitative (questionnaire), and qualitative (interviewers journals, field observations, interviews).

11.5_Risk and protective factors

A. Drug consumption among adolescents

No links have been highlighted between drug use in adolescent students and their social and academic situation. However, the older ones, who « go out » (street, cafés, nightclubs,...) and those who express general dissatisfaction, are more clearly at risk than the others. Addiction to smoking, alcohol consumption, truancy, psychological problems, and violence, are indicators of risks that are frequently associated with repeated drug consumption.

Methodological References

- **Enquête Santé des Adolescents, INSERM-U169**

This is a representative sample taken on a national level, of young students in the secondary cycle in public schools (junior high and high schools) from 11 - 19 years of age (n = 12,391). The rate of unanswered questions is between 1% and 3% for drug consumption.

This is for lifetime consumption of seven classes of substances: hashish, cocaine, heroin, amphetamines, inhalants, hallucinogenic, medicine used to drug oneselfRepères méthodologiques

B. Getting over drug addiction

There are many forms of getting over drug addiction, and this is one of the most poorly understood aspects in this field. It is true that in both the law enforcement sector and the health and social sector, it is rare to see drug addicts who are over the age of 40. However, can this be taken as proof that they ÇÊget overÊÈ being addicted to drugs? The notion of ÇÊgetting overÊÈ drug addiction should be used carefully. It varies greatly to authors and those directly concerned, and encompasses numerous conceptions of what can be understood by getting over drug addiction.

There are no real studies designed to evaluate what happens to drug addicts. However, some related studies have been conducted among small heterogeneous groups of drug addicts.

In 1977, P. Moutin and G. Briole conducted a survey on a population of 100 conscripts who had been hospitalised for consuming an illicit drug during their military service. They were able to analyse 33 files. When establishing the prognosis, the authors took into account drug consumption and social and family integration. Although moving toward abstinence was made easier by the desire to become independent of drugs, the future of drug addicts was also related to the interaction between individual aspects (gender, age, family, emotional relationships) as well as external elements (treatments, legal measures, etc.). They highlight the importance of family, as well as being in a stable relationship. Integration and professional stability are also first-rate factors for a favourable prognosis.

In 1978, F. Curtet and F. Davidson attempted to find 150 drug addicts who had belonged to one of two groups, after a 2-4 year period had elapsed. One of the groups included imprisoned individuals and the

other was made up of individuals who had been seen in particular institutions. The monitoring study was based upon one-half of these individuals. The evaluation criteria which were used took into account illicit drug consumption, and mental health and psycho-social prognoses. Having a high level of education, and parents who were still together, were associated with favourable developments. In the prognosis for emotional development, the authors also highlighted the importance of being in a stable relationship, as well as the importance of having basic therapeutic support.

In both of these research projects, drug addicts were classified according to what they had become. The categories turned out to be more or less equivalent - 1/3 of them had favourably evolved, 1/3 were in an intermediary situation, and 1/3 had remained in the same situation or it had deteriorated.

In 1987, G. Cagni supervised a study to find out what had become of 107 drug addicts who had stayed in an after-care centre between June, 1982, and November, 1986. They were able to do this with 49 of these individuals. The evaluation focused upon three fundamental factors: getting off of or remaining addicted to a substance, a health prognosis and a psycho-social prognosis (affective, socio-professional stabilisation). Factors such as meeting a significant other, where one lives, and having a balanced relationship with oneÕs family, all played an important role in the lives of surveyed drug addicts who had favourably evolved. More than one-half of them had favourably evolved, one-fourth of them were in an intermediary situation with a favourable prognosis, and the others had not undergone many real changes.

R. Castel supervised a research project on the subject of getting off of drugs. This research was conducted among 51 individuals, who had been recognised drug addicts and had ÇÊgot offÊÈ of drugs. They had no longer been under the hold of drugs for a period of two years or less. It appears that the majority of drug users, even heavy users, eventually get off of drugs (the mortality rate due to drug use was estimated at 10%). According to this study, getting off of drugs depends as much upon coming into contact with help, and its quality, as the point in time at which the drug addict gets help in his personal experience with drugs. In addition, deciding to get off of drugs is not always followed up by success, and ÇÊrelapsesÊÈ are frequent. Thus, controlled intermittent consumption and moving towards other substances may be considered as getting off of drugs because an entire lifestyle which has been affected by drugs is left behind. Some are able to get off of drugs without the help of any specific institution, but they often have spent a lot of time in institutions in their past (several institutions, prison). Others succeed in getting off of drugs alone. There are probably many of these cases if we go by the number of drug addicts who have never been officially treated.

Y. Charpak and F. Benjanin (EVAL) created a model based on a fictitious cohort of heroin users in Ile-de-France, by simulating this on computer. This was done using data provided by different surveys because no such cohort had been developed in France. In the most optimistic scenario (annual mortality rate of 1% excluding AIDS, definitive annual abstinence of 10%, and sharing syringes at only 10%), only 50% of heroin addicts would be abstinent and not carrying the HIV virus after ten years of use, 16% would be infected with HIV and 10% would have died.

C. Alcohol, tobacco, and various illicit drugs use among young people

Marie *Choquet, Jean-Dominique **Favre, Sylvie ***Ledoux, Gilles ****Azoulay

**Director of Research at the INSERM U 169*

****In charge of research at the INSERM U 169*

16, avenue Paul Vaillant Couturier - 94807 Villejuif Cedex, France

*** Professor of Psychiatry at the Val de Grâce Hospital*

74, boulevard Port Royal - 75005, Paris, France

*****Psychiatrist,hospitalpractitioner*

In order to understand the consumption process, which goes from experimenting to abusing, or from using licit products (alcohol, tobacco) to consuming illicit substances (cannabis, inhalants, cocaine, heroin), general population surveys are essential. They enable studies to be made on the size of the phenomenon and associated factors. These are essential in establishing priorities for public health actions and choosing targeted populations and methods of intervention. The main results of these surveys provide elements which are helpful in answering the following questions about which those working in the fields of health and prevention are wondering.

Is there an increase in the use of substances? It is not possible to conclude that there has been an increase in the use of substances, as trends vary per substance. There has been a drop in regular alcohol consumption, but an increase in seeking to get drunk. Cannabis consumption and female addiction to smoking have increased while the use of « hard » drugs has stabilized. However, it is possible to conclude that consumption models are being modified. At the present, the priority of prevention operations should mostly focus on female addiction to smoking, cannabis use, and the repeated search for drunkenness among boys. This is particularly important since recent studies have shown that for boys, becoming drunk « alone » is linked to suicide attempts.

Is there a classic profile of « young persons at risk » facing consumption? The answer is not unequivocal. Those who consume alcohol are more often of masculine gender, French origin, and live in a rural area. Smokers are most often students in professional lycées, having repeated a year. Cannabis consumers are most often the children of executives and/or divorced parents, but consumption (of any product) is not linked to the father's professional activity. Moreover, socio-demographic factors have relatively weak influence with regard to relational and personal variables. Consumers are characterized by an intense informal social life, while formal activities (cultural or athletic) have little correlation. In addition to this, a feeling of solitude and depression can be added for smokers, and female smokers in particular. Thus, prevention operations should not only focus on socially fragile populations, but should also include rural populations and executives' sons. In addition, the depressive component involved in smoking addiction should modify prevention approaches in this field.

Is exclusion from schooling a risk factor? At equal ages, young individuals in integration programs (CFI/PAQUE) smoke more than students, but consume less drugs (it must be remembered that users are more often the children of executives in the academic milieu). However, their alcohol consumption level is equivalent. Regardless of the type of product, they developped regular consumption habits well before their exclusion from school. They were already at risk during their schooling.

Is consumption a way of expressing that an individual is having problems? Consumption (particularly for tobacco and drugs) is linked to other behavior such as absenteeism and committing offenses regardless of the student's age or gender. In addition to this, it has been noted that there is a link between tobacco addiction and depression particularly among girls. As far as alcohol is concerned, it's not the quantity, but rather the mode of consumption that comes into play. Thus, young people who drink in a party type atmosphere are less likely to be at risk (particularly for suicide attempts) while

those who drink alone, « to forget » are four times more at risk. Conducting research to study consumption models and their signification should be developed.

Is there an escalating process? Taking one substance increases the risk of taking another. However, associating substances does not mean that taking one substance leads to (or is the cause of) taking another substance. In view of the multiple associations between personal problems and using substances, the hypothesis that consumption is linked to the same factors has even been forwarded. In addition, it should be noted that 30% of those who regularly consume alcohol and tobacco have never experimented with an illicit drug, and the majority of cannabis smokers (95%) does not take « hard » drugs.

Methodological References

We took several juvenile population surveys into account, particularly young students in the second cycle (departmental surveys in 1978 and 1988, national survey in 1993), 16-25 year olds concerned by the CFI-PAQUE reintegration program (1993), and boys who are of age for national service in recruiting centers (1993).

11.6_Different drug profile

A. Substances taken

As in previous years, differences noted by legal, health, and social institutions in the various substances taken by populations, have remained similar. Two-thirds of those arrested for illicit drug use are cannabis users, while the majority of drug addicts undergoing treatment in the health system are heroin addicts.

The health and social system records regular drug addicts who consume illicit drugs, or misuse licit drugs, on a regular basis. In the law enforcement field, both occasional and regular users are apprehended, but only illicit drug use is counted.

Comparing the respective percentages of each substance used with arrest (since 1980), and treatment (since 1987) data, has led to the belief that the situation is evolving. Among those arrested, the percentage of heroin users has slightly decreased while the number of cannabis users has grown. A slight increase has been noticed in the number of both heroin and cannabis users in the health and social system. The percentage of cocaine or psychotropic medicine users has remained relatively stable among persons who have been arrested or undergone treatment.

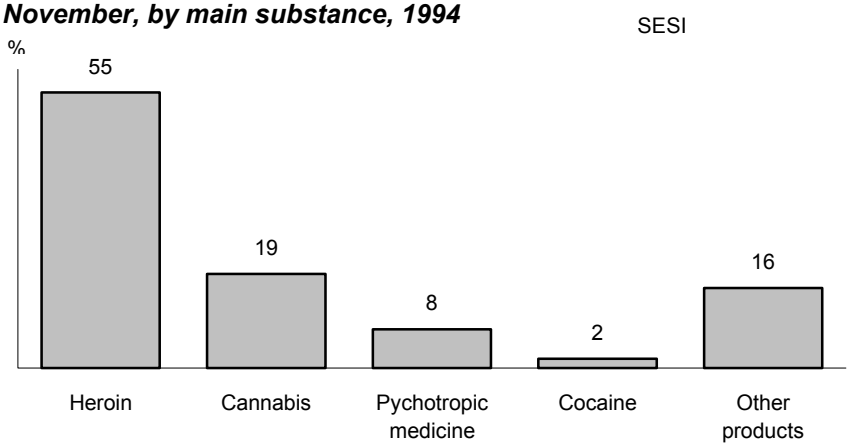
Drug addict treated in the health and social system in November 1994 and drug use-related arrests in 1995, by main substance, gender and age

OCRTIS, SESI

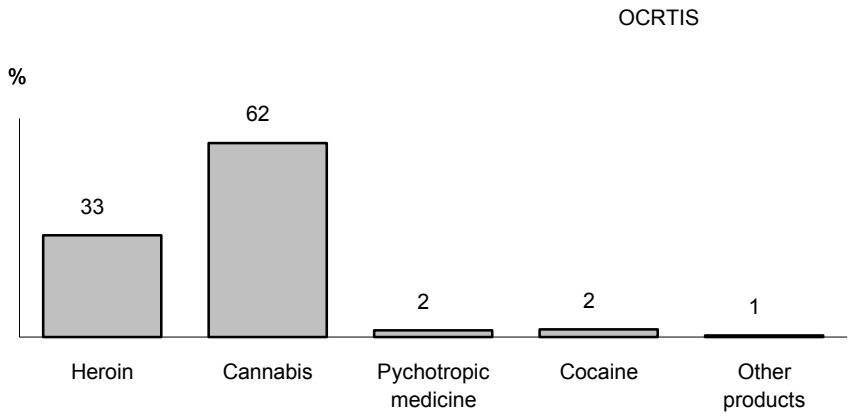
Main substance	**% of women**		**% of men**		**Average age**	
	Treatment demands	Arrests	Treatment demands	Arrests	Treatment demands	Arrests
Heroin	25,3	16,2	74,7	83,8	27,9	27,2
Codeine derivatives	27,4	-	72,6	-	30,1	-
Morphine, opium and other opiates	27,8	-	72,2	-	30,2	-
Cannabis and derivatives	16,7	6,8	83,3	93,2	24,0	22,8
Ecstasy	-	16,0	-	84,0	-	23,4
LSD *	13,2	-	86,8	-	23,5	-
Psychotropic medicine	36,6	-	63,4	-	30,1	-
Cocaine	24,1	17,0	75,9	83,0	27,8	28,2
Crack	12,6	14,6	87,4	85,4	28,2	28,4
Glues and solvents	28,6	-	71,4	-	24,3	-
All substances	**24,6**	**9,8**	**75,4**	**90,2**	**27,7**	**24,2**

* number of of cases below 100

Drug addicts treated in the health and social system in November, by main substance, 1994



Drug use-related arrests, by main substance, 1994



The main substance taken noticeably varies according to the user's age. The oldest are more seriously addicted, and usually take heroin, other opiates, psychotropic medicines, cocaine, or crack. The youngest mainly use cannabis, but also may use LSD, glues, or solvents.

The types of substances taken by those undergoing treatment in the health and social system differ according to the type of establishment. In hospitals and specialized centers, more than half of the subjects are heroin addicts. They respectively represent 56% and 66% of those treated, in these two types of structures. Most of the subjects using cannabis as the main substance are treated in social centers, where they represent 47% of the drug addicts undergoing treatment in those establishments.

Most subjects undergoing treatment for the first time in the health and social system are cannabis users, using other substances less. This applies particularly to heroin and psychotropic medicines. However, these users are also generally younger.

Users of some substances are little or poorly uncovered by these two information systems. Cocaine use, which represents around two percent of those arrested or undergoing treatment, is probably under-estimated. Arrested cocaine users are frequently polydrug users and are recorded as heroin users. In addition, it is known that a large percentage of cocaine users are socially and professionally well integrated (social/professional environments which are difficult for law enforcement services to penetrate). If they seek treatment, they prefer to see a doctor.

Crack use, which appeared in metropolitan France at the end of the 1980's, has been growing strongly since 1990. Although the percentage of arrested or treated users is minimal, it is situated around one percent. Crack use is most particularly concentrated in Paris and in the French West Indies.

After declining until 1989, LSD use has strongly risen since 1993 among arrested individuals, even if it only makes up 1% of those arrested. It has remained stable among those seeking treatment. In addition to this, a strong increase has been observed in the number of ecstasy users since 1990. This substance, as well as LSD in a smaller measure, is mainly taken during « rave parties ». Ecstasy use has also spread to nightclubs and is used in some private parties. Whatever the context, the population which uses these types of substances is generally young and well integrated, and makes up a very small percentage of those seeking treatment in specialized health and social structures for drug addiction.

Methodological References

- **November Drug Addiction Survey, SESI**

  In this survey, drug addicts who are undergoing treatment in the health and social system (specialized drug addiction centers, hospitals, health centers which are not specialized in drug addiction (CHRS, clubs and prevention teams)) are recorded. This is done whether the treatment began before or during the observation period (during the year, or the month of November). (n = 20, 392)

  Those drug addicts who are treated, *regularly use* illicit products, or *misuse* licit products.

  Rate of unanswered questions: 2.5% concerning the main substance taken.

- **The National File of Perpetrators of Drug-Related Offenses, (OCRTIS)**

  Information on drug-use related *arrests* over a one year period is found in this file. All illicit substances are concerned, for occasional or regular use. Occurrences, and not people, are listed. Some users may have been arrested several times in a one year period.

B. Polydrug consumption and intravenous administration

The November survey of drug addicts undergoing treatment in the health and social system enables information to be gathered concerning the consumption of different products, as well as intravenous drug use.

It was noted that of all drug addicts treated in November, 1994, globally 62% of them declared having taken another substance. However, this frequency may be considered minimal. Indeed, the way that the questions are designed does not make it possible to distinguish between those who only took one substance and those who did not answer the question. It appears that among all recorded subjects, the percentage of polydrug addicts has been on the increase since 1989.

The rate of polydrug addicts varies according to the substance taken, going from 53% among cannabis users, to 75% among psychotropic medicine users.

Proportion of polydrug users among treated drug addicts in November 1994

SESI

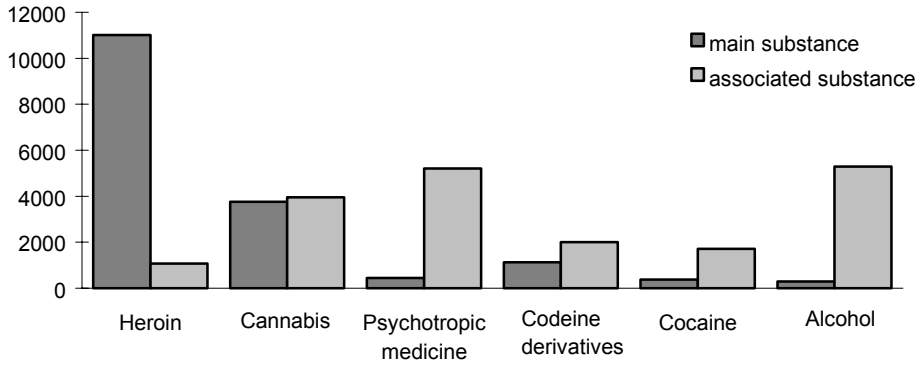
Substance mainly used	% of poly drug users
Heroin	63
Codeine derivatives	72
Morphine, opium and other opiates	57
Cannabis and derivatives	53
LSD	74
Psychotropic medicine	79
Cocaine	76
Crack	68
Glues and solvents	64
TOTAL	**62**

Alcohol and psychotropic medicine are the two most commonly associated substances. They are both used as an associated substance by approximately 42% of polydrug addicts. Cannabis is another frequently associated substance, concerning 31% of polydrug users. However, it has been noticed that these proportions fluctuate according to the main substance taken. Alcohol, for example, is used as an associated product by over 75% of those using cannabis as a main substance. However, it is difficult to know whether this is just light use or actually alcohol abuse.

Among drug addicts who are undergoing treatment, some products such as cocaine and psychotropic medicines are used as associated substances (by respectively 14% and 41% of polydrug users as opposed to two percent and eight percent when they are used as a main substance). On the contrary, heroin, used by 55% of drug addicts as the main substance, is only used as an associated substance by nine percent of polydrug users.

Number of drug addicts treated in November 1994 by substance taken

SESI



More than 63% of the drug addicts undergoing treatment in the health and social system in November, 1994, had taken or were taking drugs intravenously. This percentage was 85% among heroin users alone. Former, or current intravenous drug users, are older than the others, but as has already been noted serious drug addiction is most often found in older subjects.

Methodological References

- **November Drug Addiction Survey, SESI**

In this survey, drug addicts who are undergoing treatment in the health and social system (specialized drug addiction centers, hospitals, health centers which are not specialized in drug addiction (CHRS, clubs and prevention teams)) are recorded. This is done whether the treatment began before or during the observation period (during the year, or the month of November). (n = 20, 392)

Those drug addicts who are treated, *regularly use* illicit products, or *misuse* licit products. Any subject who has mentioned using from one to three associated substances is considered a polydrug addict. Those not haven't mentioned using associated substances may be addicted to only one substance, or may be polydrug addicts who did not answer the question. This type of questioning probably underestimates the true number of polydrug addicts.

* Alcohol is only listed as a main substance in specialized centers. It is listed as an associated substance in all establishments.

Rate of unanswered questions: 12.4% concerning intravenous drug use.

Chapter 12.Social and Cultural Aspects

12.1_Social processes, cultural context

unavailable

12.2_Attitudes and public opinion

The Baromètre Santé (Health Barometer) 1993-1994 contained two questions related to the general public's opinion of drugs. After AIDS, drug addiction was the number two concern cited as a high priority for the health of the French today. Just as in 1992, it came before alcoholism and cigarette addiction.

81% of those who answered the survey thought that consuming hashish constituted an important risk to an individual's health. Among them, nearly half considered this risk to be serious.

The general public seemed to have an understanding attitude towards drug addicts whom they considered to be ill (82%) and thought they should have access to the best possible treatment (91%). However, they were frightened by drug addicts because they appeared to be aggressive and dangerous in 59% of the cases. The general attitude is more directed towards understanding than repression: only 28% thought that they should be punished.

In conclusion, 22% of those surveyed considered that drugs should be sold without restrictions. This opinion was more frequent than in 1992 (+12%).

Methodological References

- ***Baromètre Santé (Health Barometer) 1995, CFES***

Representative sample of the population ageing from 18 - 75 years (n = 1,993) consulted in December ,1995.

Chapter 13.Drug-related Problems and Consequences

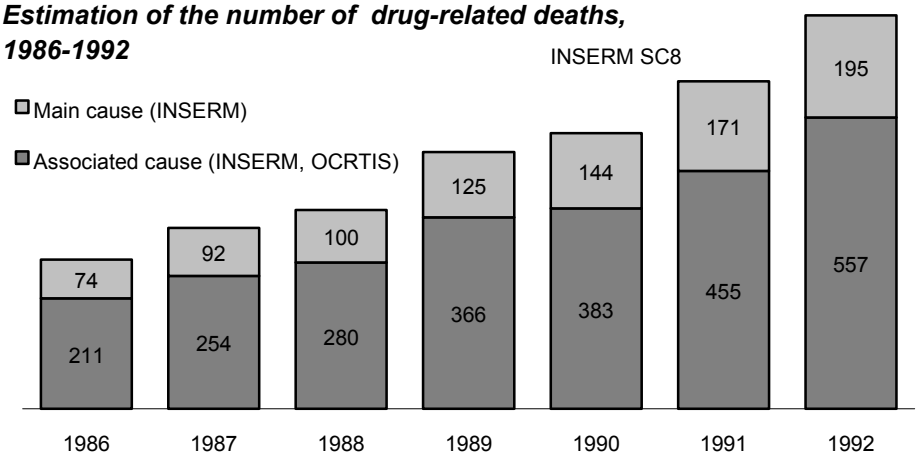
Chapter 13.Drug-related Problems and Consequences

13.1_Mortality

As a result of a lack of longitudinal studies, little is known about drug addicts and mortality. Of all drug-related deaths, which only account for part of drug addict's mortality, the deaths of intravenous drug users from AIDS, and overdose-related deaths reported by police and gendarmerie departments may

be noted. In addition to this, information taken from death certificates by the INSERM makes it possible to record deaths for which drug addiction is mentioned as the main or associated cause.

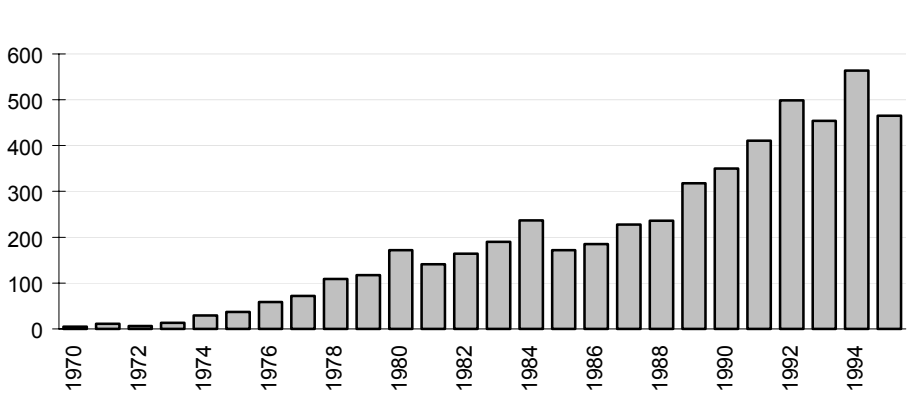
Estimation of the number of drug-related deaths, 1986-1992



An estimated 1,007 drug addicts, reported to have had AIDS, died during 1995. After increasing until 1993, this number has remained relatively stable since.

465 overdose-related deaths, 63% of which occurred at home, were brought to the attention of the OCRTIS in 1995. In 83% of these cases, heroin was the substance causing death. Compared to previous years, there were more deaths related to combining alcohol, medicine and heroin. The frequency of deaths due to medicine has been increasing since 1989 and reached 15% in 1995. Most of these deaths are a result of absorbing multiple medications.

Overdose-related deaths known by "Police" and "Gendarmerie" departments, 1970-1995



Although overdose mortality rates are based upon rare events, for which the quantity of all inclusive information is uncertain (a valid reason for being cautious when interpreting numbers), their cartography from 1990-1994 highlights large regional disparities and gives information about their evolution over a five-year period.

Several signs show that cases of overdose-related mortality increased from 1990 to 1994, but if 1995 is taken into account it would appear as though they were stabilizing over the last four years. This growth may reflect an increase in the number of drug addicts, but may also be a sign of deterioration in their state of health, or even sign of evolution in patterns of taking substances. It is also possible that this increase may be partially due to the fact that these types of deaths are being better noted.

The number of regions in which the mortality rate for drug addicts was less than two deaths per million inhabitants, dropped in half between 1990 and 1994. In 1994, this concerned only the northwest part of France. In addition, it has been observed that the overdose-related mortality rate all over France went from six to ten deaths per million inhabitants, a 65% increase, in just five years.

In fact, these numbers reflect a very unequal distribution of overdose-related deaths. Ile-de-France accounts for more than half of them each year. In 1990, Ile-de-France, and the Provence-Alpes-Côte d'Azur region were the two regions having the highest mortality rate. However, their other mortality rates, respectively 20% and 10% show a less noticeable increase than the national average. On the other hand, in the Alsace region the rates multiplied by three in a five-year period, and by 1993 were nearing those of Ile-de-France. Lorraine and the Nord-de-Pas-de-Calais region, experienced similar evolution on a smaller scale, and figured among the regions having the highest rate of overdose-related deaths in 1994.

Methodological References

- **Declarations of AIDS Cases, RNSP**

AIDS is an illness for which a mandatory declaration must be made. AIDS cases are counted according to the year when they were diagnosed, as well as AIDS deaths by the year when they occur.

There is a 20% sub-declaration rate for AIDS deaths, and a period of time passes between when the death occurs and when it is declared to the RNSP.

- **National File of Perpetrators of Drug-related Offenses, OCRTIS**

Police and gendarmerie departments record overdoses in the strictest sense of the word as well as various accidents which are directly or indirectly linked to how the substance was administered. The departmental overdose-related mortality rates are standardized by age and gender. When the number of deaths from overdose and the departments population are both relatively small, rate fluctuations may be very large from one year to the next.

- **Using information from death certificates, INSERM-SC8**

Using information from death certificates enables the number of deaths which are directly linked to drug use to be calculated, and those for which drug addiction is mentioned as an associated cause. The latter are deaths of drug addicts which are not linked to using drugs, or were not recorded as such.

Whatever information source is used, there is a sub-declaration rate for the number of overdose-related deaths, as well as an under-estimated number of deaths for which drug addiction may be considered to be an associated cause (particularly in suicide cases, car accidents, and other types of violent death).

13.2_Morbidity

The state of health of drug addicts is little understood from existing surveys. The little information we have more particularly concerns infectious morbidity (especially HIV infection, AIDS, and infection with the Hepatitis C virus).

HIV seroprevalence varies considerably by age, how long one has been addicted to drugs, ways in which drugs are taken, and consequently by the type of treatment structure since each one is differentiated with a different type of population.

The HIV serological status of drug addicts who are undergoing treatment is better known each year. However, it is necessary to be careful not to generalize results to include the entire drug addiction population. This is important because of the declarative character of provided data and the fact that possible HIV and Hepatitis associated pathologies are in themselves the initial reason for which a certain number of persons turn to help from treatment structures. This would imply that seropositive subjects are over-represented, particularly in hospitals.

HIV seroprevalence by different sources, 1993-1995

Survey	Time period	Sample size	Coverage	Drug addicts for whom HIV serology is known	Seropositive drug addicts
Hospitals (psychiatric services, general medicine and medical specialties) (SESI)	November 1994	6 626	Non specified coverage in hospitals	69%	36%
Specialized centers (SESI)	November 1994	9 282	Total coverage in the 216 specialized centers having answered the survey	69%	20%
Specialized centers (INSERM U 3102)	1993-1994	2 011	Total coverage in the 10 voluntary specialized centers	60%	21%
Specialized centers in prisons (INSERM U3102)	1994	2 175	Total coverage in the 10 specialized centers in prison	89%	14%
Inpatient specialized centers (CESES)	2nd semester 1995	1 686	Total coverage in the 92 inpatient specialized centers having answered the survey	92%	12%

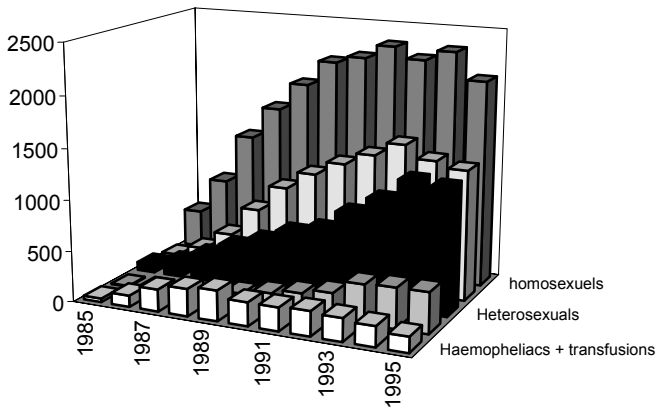
* Among those for whom serology is known

It appears that out of all drug addicts undergoing treatment, around 20% of them are seropositive. However, a 12 to 36% margin may be retained for seropositive drug addicts among those whose serology is known and who are undergoing treatment. With former or current intravenous drug users, there is a higher rate of seropositivity. A drop in the rate of HIV seropositivity among drug addicts has become apparent since 1991. Indeed, there was a drop of approximately 20% in the frequency of seropositive drug addicts undergoing treatment in hospitals and specialized centers between 1991 and 1994. In specialized inpatient centers, the rate of decrease was along the same order between 1993 and 1994, then increased the following year.

Drug addicts have been particularly affected by the AIDS epidemic. The latter first developed in homosexuals, then among intravenous drug users for whom the number of new cases reported grew very rapidly until 1990. Since the end of the 1980's, the highest growth rate for AIDS cases has been observed in the heterosexual population. It appears that the epidemic is stabilizing at the present, particularly among homosexuals and drug addicts. However, confirmed AIDS cases reflect infections contracted in the past, and not how new cases of contamination are currently evolving.

Up until March 31, 1995, 41,058 AIDS cases had been recorded since the outbreak of the epidemic (62% of these persons are known to have died). Out of all AIDS cases, 28% are either directly linked to drug addiction, or indirectly to a partner(s), or to a mother transmitting the virus to her child. The number of new cases diagnosed in 1995 among the drug addict population is estimated to be around 1,450, taking into account late declarations and a sub-declaration rate.

Number of reported AIDS cases per diagnosis year and by transmission group, 1985-1995 RNSP



The only information available concerning Hepatitis C is on drug addicts treated in specialized centers and hospitals in November, 1994. However, the serological status of more than half of them is unknown because they have either not been tested, have been tested but the test results are unknown, or finally because information about this variable was not provided. Among those for whom their serological status is known, 49% are seropositive for Hepatitis C. This rate is 57% among drug addicts having taking drugs intravenously.

Methodological References

- **November Drug Addiction Survey, SESI**

In this survey, drug addicts who are undergoing treatment in the health and social system (specialized drug addiction centers, hospitals, non-specialized social centers) are recorded. This is done in spite of whether or not the treatment began before or during the month of November (n = 20,392)

Drug addicts undergoing treatment are regular consumers of illicit products or misused licit products.
Results on HIV and HCV are only available from specialized centers and hospitals.

According to retained hypothesis concerning HCV prevalence in persons for whom serology is unknown, anywhere from a 25% to 74% margin of HCV seropositive drug addicts may be obtained.

- **Half-yearly Survey among Specialized Inpatient Drug Addiction Treatment Centers, CESES**

Drug addicts residing in specialized inpatient drug addiction treatment centers (collective, therapeutic apartments, relay apartments) subsidized by the DGS, are counted. 92 out of 106 existing centers responded to the survey in the second semester of 1995 (n = 1,686).

- **Declarations of AIDS Cases, RNSP**

AIDS is an illness for which a mandatory declaration must be made. AIDS cases are counted according to the year when they were diagnosed.

Data from 1994 and 1995 have been rectified.

There is a 15% sub-declaration rate for all the transmission groups, and a time period between when the illness is diagnosed and when it is declared to the RNSP.

The free number for AIDS Info Services is 0800 36 66 36.

13.3_Social problems : *professionnal activity and social insurance*

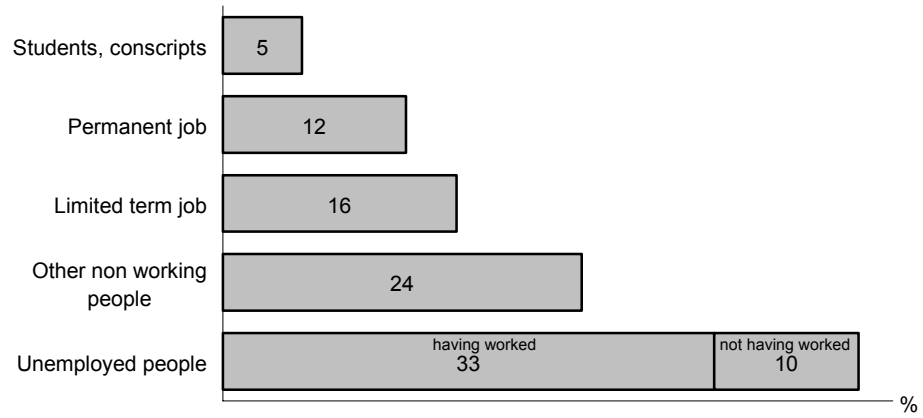
Information on professional activity and health coverage are only known for those drug addicts undergoing treatment in the health and social system during the month of November. It is therefore important to be careful when extrapolating results to the entire drug addiction population.

Integrating drug addicts into working life has not been highly successful. 72% of the drug addicts treated in November, 1994, had no professional activity, with 60% of them unemployed. In addition,

those who did have jobs were in a precarious situation, because more than half of them only had a fixed-term contract. The highest percentage of non-working drug addicts was found in social centers, but those who were undergoing treatment there were generally younger.

Finally, although drug addicts declare that they have health insurance in nine out of ten cases, eight percent of them - most particularly those under 25 years of age - have no health coverage. One quarter of those drug addicts who are undergoing treatment receive RMI payments. The highest percentage of RMI beneficiaries are found among unemployed persons that have already had a job.

Professional activity for drug addicts treated in the health and social system in November 1994 SESI



According to recent ethnographic studies (using a field approach) it seems that compared to previous years, drug addicts are experiencing intensifying poverty and unstable living conditions.

Methodological References

- **November Drug Addiction Survey, SESI**

  In this survey, drug addicts who are undergoing treatment in the health and social system (specialized drug addiction centers, hospitals, non-specialized social centers) are recorded. This is done in spite of whether or not the treatment began before or during the month of November (n = 20,392)

  Drug addicts undergoing treatment are regular consumers of illicit products or misused licit products.

  Rate of unanswered questions: 1.9% concerning professional activity, 12.9% concerning the RMI and 10.6% concerning health insurance.

13.4_Legal problems

A. Arrests for illicit drug use

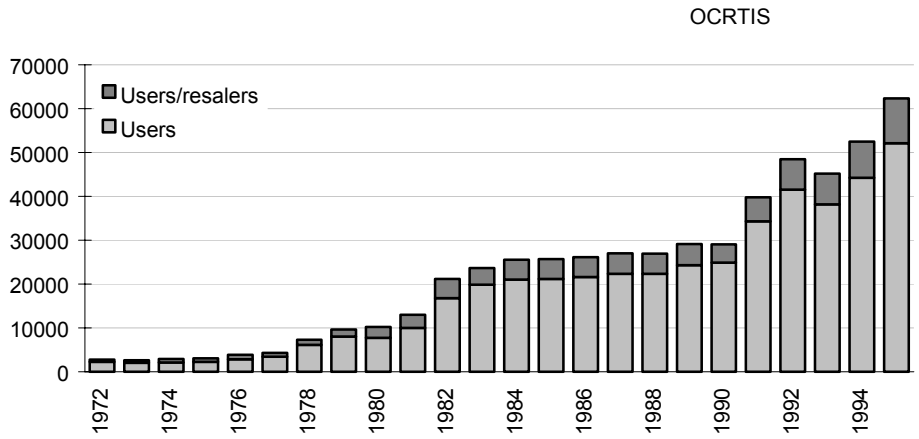
Drug use is a crime (article L.628 of the Public Health Code), and may lead to sentencing of up to one year of imprisonment and a 25,000 franc fine.

35,390 drug cases were handled by police, gendarmerie, and customs departments in 1995. They resulted in the arrests of 64,432 people for drug use or drug trafficking, some of whom were arrested several times during the year. Use was the most frequent cause for drug-related arrests, representing 90% of drug cases in 1995.

The number of arrests for illicit drug use doubled in less than five years. There were 62,325 arrests in 1995, of which 84% were for light use. The increase noticed in 1995 (19% higher than in 1994), was unprecedented if 1982 and 1991(years for which cases were better recorded) are excluded. 92% of this increase was due to an increase in the number of arrests for using cannabis. Reinforcing identity

checks within the framework of the Vigipirate operation, a result of Islamic fundamentalist terrorist attacks, may help explain part of the increase in use-related arrests, especially for cannabis, in 1995.

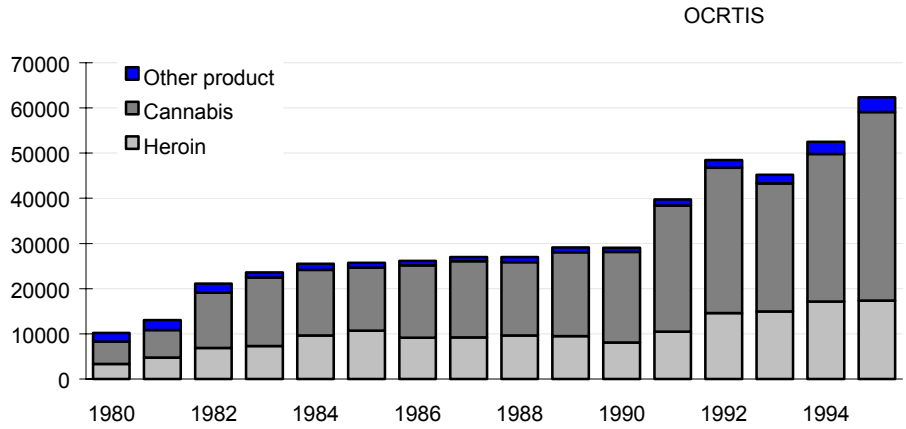
Arrests for drug use and use/resale, 1972-1995



The increase in drug use-related arrests over the last 20 years most certainly results from an increasing number of users, combined with an increase in police, gendarmerie, and customs department activities. Indeed, the repressive strategies which have been implemented limit interpretations of data on arrests. The number of recorded arrests is an indicator which is sensitive to different variations, such as the level of consumer activity, drug-related legislation, or even how laws are applied.

The substance mentioned during an arrest for illicit drug use is the main substance used by the person being arrested. Cannabis is cited most frequently, followed by heroin. Their respective percentages in drug-related arrests were 67% and 28% in 1995.

Arrests for drug use and use/resale, by substance, 1980-1995



Methodological References

- **The National File of Perpetrators of Drug-Related Offenses, (OCRTIS)**

  Information on drug use-related *arrests* over a one year period is found in this file. All illicit substances are concerned, be it for occasional or regular use. Occurrences, and not people, are listed. Some users may have been arrested several times in a one year period, resulting in double counting if statistics are calculated on an individual level.

  Only arrests for which a report has been completed by police, gendarmerie, or customs departments are recorded in this file. Cases mentioning that the police have been notified for a complaint are not taken into account.

Better recording the number of drug use arrests in 1982 and 1991, led to an noticeable increase in related statistics. The decrease measured in 1993, was mainly due to reforms in the criminal procedure code. It mostly involved departments which received the highest number of users.

B. Convictions and incarcerations for drug use

It is not easy to determine the relationship between arrests and convictions for using drugs because of the many differing classifications of drug-related offenses. In addition to this, all arrests do not necessarily lead to judicial proceedings. Cases may be closed without action being taken; the user might simply receive a warning, or orders to attend a drug rehabilitation program may be given.

Orders to Attend a Drug Rehabilitation Program

One of the objectives of ordering a person to attend a drug rehabilitation programs, a concept implemented by a law passed on December 31, 1970, is to offer treatment systems that provide alternatives to repressing illicit drug use. It gives the state prosecutor the possibility of directing a drug user to attend a treatment program instead of being the object of judicial proceedings. This alternative, which is available to the state prosecutor, is used quite differently in the departments.

8,630 drug addicts benefited from this alternative in 1995. Among them, 6,072 of them received medical-social treatment. As a result of improved cooperation between legal and health authorities, the difference in the number of persons ordered to attend drug rehabilitation programs and those who actually benefit from rehabilitation, is decreasing every year.

Compulsory therapeutic treatments sentenced and undergone, 1993-1995

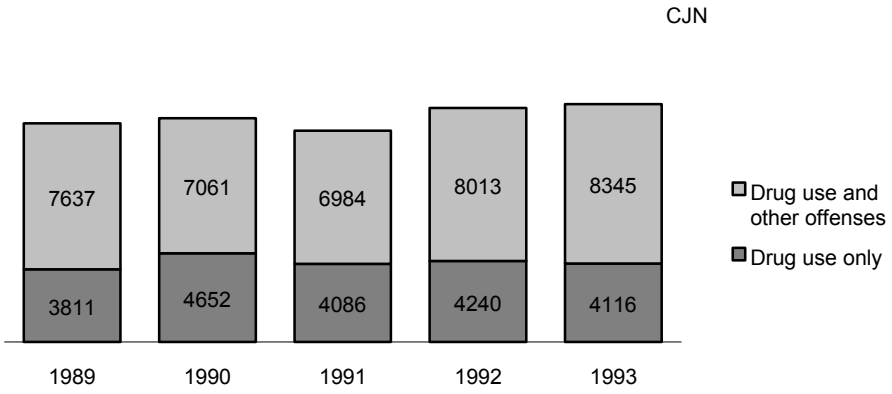
DGS, SED

	1993	1994	1995
Number of compulsory therapeutic treatments sentenced	6149	7678	8630
Number of persons having undergone therapeutic and social treatment	4064	5760	6072

Convictions for at least one drug use-related offense

In 67% of all cases for which a drug user was subject to legal proceedings for illicit drug use in 1993, he/she was also being prosecuted for other offenses. The percentage of convictions sentenced for use, out of all drug-related offenses (ILS), has continually diminished over the last five years. It dropped from 44% in 1984, to 24% in 1993. Offenses for drug use (12,461) represented 1.7% of all offenses which were punished in convictions.

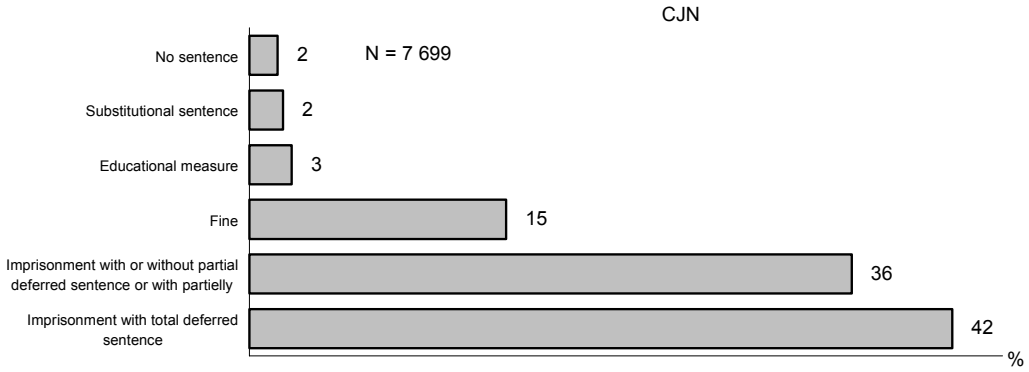
Convictions sentencing for one or more illicit drug use-related offenses, 1989-1993



Sentences are given for all offenses committed, and therefore vary strongly if other crimes are associated.

Imprisonment with total suspension of the sentence is the most common verdict: This is true in 42% of all cases, whether the drug use be associated with other offenses or not.

Convictions sentencing one or more drug-related offenses, by sentence type, 1993



In cases where multiple offenses are involved, prison sentences are more frequent than in cases only involving use and are usually longer. 44% of all users who have committed other offenses are sentenced to time in prison. In more than half of those cases, they are sentenced to over six months in prison. On the other hand, 29% of those convicted for use only, are sentenced to do time in prison but in 82% of these cases for a period of under six months.

Sentencing in the form of fines is twice as frequent when concerning drug use-related offenses only. Fines are sentenced in 21% of the cases involving drug use only, and nine percent of the cases where drug use is associated with other offenses.

Incarcerations

Some people having committed a drug use offense (alone, or associated with other offenses) and having been sentenced to time in prison, are not incarcerated. Indeed, there are cases where a person is convicted in his/her absence, or where a person is sentenced to do time in prison but the sentence may be converted to doing public interest work.

Only imprisonment for which drug use is the only or main offense (written at the top of the committal order) can be accounted for. In 1995, the prison administration counted 864 cases. This number does not represent the number of drug users in prison, since they may be in prison for having committed offenses that have no link to drug use. It does not represent all prisoners incarcerated for drug use

either, because drug use is not always written at the top of the committal order when the person has committed multiple offenses.

Methodological References

- **Framework of the Public Prosecutors Office, SED**

Annual activity statements from the court of appeals, county courts, and police courts. These statements enable the number of cases where drug rehabilitation treatment is ordered, over a one year period, in France, to be counted.

- **Drug Rehabilitation Treatment Measures (DGS)**

The health authority (DDASS) is responsible for ensuring that rehabilitation goes smoothly. If the health contract is not correctly fulfilled, proceedings for drug use are started again.

- **National Police File, SED**

Convictions may be counted in cases where one of the first four offenses written in a person's national police record was for drug use. Sentences, and length of imprisonment are only known for those who have been convicted for drug use, or when drug use is the main offense (line 1). They are probably underestimated because of cases where a person is convicted for non-drug related offenses (the drug offense is cited after the main offense). Some studies have shown that multiple offenses, linked with drug use, have led to harder sentencing, and time in prison. Only minors are sentenced with educational measures.

- **National Prisoner File, SCERI**

In this file, the number of incarcerations per year, for which illicit drug use is the only offense (figuring at the top of the committal order), are counted. This is measured from the flow of prisoners entering prisons. Therefore, this recording method does not allow all prisoners incarcerated for drug use to be counted. In addition to this, in cases involving multiple offenses, the offense figuring at the top of the committal order may be the most serious or the first offense which was noted.

Chapter 14.Availability and Supply

14.1_Sources of supply and trafficking patterns in the country

A. Drug-related money laundering

In France, 1995 and the beginning of 1996 were marked by intensified fighting against drug-related money laundering, and important legislative changes evolved which were designed to fight it more effectively.

The Results

TRACFIN (Processing of Information and Action against Clandestine Financial Circuits), was created in 1990 within the Ministry of Economics and the Budget. It was designed as a tool to fight criminal-based money laundering in conjunction with the Central Office for Repressing Grand Financial Delinquency (OCRGDF) at the Ministry of the Interior. TRACTION data shows that an increasing number of the various agents involved in this fight are mobilizing.

Financial institutions noticeably increased their participation by filing 865 notifications of suspicion in 1995 as compared to 683 in 1994 and 648 in 1993. As of October 1, 1996, TRACFIN had received a total of 3,394 notifications of suspicion, concerning several billions of francs, since it was created.

Banks alone made seventy-four percent of these notifications. The rest were from other establishments subject to this procedure such as private and public financial institutions, insurance companies, mutual insurance companies, stock exchange companies, and manual money changers.

As a result of these notifications, three hundred investigations were ongoing at the TRACFIN in 1995 compared to only 200 in 1994. As of October 1, 1996, 120 of these cases had been passed on to the

courts since 1991. They were equally spread out between laundering cases (strictly speaking), and cases concerning criminal based capital in general (under article 40 of the criminal law procedure). Several millions francs are involved. There were more than 30 cases for the first few months of 1996, showing that the implementation of legal proceedings has increased. One-third of the cases were in the Provence-Alpes-Côte d'Azur region in 1995 while they had mostly been concentrated around Paris in previous years. Information on data about the results of these proceedings is not currently available.

Legislative Evolution

Within the framework of harmonizing international and European legislation, France passed a new law relating to the fight against drug trafficking and money laundering, and international cooperation concerning confiscating criminal substances (law No. 96-392 passed on May 13, 1996). It was designed to adapt French legislation to the Council of Europe's 1990 Agreement on money laundering by putting forward two problems that had come up in applying the law over previous years: The field of applying anti-laundering legislation, and proof concerning the money's origins.

Methodological References

- **TRACFIN, Ministry of Economics and Finance, and the Ministry of the Budget**

Information on this law came from a press release sent out by the Ministry of the Budget when 1995's Custom's Activity Report was presented.

The Legislative Framework: Main Recent Laws

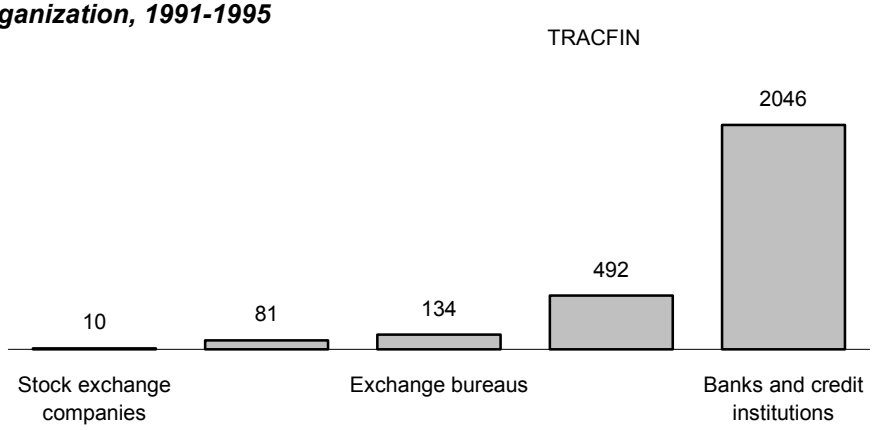
Law No. 96-392, passed on May 13, 1996, relating to the fight against money laundering and drug trafficking, and international cooperation concerning seizing and confiscating criminal substances.

Law No. 93-122, passed on January 29, 1993 relating to preventing corruption, and transparency for economic life and public proceedings.

Law No. 90-614, passed on July 12, 1990, relating to the participation of financial organizations in the fight against money laundering and capital from drug trafficking.

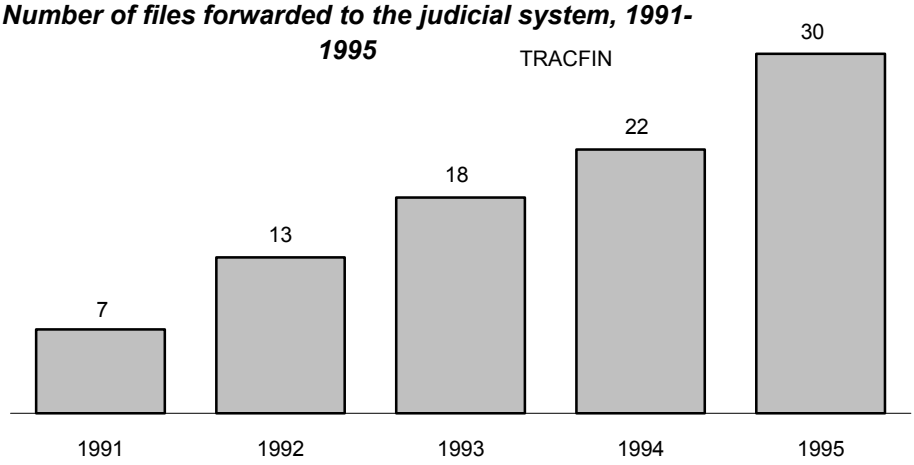
Decree made on May 9, 1990 responsible for creating a coordination group for processing information and action against clandestine financial circuits (TRACFIN).

Number of notifications of suspicion, by type of financial organization, 1991-1995



Number of files forwarded to the judicial system, 1991-1995

TRACFIN



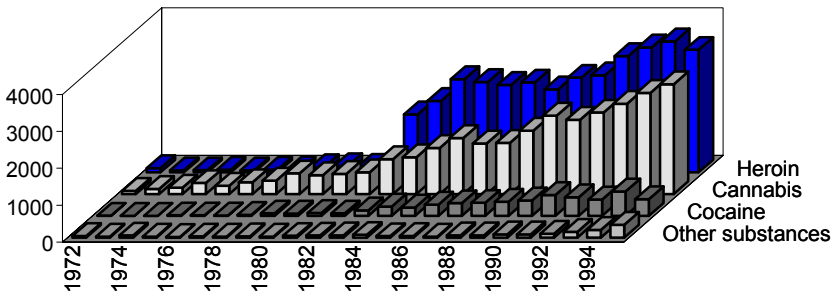
B. Arrets, sentencing, and improsonment for supplying and trafficking drugs

7,107 people were arrested for local or international drug trafficking by police, gendarmerie, or customs departments in 1995, a slightly lower figure than in 1994. However, because the situation in coming years is yet unkown, the upward trend which has been detected over the last 20 years may not be questioned. Drug trafficking, compared to drug use, has remained in the minority representing 10% of all drug-related arrests made in 1995.

Cannabis was the most frequently cited substance in drug trafficking-related arrests until 1983. Since then, more heroin traffickers have been arrested. Since 1983, the number of arrests made for trafficking cannabis and cocaine has tripled, and arrests for heroin trafficking have doubled. In 1995, 42% of drug trafficking-related arrests were for cannabis, 47% for heroin, and six percent for cocaine. Ecstasy trafficking has grown strongly since it appeared in 1990. Related arrests multiplied by 21, going from 13 in 1990, to 276 in 1995. Four percent of the traffickers arrested in 1995, were apprehended for trafficking ecstasy. LSD, amphetamines, and psychotropic medicines are substances which represent less than one percent each of all trafficking-related arrests.

Drug trafficking-related arrests, by substance, 1972-1995

OCRTIS



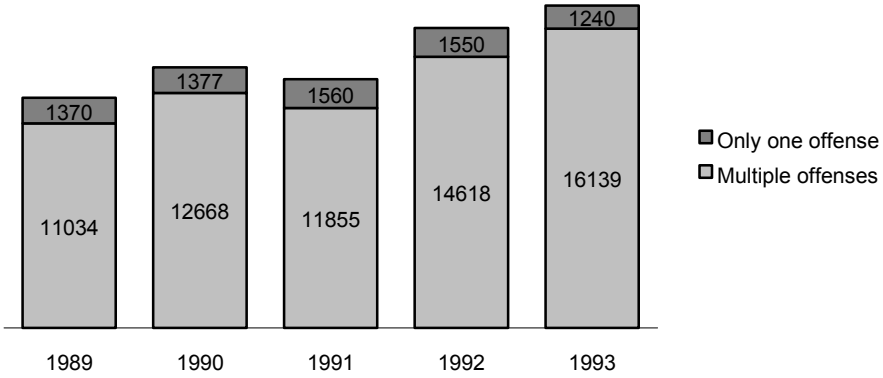
The frequency of local traffickers and dealers, 83% in 1995, has continued to increase at the expense of international traffickers who were in the majority in 1972. A higher percentage of international cannabis traffickers were arrested than international heroin traffickers, representing 45% of all arrested drug traffickers. Several international cannabis trafficking groups have been distinguished in order of importance: French, British, Moroccan, Italian, Spanish, and Dutch networks.

25 524 convictions in 1993

CJN

sentencing 51 234 drug-related offenses including	
3 633	for trafficking
5 939	for transporting
21 031	for holding/purchasing
7 807	for sale and supply
12 461	for use
350	for encouraging use
13	for other drug-related offenses

Drug trafficking, transporting and supply related offenses sentenced, 1989-1993



Imprisonments for drug-related offences, 1995

FND

12 277 imprisonments including	
7 801	for trafficking
1 026	for sale and supply
864	for use
2 586	for other drug-related offenses

Methodological References

- **National File of Perpetrators of Drug-Related Offenses, OCRTIS**

Information on drug use-related *arrests* over a one year period is found in this file. Occurrences, and not people, are listed. Some users may have been arrested several times in a one year period. The large increase in the number of trafficking-related arrests between 1982 and 1983 is partially due to better recording of available data.

- **National Police File, SED**

Drug-related legislative offenses (ILS) for which an offender has been sentenced and convicted are listed in this file. Because of frequent associations between the different qualifications of offenses in any particular case leading to conviction, the number of offenses mentioned is higher than the number of convictions.

- **National Prisoner File, SCERI**

In this file, the number of incarcerations per year, for which illicit drug use is the only offense (figuring at the top of the committal order) are counted. This is measured from the flow of

prisoners entering prisons. Therefore, this recording method does not allow all prisoners incarcerated for drug use to be counted. In addition, in cases involving multiple offenses, the first offense figuring at the top of the committal order may be considered to be the most serious or that which was first noted.

A relationship may not be defined between imprisonment and conviction-related qualifications because of different definitions.

14.2_Illicit drug market indicators : *drug seizures (number and quantity)*

As with arrests, seizing drugs depends as much upon trafficking as it does police, gendarmerie, and customs department's activity. Some large drug seizures may cause big fluctuations in numbers from one year to the next, making analyzing the quantity of drugs seized over time particularly delicate. More seizures were made but fewer drugs were seized in 1995, compared to 1994, during which a record number of drugs were seized on French territory.

Drug seizures, 1992-1995

OCRTIS

Products	1992		1993		1994		1995	
	Quantities seized	Number of seizures	Quantities seized	Number of seizures	Quantities seized	Number of seizures	Quantities seized	Number of seizures
Cannabis (kg)	42 075	17 690	45 783	16 200	58 029	17 707	42 270	22 543
Heroin (kg)	328	4 559	386	5 092	661	5 163	498	5216
Cocaine (kg)	1 625	1 069	1 715	1 168	4 743	1 281	864	1107
Crack (kg)	2	105	5	219	10	227	9	325
L.S.D. (doses)	128 359	119	430 617	121	74 004	160	70 217	158
Ectasy-MDMA (doses)	13 911	73	133 521	186	254 804	358	273 779	587
Amphetamines (kg)	13	73	43	86	80	98	103	104

Heroin dealers were the most frequently arrested, but cannabis remains the most seized drug in France, both in terms of number of seizures made and the amount seized. In 93% of the cases it is seized in resin form. The higher the amount of cannabis seized (resin and green), the lower the number of seizures made. In 71% of the cases, under ten grams were seized, while seizures of more than fifty kilograms represented 81% of the amount of cannabis seized but less than one percent of the number of seizures.

Cannabis resin mainly comes from Morocco and Spain (respectively 37% and 47%). However, of all the countries from which cannabis may come, 67% of the cannabis resin seized in France comes from Morocco. More redistribution occurs in Spain. The French market is the main destination for 39% of the resin seized in France, followed up by Holland which represents 19% of the known destinations.

The number of seizures of heroin (under five grams) remained the highest in 1995, with 69% of the seizures of heroin occurring in France. This only concerned one percent, a very small proportion of the total quantity of heroin seized. The real portion of local or international trafficking is situated at over one-hundred grams. Seizures of one-hundred grams represent seven percent of the total number of seizures and 92% of the amounts seized. For seizures of over five kilograms, these respective percentages are 0.3% and 43%.

As in former years, the heroin seized in France came mainly from the Netherlands (58% of the total, and 78% when the origin was known), a country where much redistribution occurs. Its first destination was the local French market (68% of the total, and 72% when the destination was known). However, for seizures of over five kilograms, foreign destinations are more highly represented, and France more frequently appears to be a transit country.

The majority of cocaine seizures, which follow the example of heroin, are under five grams. They represented 62% of the total number of seizures of cocaine which were made in 1995. However, seizures of over one-hundred grams of cocaine, particularly those over five kilograms, remained more frequent than for heroin in 1995. Seizures of over five kilograms of cocaine concerned three percent of the cases and 78% of seized quantities.

Cocaine, whose origins are known, mainly comes from South America. Cocaine from Brazil and Columbia alone makes up for seventy-two percent of the cocaine seized in France in 1995. France, which is a transit country for cocaine seized on its territory, represents only 12% of the known destinations. Spain held a dominating position in 1995, being the final destination for 48% of the cocaine that was seized in France. The Netherlands followed up with 14%.

Concerning seizures of ecstasy, LSD, and amphetamines, the main countries of origin and destination which were identified were respectively the Netherlands and Spain.

Methodological References

- **National File of Perpetrators of Drug-Related Offenses, OCRTIS**

Legal procedures do not always enable the country from which drugs are purchased to be known. In addition, when these countries are known, they do not always correspond to the country where the drugs were produced. Indeed, for drugs seized in France, there are many purchasing countries, (and countries of destination) which in reality are re-distribution or transit countries.

Rate (unknown origin): 21% for cannabis resin, 25% for heroin, 8% for cocaine, 9% for ecstasy and 4% for LSD.

Rate (unknown destination): 4% for cannabis resin, 5% for heroin, 24% for cocaine, 8% for ecstasy and 3% for LSD.

Chapter 15.Discussion

15.1-15.2_Main trends and new developments in drug use and consequences

This presentation of current trends is somewhat speculative: What exactly are the drugs and drug addiction trends that can be highlighted in 1996? We cannot strictly synthesize the elements described in the report, but rather outstanding representative characteristics simultaneously concerning: the support upon which our current knowledge of this phenomenon is based, founded on available quantitative data; and a more qualitative, or « expert's » approach, focusing on recent developments that have been observed.

Uses and Substances

Drug use and drug addiction are no longer essentially an urban phenomenon. These behaviors tend to spread outside of large cities. The *aging* trend has continued except among crack users, a sign that there is an earlier form of use for this substance.

According to recent ethnographic studies, (field approach) it seems that in comparison with previous years, we are witnessing an intensification in poverty and insecurity among drug addicts.

Polydrug addiction is developing. Use of **psychotropic medicines**, in comparison to all used substances, has particularly increased.

After considerably increasing over the last ten years, **heroin** consumption seems to be stabilizing.

Cocaine use, which the few available indicators lead us to believe is considerable, is still as poorly known - except through its association with taking other substances (often mentioned by users).

Crack use has still been contained to a limited level, in spite of a strong increase noted since it emerged in France in the late 1980's. It mainly affects the Parisian region and the French West Indies.

The most striking recent phenomenon, is the considerable increase in **ecstasy** and hallucinogenic drug consumption in discotheques or parties that draw young people, outside of the simple framework of « rave » parties.

An estimated seven million people in France have consumed at least one drug in their lifetime, and two million people have consumed a drug within the past year. More than nine out of ten times, **cannabis**

is the drug consumed. Use is becoming commonplace: more than one fourth of all people entering adult age have experimented with it. This occasional use covers up other habits where cannabis alone, or associated with other products (alcohol, ecstasy) plays an important role in dependent behavior.

Repressing Drug Trafficking and Use

The increase in the number of drug **seizures** observed over the last few years, lets up in 1995 for all drugs except ecstasy.

In Paris, the going street **prices** for heroin and cocaine, have decreased over the last few years. As for product **purity**, according to the consumers the quality of heroin has improved while the quality of cannabis and cocaine has worsened.

Arrests for illicit drug use (62,000 in 1995) have continued to show a strong increase (+19% over last year), but this is mainly for cannabis. **Court ordered rehabilitation programs**, an alternative to prosecution, are being used in more and more cases (8,600 in 1995) and is the object of improved coordination between legal and health services.

The share of minor and medium **delinquency** attributable to drug addicts remains a difficult indicator to *measure* particularly because a large part of related occurrences are never cleared up. Monographic research carried out in Paris during 1990 indicates that in any case the frequently cited figure of 50% is overestimated.

Treatment, State of Health

The **health and social treatment system** for drug addicts has continued to become stronger and more diversified. More than 65,000 drug addicts were treated in specialized care centers in 1995 (up 22% in one year). General practitioners have seen an increase in their share of treating certain drug addicted patients. The specialized and general systems are better integrated into the framework of a more global and better coordinated treatment. The availability of **substitute treatments** (Methadone and Subutex) has considerably developed since 1993. The number of drug addicts benefiting from these treatments has gone from a few dozen to more than 23,000 in September, 1996.

Many drug addicts have been infected by **HIV**: out of all of the AIDS cases reported since 1978, 28% are linked to drug addiction. Currently, 20% of the drug addicts who have undergone treatment are infected by HIV. The latest indicators in this matter tend to show a stabilization, even a decrease in the number of drug addicts infected by HIV. This evolution highlights the importance of prevention efforts that have been made over the last ten years.

Many drug addicts are also infected by **hepatitis** (around one out of two shows positive for hepatitis C), but their serological status is less well known in this area.

Treating infectious problems is becoming more and more frequent. It is important that this not conceal other somatic problems and psychiatric pathologies experienced by drug addicts.

Even if positive results have been recorded after improving the accessibility of syringes, and increasing the number of actions undertaken within the framework of a global strategy at **harm reduction**, certain risky practices have endured. This is the case with re-using syringes and sharing other injection materials than syringes.

Mortality linked to drug addiction has become one of the main causes of death in young adults (along with accidents and suicides). The number of deaths resulting from overdose (one of the components in drug addicts mortality), which strongly increased during the 1980's, has been stabilizing over the last four years. Heroin remains the most dominant product implicated, but the number of deaths caused by medicines has noticeably increased (17% in 1995).

15.3-15.4_Methodological limitations and evaluation of data quality

A complex field to observe

The essential part of French legislation on drugs and drug addiction comes from a law passed on December 31, 1970. It contains several objectives and is two-sided: to repress drug trafficking and narcotics use, and to organize care for drug addicts. While laying down the principle of prohibiting narcotics use, the law proposes an alternative to repressing drug use: therapeutic treatment. It also specifies two major principles in organizing care: that it be both free and anonymous for drug addicts that are treated. This legislative framework gives structure to our knowledge of this law. The two largest existing sources (health and law enforcement) reflect the duality of a drug addict as established by the law. The rule of protecting anonymity does not facilitate epidemiological studies of those who are being treated and monitored.

By nature, drug use is difficult to spot and therefore difficult to describe. The French system for observing drug use in the general population is incomplete. Nevertheless, many data are available. Most often, they are provided by institutions operating directly in the field. Therefore, they only reflect a part of the phenomenon as seen from a particular angle, that of an institution.

The information sources that were examined to successfully complete this report may be categorized in the following manner:

- Institutional sources - coming from health, social, and legal institutions involved in fighting drugs and drug addiction, whose main objective is to measure and direct their action;

- Studies of particular populations which are directly concerned by drug addiction, performed by research teams or administrations that are not directly committed to fighting drugs and drug addiction but contribute knowledge about the phenomenon.

- General population surveys aimed at measuring the extent of drug use and studying the global population's behavior and attitudes towards drugs.

Definition Problems

Definitions and names vary according to sources. It's alternatively a question of drug addicts (health care services), « toxicophile » behavior (military health department), drug users (police and gendarmerie departments), and drug consumers (general population surveys). The term « drug addict » is more pragmatically than theoretically defined. In some ways, it's an element of an individual's identity that is noted by the institution that discovers him/her, and recorded as such into its statistics.

Between drug use and drug addiction, there is a wide scale of behaviors and use patterns: occasional or regular use, limited or repetitive abuse with all of the ensuing consequences on an individual's physical and psychological state, and dependency when a person becomes prisoner to finding the substance he lacks.

All of these nuances are often reduced down to the description - drug addict, or drug addiction, which only increases confusion over how the phenomenon is perceived - especially when making a quantitative evaluation: How many drug addicts are there? Fluctuations in these evaluations are even stronger because they concern different populations. Indeed, the size ratio varies from one to ten depending upon whether use, or dependency, is taken into consideration. Consequently, whatever the term used, attention must be paid to the need of specifying the perspective from which the observation is being made: drug addicts being treated in the health and social system, arrested drug users by the law enforcement system.

15.5-15.6_ New information needs, gaps, and priorities for future work.

What emerged from this work, was the fact that there are several gaps in our knowledge of drugs and drug addiction. The following measures would enable the main gaps to be filled.

On one side, the global system of knowledge of drugs and drug addiction, which currently is essentially based upon statistical institutional sources, must be reinforced by:

- setting up an observational system for drug use in the general population - the only valid way of estimating the amount of this use and a methodological base for more targeted studies on specific categories of use;
- launching a longitudinal monitoring system for describing the dynamics (trajectories) of drug use, drug addiction, and their consequences.

On the other side, this global perception should be enriched by a study programme on more precise aspects such as :

- the mortality-morbidity of drug addicts,
- public policies,
- types of use and behaviours,
- knowledge of populations and trajectories,
- trafficking,
- evaluating these actions.

PART IV : DEMAND REDUCTION INTERVENTIONS

Chapter 16.Policy Dimension

Health policy concerning the fight against drug addiction

The health policy concerning the fight against drug addiction is based upon a law enacted on December 31, 1970 which is organised around two major principles: Care is both anonymous and free, and is supported by a specialised system whose mission was redefined by a decree made on June 29, 1992. For a long time, this policy was exclusively oriented towards total abstinence through detoxicating drug addicts. However, since the triennial plan was adopted in 1993, a more open policy towards treating addicts with substitute treatments was set up. In 1996, the main lines for developing and working in the field of health and social treatment for drug addicts developed around three points.

- increasing the number of and possibilities for housing. The number of spaces doubled between 1993 and 1996, and the types of accommodation became more diversified. There are currently 1,217 beds associating more traditional after-care accommodations, therapeutic apartments, therapeutic communities, etc.;
- implementing substitute treatment programmes involving doctors and hospital professionals at various degrees, and making two medicines (specifically for treating major addictions to opiates) available on the market
- continuing the harm reduction policy was integrated into global treatment for drug addiction and should make it possible to fight infections (hepatitis, HIV, abscesses) which strongly affect this population. and also to favour, or even enable real access to care. This policy, which was set up by two offices at the General Health Department, should offer the most marginalized drug addicts, most often the youngest, help and an opening towards seeking treatment as much for somatic pathologies as for their addiction.

The drug addiction prevention policy has taken on a larger dimension over the last few years which should take into account all drug addicts, while including the evolution in consumption patterns and new products.

This major evolution, politically supported, makes it possible to offer patients several possible choices of treatment or help. In addition to withdrawal, with has kept its place as real and necessary treatment, substitute treatments were proposed and means for favouring access to care.

This concretely evolved in several ways :

⇒ by diversifying inpatient treatment corresponding to the different profiles of drug addicted individuals: therapeutic apartments, transitional apartments, therapeutic communities;

⇒ by the spectacular development of substitute treatments (Methadone® and Subutex®), two medicines which are prescribed differently but should always be associated with psychosocial treatment.

The first prescription of methadone is reserved for specialised government-regulated drug addiction treatment centres which have the possibility of working with general practitioners when the patients state makes this possible. Concerning Subutex, France is the only European country where this medicine has been marketed and may be prescribed by doctors. The number of patients treated with it has been steadily increasing and reached 30,000 individuals at the end of December, 1996.

⇒ by involving care providers who had not dealt with treating drug addicted patients very much up until now. Training hospital personnel has made it easier to accommodate these individuals in hospitals. The different pathologies presented by these patients can now be treated, and functional links have been established with the usual field workers. At the same time, developing drug addiction-city-

hospital networks has shared among general practitioners a treatment culture which helps them to better understand drug addicts.

All of these agents working together have led to improvements in treatments and making treatment possible

The evolution of specialised systems must now face an evolution in substances and use patterns, particularly ecstasy and cocaine consumption which concerns a different population.

The complementarity of specialised and general health systems is carried on through a policy of social-re-integration which is a necessary step in socially and economically re-integrating drug addicted patients.

Methodological References

Text written by : DGS (General Health Department) - SP3 office
See appendices : list of legal texts related to the medico-social treatment of drug addicts

Chapter 17.Thematic Dimension - Outline of Demand Reduction

17.1_First childhood intervention

MILDT and DGS

In 1995, the MILDT and the DGS produced 4 **information sheets** on adolescence which are included with the health record given to parents after each child is born. These sheets are designed:

- (for the time being) to inform parents on the stage of adolescence which brings about natural changes, but also the risk of weakening the adolescent (information, educating parents) -
- (over the next 10 years) to make the adolescent him/herself aware of and responsible for his/her own health and the changes brought about during this period.

A diagram enables individuals to find persons and places providing information and help within the framework of the health and social system, associated networks, school and administrative networks.

17.2_School programmes

Ministére de l'Education Nationale (Ministry of National Education)

- **Prevention actions** are designed to fight all forms of dependency and are integrated into the academic programme in subject areas such as: civic education, physical and athletic education, and the sciences. Promoting health in this manner is carried out with the participation of teachers, the health promotion department - for students, Maternal and Child Protection services, specialised health networks, and outside personnel.

- Health classes are therefore organised much in the same way as winter sports or ecology classes.
- Drug addiction prevention actions have been implemented in CM2 level classes upon the initiative of several large cities with the accord of local education authorities. This is the case in Paris, where all CM2 students are offered an information session. A video cassette called « Histoire de Pascal » serves as a support tool for debates which are conducted by a medico-social team and the teacher. This action was evaluated in 1991-

1992 by the Direction de l'Action Sociale, de l'Enfance et de la Santé de la ville de Paris (Department of Social Action, Childhood and Health for the city of Paris).

- **Comités d'environnement social** - (Social Environmental committees) (CES), created in 1990, group together the educational community and those involved in social activities, and the neighbourhood (associations, institutional actions) with school principals. They develop prevention policies which establish a true link between schools and their environments and co-ordinate initiatives concerning prevention. Their operations fit into school projects presupposing that limited, realistic, and easily applicable operational objectives have been defined. A report on these operations must be sent to the Education offices. CESs work with collèges and lycées in general education, and professional education lycées in prioritary educational zones in particular. Since 1993, the Social Environmental Committees (CES) actions have spread to the primary educational level. CM2 and collèges teachers meet from time to time in order to prevent problems of violence and drug addiction, and to prepare CM2 students for entering the collège. The CESs are financed by the MILDT, and the Ministry of National Education has participated in their financing since 1995.

- Lycée and Collège Administrations, in collaboration with the MILDT, publish **documents**.

  - Production of two documents: : Developed to help principals and educational teams in their prevention operation in lycées, collèges, and primary schools. « Repères pour la prévention des conduites à risque dans les établissements scolaires », « Repères pour la prévention des conduites à risque à l'école élémentaire ».

  - Production of video cassettes: The first video cassette, « la lettre à Jean », accompanied by a pedagogical booklet is distributed within the school system, but also to partners. This tool is used in training personnel. A second 32 minute video titled « Tempo solo » to be used among collège students, is in the process of being distributed. It is made up of two modules: One is designed for students in the 6th and 5th grades, the other is for students in the 4th and 3rd grades; It is designed to help adolescents become conscious of the detrimental effects of drugs through friendship with two collège students who have been confronted with this problem. The video cassette, accompanied by a pedagogical leaflet is available in all collèges, in National Education training organisations, documentation centres as well as among partners.

Gendarmerie Nationale.

- The **FRAD** (Formateurs Relais Anti-Drogues) - (Relay Anti-Drug Trainers) are increasingly being asked to come into schools (collèges and lycées). They demystify drugs for adolescents by providing information and encouraging dialogue. Since the middle of 1996, a video cassette called « Animal Dealer » has given them support in sharing their message. This tool, created by the pedagogical department of the gendarmerie, lays out the phenomenon's problems and denounces the dealer's role. The prime objective is to make young people responsible for their own possible drug consumption and to help them make the right decisions.

17.3 _Youth programmes outside schools

MILDT / Ministère de la Jeunesse et des Sports - (Ministry of Youth and Sports)

- Resource persons from the regional or departmental youth and sports departments bring financial and pedagogical support from their ministry to carry out **prevention actions** which have been selected :

  - awareness and training actions among field workers, teachers, social workers, doctors, parents, etc;
  - various organised activities which enable young people to express themselves, communicate and take initiatives;
  - athletic activities among young people who are having problems and do not come to traditional athletic structures.

- The **centres information jeunesse - (Youth Information Centres)** (CIJ), are under the responsibility of the Ministry of Youth and Sports. Their main objective is to have direct contact with young people under the age of 25, and provide them with information on questions about daily life. The 33 Youth Information Centres are mostly located in different regions. The centres make up a flexible and active « youth information » network, in co-ordination with the Youth Information and Documentation Centre (CIDJ), which is capable of innervating the local social fabric through using local structures (departmental and community):

  - the first type of actions is centred around orientation, information, and documentation,
  - the others are centred around awareness and related activities (open house days, debate workshops, promoting youth projects or drug addiction prevention associations etc.)

- Each year new « **points info-santé** » - (info-health points) are being created within youth information centres with interministerial funding. These « info-health points » are run in collaboration with health personnel doctors. Training sessions are conducted among the heads and personnel working in these structures, by regional Youth and Sports departments

- The Centres d'Entraînement aux Méthodes Educatives Actives - (Training Centres for Active Educational Methods) (CEMEA) have implemented. « **temporary housing** » possibilities at major cultural and musical gatherings. They are available for restless, wandering young people who for the most part consume toxic licit or illicit substances. Such actions were conducted at the « Printemps de Bourges », the « Festival de théâtre de rue d'Aurillac » and at the « Francofolies de la Rochelle ». Each of these actions was evaluated and a methodological guide has been written for mayors who organise such festivals.

Ministére de l'Interieur-(Ministry of the Interior)

- The **Centres de Loisirs Jeunes - (Youth Leisure Centres) (CLJ)** were initially created during summer holidays on beaches. Starting in 1991, their operations were reoriented towards urban areas and problem areas in suburbs. 37% of these CLJs perform their activities on Wednesdays, Saturdays, and during short school holidays.

- The **Opérations Prévention Eté - (Summer Prevention Operations) (OPE)** fit into an interministerial framework. They consist of offering leisure activities and athletic activities during summer, to young people in urban areas who are exposed to risks of marginality.

17.4_Mass media campaigns

MILDT / CFES

- Television and radio campaigns are used to transmit a very clear message showing the community's will to better prevent drug addiction. **Three campaigns** have already taken place at irregular intervals. The MILDT has sponsored studies: a survey was conducted in December, 1996, a qualitative survey should be conducted in 1997 in order to prepare a new national communication campaign.

- The **journée nationale et semaine européenne (National Day and European Week)** for prevention, was organised by the CFES in 1994. At this time, campaign was evaluated (tested before and after the campaign), subsidies were granted to various associations which had lead communication or prevention actions for the campaign (ANIT, DIS, FTPJ, tabou santé, CECD, SOS Drogue International ...).

17.5_Telephone help lines

DRUG INFO SERVICES

There has been a national drugs and drug addiction telephone helpline service in France since 1991. It is available 24 hours per day, and may be reached by dialing a free number: 0 800 23 13 13.

There are telephone helpline centers in six cities: Lille, Lyon, Marseille, Paris, Strasbourg and Toulouse. The last two opened at the end of 1996. In 1995, 580,000 calls were received, 30% more than in 1994.

Drug Info Services Missions

Drug Info Services is an interministerial service, set up as a public interest group. Its main mission is made up of three sections:

- Listening, supporting, and counseling persons needing help in facing problems which are linked to drugs or to preventing drug use.
- Providing information on products, effects, use-related risks, the law, and the care system.
- Orientating callers towards organizations which are fully competent in areas such as prevention, care, integration, and risk reduction.

In addition to the above, and upon a request made by the Interministerial Mission for the Fight Against Drugs and Drug Addiction, a national repertory of specialized drug addiction structures has been published by Drug Info Services since 1993. Over 700 structures throughout the territory are listed in 1996/97's edition.

17.6_Community programmes

Ministére de l'Education Nationale (Ministry of National Education)

- **Comités d'environnement social** - (Social Environmental committees) (CES), created in 1990, group together the educational community and those involved in social activities, and the neighbourhood (associations, institutional actions) with school principals. They develop prevention policies which establish a true link between schools and their environments and co-ordinate initiatives concerning prevention. Their operations fit into school projects presupposing that limited, realistic, and easily applicable operational objectives have been defined. A report on these operations must be sent to the Education offices. CESs work with collèges and lycées in general education, and professional education lycées in prioritary educational zones in particular. Since 1993, the Social Environmental Committees (CES) actions has spread to the

primary educational level. CM2 and collèges teachers meet from time to time in order to prevent problems of violence and drug addiction, and to prepare CM2 students for entering the collËge. The CES are financed by the MILDT, and the Ministry of National Education has participated in their financing since 1995.

MILDT and Ministère de la Jeunesse et des Sports (Ministry of Youth and Sports)

- The Centres d'Entraînement aux Méthodes Educatives Actives - (Training Centres for Active Educational Methods) (CEMEA) have implemented. « **temporary housing** » possibilities at major cultural and musical gatherings. They are available for restless, wandering young people who for the most part consume toxic licit or illicit substances. Such actions were conducted at the « Printemps de Bourges », the « Festival de théâtre de rue d'Aurillac » and at the « Francofolies de la Rochelle ». Each of these actions was evaluated and a methodological guide has been written for mayors who organise such festivals.

Ministère de la Défense - (Ministry of Defence): National Gendarmerie.

The **FRAD** (Formateurs Relais Anti-Drogues) (Relay Anti-Drug Trainers) work with adults: parents of students, local community agents, elected officials, district association members, gendarmes. They show narcotics from a special case containing drug samples. They heavily emphasise the importance of communication between adults and children.

17.7_Groups experimenting with drugs

unavailable

17.8_Outreach work

unavailable

17.9_Low threshold services

Direction des Actions Sociales (Department of Social Action)

There are currently 3 emergency housing centres (**Sleep-ins**) for drug addicts who are in a precarious situation. They ensure emergency housing at night, and offer the possibility of having consultations which provide health and social direction during the day. These structures are built around the concept of citizenship and community work.

DGS - (General Health Department) - AIDS Division

Since 1993, a certain number of drug addiction host areas offer their clientele prevention materials. Most often, these are « threshold centres », free clinics and medical social centres. They enable contact to be established with the most marginalised drug addicts who do not wish to, or cannot, stop their intoxication. Quite often, these drug addicts have a hard time taking care of their health because of their precarious social conditions. These 25 contact centres do not attempt to treat dependency problems but rather constitute daily help for active drug addicts (information, syringe exchange, hygiene, rest, medico-social services). These contact centres may also be considered as a starting point in the care system. They allow contact with those who are the most excluded from all channels of help, and who do not wish to or have not yet taken any steps to seek care.

17.10_Prevention of HIV infection among drug users

DGS - Division SIDA

Above and beyond the « threshold centers », the harm reduction prevention policy for drug addicts usually offers prevention tools such as prevention kits, syringe exchange programs, and automated syringe distribution/recovering machines.

There are several types of prevention kits (2 1ml syringes, 1 or 2 alcohol swabs, from 0 to 2 cardboard holders, 1 or 2 doses of sterilized water, prevention messages, free numbers for AIDS information services and Drug Information Service):

l Stéribox®, only sold in pharmacies, or distributed in exchange for a token from machines placed outside pharmacies during off hours. In 1995, approximately 160,000 Stéribox® per month were sold in France.

l « Le Kit® » bag, « Le Kit® » box and « Le Kap® » created recently and distributed in prevention programs and automatic distributors.

There are currently 51 *syringe exchange programs* which establish an initial contact with the drug user through exchanging syringes, distributing condoms, and providing prevention advice. They are particularly intended for those drug users who do not frequent, or little frequent care areas and medical-social networks. Syringe exchange program teams work closely with drug users and are most often based in a mobile unit, or bus (32). Several programs have also been implemented in association offices (9), or certain pharmacies which are actively involved in harm reduction (10). Finally, in some cases, teams are led to do « street work » in order to establish contact with drug users.

The 61 *distributors* include syringe distribution/recovery machines (a used syringe is exchanged for a « Le KAP » prevention kit), electronic machines which deliver tokens, and simple distributors (a token is exchanged for a « Stéribox » kit or a « Le Kit » box). There are also 42 simple machines designed to avoid syringes being simply discarded in public areas.

17.11_Substitution programmes/Maintenance programmes

DGS - (General Heath Department) - SP3 Office

How to treat drug addicted patients has been greatly discussed over the last few years. The apparition of AIDS, and the high number of HIV infected drug addicts, led the French public authorities go beyond psychotherapeutic treatment targeting abstinence, by proposing the implementation of substitute treatments as a complement to the harm reduction policy. There are no substitute programmes or maintenance treatments - these personalised substitute treatments are prescribed to particular individuals within a very structured framework.

As early as 1994, the political will to implement these treatments became clear. This opening therefore became concrete when two medications, specifically indicated for **treating drug addiction to opiates,** were placed on the market**:** METHADONE® in 1995 and SUBUTEX® in 1996.

In September, 1996, there were 84 centres where substitute treatments with Methadone were available. There are an estimated 4,000 individuals taking Methadone in specialised centres, to which may be added 600 others who are being treated with Methadone through their personal doctor.

- General principles of substitute treatments :

These two medications were chosen from an angle of providing care and not maintenance. The individualised structured frameworks are different in order to meet the needs of a larger

population. Because of their pharmacological characteristics, stabilising treatments is made easier, and the patient experiences a certain comfort.

METHADONE® is an opiate which causes serious addiction, linked to strongly affecting receptors, and has marked withdrawal syndromes which vary when one stops taking it. SUBUTEX® is not quite as addictive, and the risks of overdose are nearly non-existant except when associated with other medications.

These treatments should make it easier to treat a patient's various psychological, medical, and social problems, and require a specific global therapeutic plan for each individual either within an institutional framework (Methadone), or a more flexible framework (Subutex).

In order to make general practitioners aware of these medications, and help them to treat drug addicts, training sessions were organised for them, pharmacists and other related professionals.

- Prescribing these medications :

Since 1994, the number of specialised centres which are authorised to prescribe Methadone has been on the increase, but the decisive change occurred in 1995 when all specialised drug addiction treatment centres were given the right to prescribe this medication without preliminary authorisation. The right to prescribe it for the first time was reserved to doctors working in these centres. After global treatment has been administered in a specialised centre, a regular doctor who is willing and trained, may take up the relay. This practitioner, who has been accepted by the doctor from the specialised centre, is chosen by the patient. He accepts to administer treatment within a global health framework which goes far beyond simply writing a prescription, but requires a patient-doctor relationship including medical examination, listening and dialogue.

- The INSERM (National Institute for Health and Medical Research) which has been given the responsibility of evaluating this treatment on a regular basis, has cited that compared to the drug addicted population, women are over-represented, the average age is higher, and certain social problems are associated.

SUBUTEX®, which was placed on the market in February, 1996, is a synthetic morphinic, agonist/antagonistic which lasts for around 29 hours. The withdrawal syndrome comes later and less intensive than with Methadone because it is less addictive. It does not have a euphoric effect, but a ceiling effect. It is taken orally, once per day.

This medication (dose of 0,4mg, 2 and 8mg) is for patients who for the most part are already being monitored by a doctor. SUBUTEX® may be prescribed, with a model counterfoil prescription book, by any treating doctor after completion of a medical examination within the framework of global therapeutic treatment, and networking (specialised drug addiction treatment centres, general practitioners, pharmacies, hospitals). These practices of working together have been notably implemented within the drug addiction-city-hospital networks for globally treating drug addicts.

17.12_Detoxification

see chapter 17.13

17.13_Outpatient treatment

The structures described below only concern specialised drug addiction structures which are directly financed by the State. There are other specialised structures which may be financed by Departmental Councils, municipalities, private donations

Specialized structures, designed to provide care for drug addicts were implemented by a law passed on December 31, 1970. This law also guarantees free and anonymous care for those who want it, both for withdrawal in public health establishments and treatment in specialized care structures set up for drug addicts. This is a specific structure, compared to monitoring patients in the psychiatric sector, or compared to treatment provided for alcoholic patients. 60% of it is run by associations, and 40% by public hospitals.

Specialized outpatient drug addiction treatment centers, of which 184 are government regulated, ensure global treatment for drug addicts: they provide medical, psychological, social, and educative monitoring for people; they work towards helping them reintegrate both socially and professionally, and offer support to families. They may help patients undergo withdrawal in the outpatient center, or accompany them while they undergo withdrawal in hospitals, and direct them to in-patient health care centers. Six specialized outpatient centers are distinguished by the fact that they run specific in-patient hospitalization units when situated at the interior of a hospital.

There are 54 government regulated ***specialized in-patient drug addiction treatment centers***, (residential therapeutic centers and therapeutic communities, for 664 people). They house drug addicts following withdrawal, and contribute to strengthening them psychologically and preparing them to reintegrate both socially and professionally.

Care centers specializing in drug addiction, with or without housing, run 32 *permanently manned host areas*. They also run 64 ***therapeutic-relay apartment networks*** (for 435 people) and 29 ***host family networks*** (for 150 people) for specific therapeutic post-detoxification monitoring or during a substitute treatment. 17 centers offer transitional or emergency housing (for 118 people) for people stabilizing from withdrawal, getting out of prison, or waiting to find housing. A certain number of specialized centers also have **« *hotel nights*** », but it is difficult to quantify them.

There are also 16 ***specialized drug treatment centers operating in prisons***. They are installed in prisons, with a mission of ensuring global medical-social treatment for addicted prisoners, as well as preparing them for getting out of prison. They fall under the medical authority of the hospital practitioner who is responsible for the psychiatric sector in prisons and the joining hospital director.

Since 1994, 33 state regulated ***city-hospital drug addiction networks*** have been created. They are run by general practitioners and people active in working with drug addiction in a same region. They are responsible for ensuring a liaison and care continuity between the various places where drug addicts are treated: general medicine, hospital departments, care centers specializing in drug addiction.

17.14_Inpatient treatment

It is not possible to distinguish between specialised inpatient and outpatient centres in France. See chapter 17.3

17.15_Self help groups

unavailable

17.16_General health care

EVOLUTION IN DRUG ADDICTS BEING TREATED BY GENERAL PRACTITIONERS BETWEEN 1992 AND 1995

Dr. Juliette *Bloch, Françoise **Nory-Guillou, Clary ***Monaque, Dr. Yves ****Charpak

*bio-statistician doctor at Eval

**Sociologist at Eval

***Clinical research attaché at Eval

****Doctor in epidemiology at Eval

75, rue du Faubourg St. Antoine 75011 Paris, France

The place held by drug addiction in general practitioners practices

The number of drug addicts going to general practitioners changed in 1995. Thus, in 1995, the proportion of doctors who reported not having seen a drug addict in the last year more than doubled (32% compared to 12%), while the proportion of those who had seen over twenty drug addicts in the last dropped in half (from 15% to 6%). The average number of drug addicts seen per doctor over a one year period went from 9.4 in 1992, to 5.2 in 1995.

However, along with this apparent decrease, a phenomenon of securing loyal patients has appeared: In 1995, doctors saw former drug addicts more often, and two-thirds of them had regular drug addicted patients, compared to one-third in 1992.

Treating Drug Addicts

More than three-fourths of the doctors who see drug addicts reported that they had prescribed medicine to them. This number slightly increased in 1995 (bordering being significant). Doctors spontaneously cited fewer different products in 1995 than in 1992. Prescribing analgesics, including Antalvic and Di-Antalvic decreased and prescribing morphinics and similar products (morphinomimetics and opioides) slightly increased. There was also a clear increase in daily dosages for the most cited products (Tranxène 50, Rohypnol, Di-Antalvic, and Viscéralgine), and a strong decrease in prescribing « insufficient » doses (for example Temgesic).

Along with medicinal prescriptions, change was noted in practicing AIDS tests (twice more frequently proposed in 1995 than in 1992 (80% compared to 40%)), while tests for other sexually transmitted diseases were proposed half as often as before (but the difference is insignificant).

One last evolution that may be pointed out, was improvement in the relationship between general practitioners and institutions or the professionals to whom they possibly send their drug addicted patients (hospitals, psychiatrists, associations or specialized treatment centers). In 1992, only one-third of the doctors reported having a customary correspondent while practically all doctors had at least one usual correspondent to whom they sent their patients in 1995.

Opinions

The number of doctors who believed that general medicine has a role in treating drug addicts slightly increased (although not significantly). On the other hand, there was significant improvement in favorable attitudes towards substitute products: 52% of the doctors were fairly favorable in 1995 compared to 23% in 1992. At the same time, there was increased awareness that these products have a potential role in AIDS prevention, and delinquency which is often associated with drug addiction, as well as a role in the therapeutic arsenal.

Conclusion

Conducting two similar surveys among one-hundred general practitioners, at a three year interval, brought to light that there has been evolution in treating drug addicts. These observations are most likely related to recent upheaval in the French society's understanding of drug addiction. Implementing regulations and financing methadone programs, as well as passing legislation concerning the prescription of high doses of buprenorphine (Subutex) by general practitioners has gone together with a better perception of substitute products on the part of general practitioners, and more targeted medicinal prescriptions. The beginning of public debate indicating a transition in the status of a drug user from delinquent to an ill person, could cause general practitioners to become more implicated as a care-giver to the drug addict (patient). The results of this work seem to be taking this direction.

Methodological References

The results of two surveys, conducted using the same methodology in 1992 and 1995 were compared. The first survey concerned 120 general practitioners, practicing in one of the four regions having a high density of drug addicts (Ile-de-France, Provence-Alpes-Côtes d'Azur (PACA), Nord Pas-de-Calais and Rhone-Alpes). The second survey concerned 288 general practitioners, of which 140 were from the four regions studied in the previous survey, and was conducted all over the French territory.

The two samples were made up by drawing from France-Telecom lists, with a replacement procedure pre-established in case someone refused to answer. The interviews were conducted over the phone. 1995's questionnaire used a large part of the questions asked in 1992, so that the two surveys could be compared. The statistical analysis was performed using SAS software. Differences that are mentioned between the two periods, are those which are significant on a 5% threshold.

The rate of persons refusing to answer questions was 20% in 1992, and 30% in 1995. However, in both surveys the final sample is representative of the population of general practitioners. The selection of samples brought on a slight sub-representation of practitioners from sector 2, and an over-representation of new and women practitioners in 1995.

17.17_Harm reduction

DGS - SIDA

Above and beyond the « *threshold centers* », the harm reduction prevention policy for drug addicts usually offers prevention tools such as prevention kits, syringe exchange programs, and automated syringe distribution/recovering machines.

There are several types of prevention kits (2 1ml syringes, 1 or 2 alcohol swabs, from 0 to 2 cardboard holders, 1 or 2 doses of sterilized water, prevention messages, free numbers for AIDS information services and Drug Information Services):

- Stériboxes, only sold in pharmacies, or distributed in exchange for a token from machines placed outside pharmacies during off hours. In 1995, approximately 160,000 Stériboxes per month were sold in France.
- « Le Kit » bag, « Le Kit » box and « Le Kap » created recently and distributed in prevention programs and automatic distributors.

There are currently 51 *syringe exchange programs* which establish an initial contact with the drug user through exchanging syringes, distributing condoms, and providing prevention advice. They are particularly intended for those drug users who do not frequent, or little frequent care areas and medical-social networks. Syringe exchange program teams work closely with drug users and are most often based in a mobile unit, or bus (32). Several programs have also been implemented in association offices (9), or certain pharmacies which are actively involved in harm reduction (10). Finally, in some cases, teams are led to do « street work » in order to establish contact with drug users.

The 61 *distributors* include syringe distribution/recovery machines (a used syringe is exchanged for a « Le KAP » prevention kit), electronic machines which deliver tokens, and simple distributors (a token is exchanged for a « Stéribox » kit or a « Le Kit » box). There are also 42 simple machines designed to avoid syringes being simply discarded in public areas.

17.18_After-care

see chapter 17.13

17.19_Gender-specific issues

unavailable

17.20_Parenthood and drug use - children of drug users

unavailable

17.21_Parents of drug users

Direction des Affaires Sociales

In France, there are *58* ***listening areas for young people or parents***. These prevention units, which are financed by the state, fulfill a role of providing information to the entire public. They offer an initial host area for young people experiencing problems, in danger of drug addiction, users, their families, and those around them. This is done in order to provide support, and if necessary company for those who want it, as well as to help parents take the drama out of the situation.

17.22_Drug use in prisons

DGS - (General Health Department) - SP3 Office

- Treating drug users in prisons

The responsibility for psychiatric care in prisons has been given to public hospitals (regional medico-psychological departments - SMPR). These missions include fighting alcoholism and drug addiction. Initially, prison drug addiction units were set up experimentally within the SMPRs). Sixteen such units were thus created between 1986 and 1988. Since 1992, they have been given the status of specialised prison drug addiction treatment centres. The teams working in these structures have been placed under the technical responsibility of the hospital practitioner, head of the SMPR, and under the administrative responsibility of the attached public health establishment director. Their mission is to co-ordinate all actions favouring addicted prisoners, and to prepare them for getting out of prison. They also try to find addicts among those who have just arrived, serve as counsellors to the prison departments concerned by this problem, and interface with external institutions where drug addicts are treated.

Health reform, related to treating prisoners and to their social protection, reinforces the role fulfilled by specialised prison drug addiction treatment centres. Because of the applied reforms which give the responsibility of treating prisoners to public hospitals, **unités de consultation et de soins ambulatoires** (consultation and outpatient care units) (UCSA) are going to become involved in health treatment actions for drug addicts in co-ordination with teams from the general psychiatric sector and psychiatric sectors in prisons.

Actions within the framework of this new organisation include :

- detoxification upon entering detention
- testing and treating somatic complications linked with using toxic substances
- finding and treating psychopathological problems which are behind addictive behaviour
- continuing all forms of treatment including substitute treatments

Substitute treatments (SUBUTEX or METHADONE) which have been started before imprisonment must be continued.

Since 1996, an initiation to the SUBUTEX treatment has been possible but must fit into the framework of global and co-ordinated treatment.

Since 1996, this has been the case for METHADONE as well, for imprisoned drug addicts who are addicted to opiates, within the framework of a process of health and social integration.

Direction des Actions Sociales / Direction de l'Administration Pénitentiaire (Department of Social Action/Prison Administration

An experimental programme called **Quartier Intermédiaire Sortants** (QIS) was implemented in March, 1992, in the Fresne prison. This pilot project has spread to seven other penitentiary institutions (Lille, Lyon, Marseille, Metz, Strasbourg, Nice, and the women's prison in Fresne). One of the top priorities of the QIS is to help outbound prisoners, especially the most deprived and needy on a physical and psychological level. More particularly, it works on social treatment for drug users and other dependencies. It becomes involved during the last month in prison, and more and more during the first month after the prisoner has been liberated. It involves true group work during which global treatment enables the prisoner to recuperate the essential elements of re-discovering citizenship before leaving prison. This programme is designed to help prisoners reintegrate both socially and professionally therefore limiting re-imprisonment.

Direction de l'Administration Pénitentiaire / MILDT - (Prison Administration/MILDT

Medical-psychological sessions are led by psychiatrists and psychologists from the viewpoint of providing better institutional treatment. They are performed with probation and help committees for released prisoners (CPAL). These committees ensure that sentencing and measures decided upon by legal authorities are carried out. These sessions are also performed in prisons and jails which are not endowed with drug addiction treatment units. The role of these specialists is to use their analytical work to support teams which are being confronted by increasingly difficult situations. For the last few years, these sessions have been reoriented towards a more institutional style of treatment. This was first tried with released prisoners, and then in jails and prisons as the level of health means allotted to the establishments increased. This new orientation is an attempt to get away from fulfilling a role of direct therapeutic treatment and putting forward a more voluntary step towards the healthcare system. The MILDT finances these interventions.

17.23_Drug use at the workplace

unavailable

17.24_Other activities : documentation

Direction des Actions Sociales - (Department of Social Action)

Making **trustworthy documentation** available to the public: **Toxibase** is a computerised documentary database on drug dependency which groups 10,000 indexed documents together. A network of librarians, situated in nine different reception centres, answers requests for information or access to care. Toxibase may be accessed through any minitel or on the Internet. The Toxibase association reassesses the situation annually.

Ministére de l'Education Nationale - (Ministry of National Education)

- Lycée and Collège Administrations, in collaboration with the MILDT, publish **documents**.

- Production of two documents: developed to help principals and educational teams in their prevention operation in lycées, collèges, and primary schools. « Repères pour la prévention des conduites à risque dans les établissements scolaires », « Repères pour la prévention des conduites à risque à l'école élémentaire ».

- Production of video cassettes: The first video cassette, « la lettre à Jean », accompanied by a pedagogical booklet is distributed within the school system, but also to partners. This tool is used in training personnel. A second 32 minute video titled « Tempo solo » to be used among collège students, is in the process of being distributed. It is made up of two modules: One is designed for students in the 6th and 5th grades, the other is for students in the 4th and 3rd grades. It is designed to help adolescents become conscious of the detrimental effects of drugs through friendship with two collège students who have been confronted with this problem. The video cassette, accompanied by a pedagogical leaflet, is available in all collèges, National Education training organisations, and documentation centres as well as among partners.

MILDT

- Publishing guides: « Jalons pour des actions de prevention » - (Milestones in Prevention Actions) - analysis and indexing of new prevention tools in collaboration with the Ministère de la Jeunesse et des Sports - (Ministry of Youth and Sports).

- Publishing information brochures about Ecstasy, designed for professionals.

- Drawing up and disseminating a referential text concerning prevention for all the actors working in the prevention field (forthcoming).

Chapter 18.Evaluation, Research and Training

18.1_Evaluation

Preliminary comment: this chapter is the result of investigations in the field which have just begun, and is only partially covered.

Ministère de la Jeunesse et des Sports - (Ministry of Youth and Sports)

- A letter is sent to each department asking it to fill out an evaluation sheet containing information about its operations, in order to help foresee and define strategies and various types

of intervention. This information is useful in preparing training sessions and reinforcing the co-ordination of local interministerial operations. These evaluation sheets are filled out by

- the operating department (description of the department, diagnosis, description of operations, associated partners, involvement with youth and sports, groups addressed, covered area, expectations and evaluation of objectives, evolution in partnership's co-financing, description of the operation's total cost

- the resource person in charge of the prevention file. This part of the evaluation enables a quantitative and qualitative synthesis to be made for all local operations and to take into consideration the opinions, observations, and proposals of the resource people responsible for setting up intervention themes and strategies concerning prevention.

DGS (General Health Department)- AIDS Division

Evaluation actions are growing in importance: These are set up by the AIDS Division and are coming together little by little :

- evaluating how effective bleach is,

- evaluating prevention kits,

- evaluating the effectiveness of syringe exchange programmes through a standard activity report from associations, harmonising Syringe Exchange Programmes to be set up, and a study of a specific group of users going to a particular structure, from a public health perspective.

- asking readers (users, field workers) to evaluate the ASUD paper.

MILDT :

- All the conventions on objectives in fighting drug addiction make provisions for quantitative and qualitative instruments used to measure their effectiveness. The goal of these conventions is to strengthen co-ordination between the various governmental departments which contribute to fighting drug addiction, and to strengthen the health and social system from a legal perspective. The conventions must:

- propose adapted housing that combines a health and social presence,

- favour complementarity and coherence between the responses contributed by the various systems.

The first 15 departments which benefited from these measures, were evaluated twice: by both the prefect and the public prosecutor in 1994 and 1995. The 15 new departments will be subject to the same measures in 1997. If the evaluation conclusions are favourable, the means which were made available may be extended. From this perspective an intermediary report on the suggestions which have been implemented must be sent to the supervising ministries, so that financing can be budgeted for the following year.

- During the National Day and European week, the campaign was evaluated. A test was conducted before and after the campaign.

Direction de l'action Sociale, de l'Enfance et de la Santé de la ville de Paris. - (Department of Social Action, Childhood and Health for the city of Paris)

The city of Paris, offers an information session on drug addiction to all CM2 students. A video cassette called « Histoire de Pascal » serves as a support tool for debates which are conducted

by a medico-social team and the teacher. This action was evaluated in 1991-1992: « Evaluation de l'action « Histoire de Pascal » taught in CM2 classes during the school year 1991-1992 » Docteur L.Chérié-Challine - Docteur G.Richard, Département de Paris.

Ministère de l'Education Nationale. - Ministry of National Education

The French Observatory of Drugs and Drug Addiction has integrated a study on « Les comités d'environnement social et les conduites d'usage de drogues illicites en milieu scolaires » - (Social Environment Committees and Illicit Drug Use Behaviour in Schools » into its annual study programme. This is done by R. Ballion, Centre d'Analyse et d'Intervention Sociologiques (CADIS), CNRS - (Centre for Sociological Analysis and Intervention). Among other objectives (see chapter 18.2), the study is aimed at establishing how the Social Environment Committees are developing: how they are made up, their functioning and the effects they generate.

18.2_Research

Since 1988, the MILDT has undertaken a process of developing research on the drugs and drug addiction theme. A process of mobilising researchers was started in the form of a thematic work group which would draw up a report on the situation: this led to writing several requests for help from all of the disciplines: clinical, epidemiological, neurobiological, sociological, ethnological, legal, etc.

These research teams are generally public, and belong to large research organisations such as the INSERM and the CNRS, but also include other associated and private teams. They are financed by State funds. This is most generally done on a national level, but is sometimes done on a regional level (for example: by regional health observatories).

A research group (GDR) called « Psychotropes, politiques, société » - (Psychotropics, policies, society) was created within the Centre national de la recherche scientifique (CNRS) - (National Centre for Scientific Research), in 1993. The objectives which this group set for itself included developing the social sciences concerning psychotropic substances, favouring the setting up of a French scientific milieu in this area, and to strengthen its links with international research. In the beginning, the GDR drew together 9 laboratories, study centres, and research institutes.

This research was made known through several common channels: seminars, conferences, letters, publications (books, magazines), a French magazine « Psychotropes » - (« Psychotropics », a documentary database « Toxibase », thematic journals. A synthesis of the state of neurobiological knowledge of illicit substances consumed, was carried out. In the field of human and social sciences, work which was supervised by the Descartes association led to publishing three works falling under the general title « Penser la drogue, penser les drogues »: the current situation, prohibited drug markets, bibliographical repertory.

In addition to this general action, some ministries took their own initiatives in the field of research. Here are some examples:

Ministère de l'Education Nationale - (Ministry of National Education)

The Administration of Lycéés and Collèges carries out and co-finances studies. This year, two studies were financed :

- « Fonctionnement des collèges et prévention des conduites à risque » - (Functioning of collèges and the prevention of risky behaviour) Association de Développement d'Etudes Sociologiques et SPORTives (DESPORT) - (Association for the Development of Sociological and Athletic Studies) September, 1996. This survey is based upon the relationship maintained between risky behaviour among young people and academic life in collèges. A questionnaire

was distributed in all of the collèges, and interviews were held with various actors inside and outside of the educational community in ten schools.

- « Les comités d'environnement social (CES) et les conduites d'usage de drogues illicites en milieu scolaire » (Social Environment Committees and illicit drug use behaviour in schools)- R. Ballion, Centre d'Analyse et d'Intervention Sociologiques(Centre for Sociological Analysis and Intervention) (CADIS), CNRS. This research, financed by the OFDT is in the process of being conducted. Its goal is :

  - to establish an account of the development of CES's: their construction, functioning, and the effects they are generating,
  - to move ahead with knowledge of phenomena which are linked to illicit drug use in schools.

Two types of investigation are being used: a qualitative analysis among students in lycées and collèges and actors from inside and outside of schools, and two surveys in the form of a questionnaire focusing on a national sample of lycées and collèges having a CES, and a national sample of lycée students.

Institut National de Recherche Pédagogique / Département « politiques, pratiques et acteurs de l'éducation » / Unité « école et santé » - National Institute for Pedagogical Research/ « Politics, Practices, and Actors in education »/ »School and Health » Unit

Two types of investigation were conducted :

- Research operations within the academic arena which accompany educational teams when educational operations are implemented in schools:

  - « La prévention à l'école.- 2 - Contribution à la mise en place d'actions pour la santé au collège et au lycée, analyse de leurs dynamiques, évaluation de leurs effets. » - (« Prevention at School 2 - This contributes to implementing health-related operations in collèges and lycées, analysing their dynamics, and evaluating their effects ») N. Leselbaum, C. de Peretti - INRP - Paris - 1992 - 150 pages.
  - « La prévention à l'école. Guide-ressource des actions d'éducation à la santé liées à la prévention des cancers menées dans les lycées et collèges. » - (« Prevention at School. Resource Guide on health education actions linked to preventing cancer, which are being undertaken in collèges and lycées » N. Leselbaum - INRP - Paris - 1990.
  - « La prévention du Sida. Guide ressource des actions d'éducation à la santé liées à la prévention du Sida menées dans les lycées et les collèges. » - (AIDS prevention. Resource guide on health education actions, linked to AIDS prevention, which have been undertaken in collèges and lycées ») C. de Peretti, M. Karsenti, N. Leselbaum - INRP - Paris - AFLS - 1993.

- Studies are undertaken in order to:

  - understand the level of licit and illicit drug consumption among young students, as well as their attitudes and opinions towards the various substances,
  - to discover various prevention actions which have been implemented by National Education personnel groups (teachers, principals)

- to shed light upon decisions that have been made on a ministerial, regional, and local level,
- to adapt training programmes and sequences which are designed for adults and students,
- to start educational actions to prevent an increase in the number of persons consuming toxic substances.

These are tools for measuring the situation and helping in decision making.

Madame de Peretti conducted three studies:

- « Tabac, alcool, drogues illicites : opinions et consommations des lycéens » - (Tobacco, Alcohol, and Illicit Drugs, Lycéens' Opinions and Consumption) de Peretti, N. Leselbaum - INRP - Paris - 1995 -
- « Les attitudes et les opinions des chefs d'établissement à l'égard des toxicomanies » - (The Attitudes and Opinions of Principals Regarding Drug Addiction) N. Leselbaum (dir.) - INRP - Paris - 1991 -
- « Les lycéens des banlieues difficiles et les substances psychoactives» - (Lycéens in Problem Suburbs, and Psychoactive Substances) C. de Peretti - INRP - Paris - 1996 - (study report)

18.3_Training

Direction des Actions Sociales - (Department of Social Action)

The DAS finances training programmes in 22 regions with the help of interministerial credits. It delegates responsibility for these programmes to different associations which draw up and disseminate annual activity reports for their financing institutions. Their analyses enable the various types of implemented training programmes and the means allocated to them, to be known (awareness and information training, specific training for drug addiction specialists and for those who may deal directly with young people in danger of becoming addicted or who are already addicted, research-action activities combined with counselling activities).

MILDT / Ministère de la Jeunesse et des Sports - Ministry of Youth and Sports

- Framework for training non-professionals

Since 1987, national youth and popular education associations which are authorised to prepare directors and workers in leisure and vacation centres for obtaining their diploma, have received an additional subsidy for projects which include drug awareness training. These workshops tackle risky behaviour among young people, adolescents and adults, exclusion modes, and socialisation practices.

- Training professional field workers

These actions concern athletic teachers, socio-educational workers, community workers, and hosts in the youth information centres. They take place within the framework of youth and sports workshops for which a diploma is offered, and particularly within the framework of the State diploma for field work functions.

- Additional training for resource-persons

Each regional or departmental Youth and Sports administration has one drug addiction resource person. His/her mission is to contribute to setting up a policy in his department or region, to support local prevention actions, and to co-ordinate their implementation with multiple partners. These persons take additional workshops.

Ministère de l'Intérieur - (Ministry of the Interior)

Over the last 15 years, **police anti-drug trainers** have ensured training for their colleagues (inspectors, patrolmen) on specific techniques used in fighting drug addiction, and provided them with information on changes in legislation, practices, and orientations on an institutional level in the area of drugs. For the last several years, more and more outsiders have been requesting their services. The policy of providing information to the outside is co-ordinated by the Departmental Correspondent and Conscription Heads. It deals with different forms of drug addiction and related danger, as well as with the police's role in this area. The police met with these 400 PFADs in order to evaluate their knowledge and the way in which they deal with the subject. A handbook designed for police officer use was put together after this field survey. Its objective is to reframe the PFAD's views, so that they fit into the Ministry of the Interior's philosophy, to maintain current knowledge concerning drug use, drug trafficking, and the fight on a national and international level, and current themes. In addition, a video tool is being prepared. These PFAD are designated volunteers. They do not have a special legal status. They are initially trained for a three week period, but are not tested at the end of the session.

Ministère de l'Education Nationale - (Ministry of National Education)

There are four types of training for personnel:

- school training sessions are given when a call for training on preventing risky behaviour is made by the missions académiques de formation des personnels de l'Education Nationale - (academic training mission for National Education personnel) (MAFPEN). They are performed during the school year, and are followed up by a detailed report.
- national training sessions are held once per year, and are addressed to all people working in national education (education office, department, school). In 1996, the themes tackled during these sessions concerned relations both in and out of the classroom. Those trained constitute a support network for further field actions.
- summer university sessions are held every year and deal with research concerning prevention.
- A section on violence has been included in training future teachers in Instituts Universitaires de Formation des Maîtres (University Training Institutes for Masters) (IUFM). At this time, the theme of drug addition prevention may be brought up.

National Gendarmerie

Relay Anti-Drug Trainers (FRAD) have been conducting prevention operations since 1990. These operations are addressed to different audiences: internally, to co-gendarmes in the various departments, and externally to young students and adults. Relay Trainers carry out this mission on a voluntary basis, outside of their regular work schedule. Most of them are non-commissioned officers, belonging to a unit of more than 10 gendarmes,but self-motivation is as

important a criterion as rank. The FRAD take an intensive 15-day workshop to prepare them for their mission.

Direction de l'Administration Pénitentiaire - (Prison Administration):

Every year, continuing and organising numerous anti-drug operations is made possible by credits from the MILDT. This applies to both the Ecole nationale d'administration pénitentiaire (National Prison Administration School) (ENAP) and to a decentralised level in the various regions and for available services. These training sessions provide an area for exchanging information on prevention and problems which are linked to drug addiction and AIDS.

- The ENAP performs awareness and information operations for future supervisors, teachers, and assistant principals, as well as for students who will become « anti-drug trafficking trainers ». Several training sessions per year are designed to provide information to « further education» personnel. As a general rule, it is designed to target two objectives: to prevent and limit drug trafficking in prisons and jails, and to improve treatment for prisoners by developing networking with other professionals (particularly health professionals). This training is mandatory in order to help the various personnels update their knowledge, and to avoid letting addictive behaviour become commonplace.

- The nine regional departments, and the overseas departments and territories mission, all manage the budget they receive. They are capable of implementing innovative training operations. An example of this is the Regional Department in Strasbourg. It has developed training sessions which enable supervisors, social workers and management personnel to exchange information about their experience in treating drug addicts in the prison environment, with their Belgian, Dutch, and Luxembourgeois counterparts.

- Preventing drug addiction also comes through globally understanding the health concept. Since 1990, educational health-related actions have been developed for prisoners.

- A symposium on « Health Education in Prisons and Jails » was held in Paris in 1995. It was co-financed by the Administration Pénitentiaire (prison administration), the Ministère de la Santé (Ministry of Health), the Comité français d'éducation à la santé (French Committee on Health Education) (CFES), and the Ecole nationale de la santé publique (National School for Public Health) (ENSP). It brought together all of the professionals concerned by this problem, and enabled several remarkable prevention-oriented and health educational operations to be promoted among prisoners. A methodological guide, which will make it possible to spread these initiatives to all the establishments, is in the process of being written.

Chapter 19.Developments and Information Needs

see chapters 16,17 and 18.

CONCLUSIONS

What emerged from this work, was the fact that there are several gaps in our knowledge of drugs and drug addiction. Certain of the following work orientations would help find a solution to this problem in a certain measure. On one side, the global system of knowledge of drugs and drug addiction, which is currently essentially based upon statistical institutional sources, must be reinforced by:

- setting up an observational system for drug use in the general population - the only valid way of estimating the amount of this use and a methodological base for more targeted studies on specific categories of use;

- launching a longitudinal monitoring system for describing the dynamics (trajectories) of drug use, drug addiction, and their consequences.

On the other side, this global perception should be enriched by a study programme on more precise aspects. The Observatory, which is responsible for running and co-ordinating the field of studies and research, is currently determining priority orientations for the coming years together with its statuary organisations (management board and scientific college) articulated with initiatives that are being developed elsewhere:

- Ministère de la Recherche (Ministry of Research)

- INSERM and MILDT Intercommission

- GDR « Psychotropes, politique et société » - (Psychotropics, policy and society) at the CNRS

Therefore, two appeals will be launched in 1997. The first, launched by the MILDT and the INSERM « comportements en matière de consommation » - (consumption behaviours) intercommission, is based upon the following themes:

- Factors of protection from and vulnerability towards addiction.
- Temporality of behaviours and consumption.
- Forms of supply and the impact on consumption.
- Health and consumption behaviour.
- Analysis and evaluation of public policies and their determining factors.

The second, launched by the OFDT is based upon the following themes:

- Mortality-morbidity of drug addicts.
- Public policies.
- Types of use and behaviours.
- Knowledge of populations and trajectories.
- Trafficking.
- Evaluating actions.

ANNEXES

Mobilized network

Centre européen pour la surveillance épidémiologique du SIDA (CESES)

Centre français d'éducation pour la santé (CFES)

Commission des stupéfiants et psychotropes

Drogues Info Service (DIS)

Fédération nationale des observatoires régionaux de la santé (FNORS)

Groupement de recherche "Psychotropes, Politiques et Société" du CNRS (GDR PPS)

Institut national de la santé et de la recherche médicale (INSERM) : unités 169 et 302

Institut national de la statistique et des études économiques (INSEE)

Institut de recherche en épidémiologie de la pharmacodépendance (IREP)

Observatoire européen des drogues et des toxicomanies (OEDT)

Réseau national de santé publique (RNSP)

Réseau national de documentation sur les pharmacodépendances (TOXIBASE)

Société d'entraide et d'action psychologique (SEDAP)

ADMINISTRATIONS

Premier Ministre

Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT)

Secrétariat Général du Comité interministériel pour les questions de coopération économique européenne (SGCI)

Ministère de la défense

Direction centrale du service de santé des armées (DCSSA)

Direction générale de la gendarmerie nationale (DGGN)

Ministère de l'économie et des finances

Direction générale des douanes et des droits indirects (DGDDI) : Sous-direction des affaires juridiques et contentieuses et de la lutte contre la fraude, bureau D/3

Ministère de l'intérieur

Mission de lutte anti-drogue (MILAD)

Office central pour la répression du trafic illicite des stupéfiants (OCRTIS)

Ministère de la justice

Direction de l'administration générale et de l'équipement (DAGE) : Sous-direction de la statistique, des études et de la documentation (SED)

Direction de l'administration pénitentiaire (DAP) : Service de la communication, des études et des relations internationales (SCERI)

Direction des affaires criminelles et des grâces (DACG) : Sous-direction de la justice criminelle, bureau de la protection des victimes et de la prévention

Ministère du travail et des affaires sociales

Direction générale de la santé (DGS) : bureau SP3, division SIDA

Service des statistiques des études et des systèmes d'information (SESI) : bureau ST2

Ministère de l'aménagement du territoire, de la ville et de l'intégration et Ministère du travail et des affaires sociales

Direction de l'action sociale (DAS) : bureau DSF1

Contributions to this report

Director of Publication

Jean-Michel COSTES directeur de l'OFDT

Supervision and Writing

Chloé CARPENTIER responsable des travaux statistiques à l'OFDT
Annie VELTER chargé d'études à l'OFDT

Group Project Members

Delphine ANTOINE Ministère du travail et des affaires sociales, SESI
Gérard CAGNI SEDAP - TOXIBASE
Françoise FACY INSERM Unité 302
Isabelle GREMY ORS Ile-de-France
François-Rodolphe INGOLD IREP
Dominique PECHEUX Ministère de l'intérieur, OCRTIS
Michel SCHIRAY CNRS - CIRED - GDR PPS

Authors of Articles

Gilles AZOULAY
Juliette BLOCH
Yves CHARPAK
Marie CHOQUET
Françoise FACY
Jean-Dominique FAVRE
François-Rodolphe INGOLD
Sylvie LEDOUX
Clary MONAQUE
Françoise NORY-GUILLOU
Mohamed TOUSSIRT

Thanks for their participation

Jacques ABGRALL
Annick ANDRIER
Claude ANFRAY
Pierre ANGEL
Jacques ARENES
Elisabeth AUBOURG
Nicole BARANGER
Denise BARRIOLADE
Marie-Danièle BARRE
Jean BEGUE
Dominique. BILLET
Jean-Pierre BOMPEIX
Azzédine BOUMGHAR
Yvan CHAZALVIEL
Baptiste COHEN
Sylvain DALLY
Véronique DECOLLE
Jean-Pierre DESCHAMPS
Jean-Marie DEVEVEY
Carle DOUTHEAU
Franck DUBIN
Eric DUSSEUX
Philippe EONO
Alain EPELBOIN
Alain EHRENBERG
Claude FAUGERON
Georges FRAGA
Jean FRANCKA
Nathalie FRYDMAN
Dominique de GALARD
Bertrand GARROS
Michel GAUTHIER
Danielle GRIZEAU
Karine GROUARD
Nicole GUIGNON
Christine GUYOMAR
Jean-Bernard HARTH
Françoise HATTON
Roger HENRION
Marie-Pierre HOURCADE
Claude JACOB
Marie-Pierre JOLY
Claude JOUVEN
Annie KENSEY
Pierre KOPP
Bernard LAFONT
Brigitte LAFOURCADE
Georges LAGIER
Eusèbe LALEYE
Frédéric LE CARVAL
Michel LECOLLE
Laurence LEFEVRE
Bernard LEGOUEIX
Octave LEPRETRE
France LERT
René LEVY
Jean-PatrickLOUBOUTIN-CROC
Jon MAGNUS
Kamel MALEK
Danielle MILLION
Frédérique MILLION
Hélène MORFINI
Françoise MOYEN
Nadine NEULAT
René PADIEU
Christiane. de PERETTI
Elda PHILIPPE
Jean-Claude PHILIPPE
Josianne PILLONEL
Murielle RABORD
Jean-Loup REY
Philippe. RIO
Jean-François RIOUFOL
Nathalie ROUFFIAC
Carole RUBINO
Valérie SAGAN
O. SAMPEUR
Patrick SANSOY
N. du SAUSSOIS
Caroline SIX
Odile TIMBART
Alain TOURRE
Marc VALLEUR
Danielle VASSEUR
Delphine VIGUIER

General bibliography

The works cited here-below are both general and transversal works dealing with drugs and drug addiction. A more specific bibliography of the different subjects approached in the report can be consulted on each subject sheet.

• Répertoire des sources statistiques sur les drogues et les toxicomanies, OFDT, nouvelle édition à paraître.
• Drogues et toxicomanies : indicateurs et tendances, édition 1996, OFDT, Paris, décembre 1996.
• Rapport au Ministre de la Justice et au Secrétaire d'Etat à la Santé sur : infections à VIH, hépatites, toxicomanies dans les établissements pénitentiaires et état d'avancement de la loi du 18 janvier 1994, Marc GENTILINI, Jean TCHERIATCHOUKINE, novembre 1996.
• Rapport au Ministre de la Justice du groupe de travail sur la lutte contre l'introduction de drogues en prison et sur l'amélioration de la prise en charge des toxicomanes incarcérés, Inspection générale des services judiciaires, juillet 1996.
• Rapport d'information : entre répression, tolérance et permissivité, la politique des Pays-Bas en matière de toxicomanie, Michel GHYSEL, Assemblée Nationale, mars 1996.
• Rapport sur la convention d'application de l'accord de SCHENGEN, Paul MASSON, Sénat, janvier 1996.
• Livre blanc, Sécurité routière, Drogues licites ou illicites et médicaments : rapport au Premier ministre, Sous la présidence de G. LAGIER, La documentation française, Paris, 1996.
• Drogues et Toxicomanies : Indicateurs et tendances - Edition 1995, C. Carpentier et J.M. COSTES, OFDT-DGLDT, Paris, 1995.
• Rapport de la commission de réflexion sur la drogue et la toxicomanie, Sous la présidence de R. HENRION, Ministère des Affaires Sociales de la Santé et de la Ville, La documentation française, Paris, 1995.
• La santé en France : rapport du Haut Comité de Santé Publique, La documentation française, Paris, novembre 1994.
• Rapports du Comité Consultatif National d'Ethique pour les Sciences de la Vie et de la Santé sur les toxicomanies, Paris, 23 novembre 1994.
• L'information statistique sur les drogues et les toxicomanies, R. PADIEU, DGLDT, La documentation française, Paris, 1994.
• Le système d'information statistique français sur les drogues et les toxicomanies en 1994 - description sommaire et propositions d'action, J.-M. COSTES, DGLDT-OFDT, Paris, octobre 1994.
• Etude multi-villes : tendances de l'abus de drogues dans treize villes européennes, Conseil de l'Europe, Strasbourg, 1994.
• La demande sociale de drogues, Sous la direction de A. OGIEN et P. MIGNON, DGLDT, La documentation française, Paris, 1994.
• Penser la drogue penser les drogues : état des lieux, Textes réunis par A. EHRENBERG, Editions Descartes, Paris, 1992.
• Colloque réseau-INSERM "toxicomanie - santé publique" 14 et 15 mai 1992 - Dijon, édité par F. FACY et G. CAGNI, Dijon, 1992.
• Lutte contre la toxicomanie et le trafic des stupéfiants : rapport au Premier ministre, C. TRAUTMANN, La documentation française, Paris, 1990.
• Rapport de la mission d'étude sur l'ensemble des problèmes de la drogue, M. PELLETIER, La documentation française, Paris, 1978.
• Psychotropes : revue internationale des toxicomanies, publication trimestrielle, Masson, Paris.
• Toxibase : revue documentaire, publication trimestrielle, Toxibase, Lyon.

Acronyms

AFLS: Association Française de Lutte contre le SIDA (French Association for the Fight against AIDS)
BEH: Bulletin Epidémiologique Hebdomadaire (Weekly Epidemiological Bulletin)
BEP: Brevet d'Etudes Professionnelles (Certificate of Professional Studies)
CAGE: Cut Annoyed Guilty Eyes-opener
CAP: Certificat d'Aptitude Professionnelle (Certificate of Professional Aptitude)
CESDIP: Centre de Recherches Sociales sur le Droit et les Institutions Pénales (Center for Social Research on Law and Legal Institutions)
CESES: Centre Européen pour la Surveillance Epidémiologique du SIDA (European Center for the Epidemiological Monitoring of AIDS)
CFES: Comité Français d'Education pour la Santé (French Center for Health Education)
CHRS: Centre d'Hébergement et de Réadaptation Sociale (Center for Housing and Social Readjustment)
CIRED: Centre International de Recherche sur l'Environnement et le Développement (International Research Center on the Environment and Development)
CJN: Casier Judiciaire National (National Police Record)
CRIPS: Centre Régional d'Information et de Prévention du SIDA (Regional Information and Prevention Center for AIDS)
DACG: Direction des Affaires Criminelles et des Grâces (Department of Criminal Affairs and Pardons)
DAS: Direction de l'Action Sociale (Department of Social Services)
DCSSA: Direction Centrale du Service de Santé des Armées (Central Management for the Military Health Department)
DDASS: Direction Départemental de l'Action Sanitaire et Sociale (Departmental Management for Health and Social Action)
DETA: Diminuer Entourage Trop Alcool
DGLDT: Délégation Générale à la Lutte contre la Drogue et la Drug addiction (General Delegation for the Fight against Drugs and Drug Addiction)
DGS: Direction Générale de la Santé (General Health Department)
DIS: Drogues Info Services (Drug Information Services)
EVAL: Bureau d'Etudes Evaluation Médicale, Médico-sociale, Santé Publique (Office for Medical Evaluation, Medico-Social, and Public Health Studies)
GAFI: Groupe d'Action Financière International (International Financial Action Group)
GDR PPS: Groupement de Recherche « Psychotropes Politique et Sociétés » (Psychotropic Drugs, Policies, and Society Research Group)
GRASS: Groupe de Recherche et d'Analyse du Social et de la Sociabilité (Research and Analysis Group for Social Issues and Sociability)
IHE: Institut de l'Hygiène et de l'Epidémiologie (Hygiene and Epidemiology Institute)
ILS: Infraction à la Législation sur les Stupéfiants (Drug-related Offense)
INRA: Institut National de la Recherche Agronomique (National Institute for Agronomic Research)
INSEE: Institut National des Statistiques et des Etudes Economiques (National Institute for Statistics and Economic Studies)
INSERM: Institut National de la Santé et de la Recherche Médical (National Institute for Health and Medical Research)
IREP: Institut de Recherche en Epidémiologie de la Pharmacodépendance (Research Institute for Drug Addiction Epidemiology)
MILDT: Mission Interministérielle de Lutte contre la Drogue et la Drug addiction (Interministerial Mission for the Fight against Drugs and Drug Addiction)
OCRGDF: Office Central de la Répression de la Grande Délinquance Financière (Central Office for the Repression of Grand Financial Delinquency)

OCRTIS Office Central pour la Répression du Trafic Illicite de Stupéfiants (Central Office for the Repression of Drug-Related Offenses)
OFDT: Observatoire Français des Drogues et des Toxicomanies (The French Monitoring Center for Drugs and Drug Addiction)
OMS: Organisation Mondiale de la Santé (World Health Organization)
ORS: Observatoire Régional de la Santé (Regional Health Observatory)
ORSIF: Observatoire Régional de la Santé d'Ile -de-France (Regional Health Observatory for Ile-de-France)
PACA: Provence-Alpes-Côtes d'Azur (Provence-Alpes-Côte d'Azur)
PNUCID: Programme des Nations Unies pour le Contrôle International de Drogues (United Nations Program for International Drug Control)
RMI: Revenu minimum d'Insertion (Minimum benefit paid to those with not other source of income)
RNSP: Réseau National de la Santé Publique (National Public Health Network)
SCERI (FND): Service de la Communication, des Etudes et des Relations Internationales (Fichier National des Détenus) (Division - Communications, Studies, and International Relations (National Prisoner File))
SED: Sous-Direction des Statistiques, des Etudes et de la Documentation (Sub-division - Statistics, Studies, and Documentation)
SEDAP: Société d'Entraide et d'Action Psychologique (Society for Help and Psychological Action)
SESI: Service des Statistiques, des Etudes et des Systèmes d'Information (Department of Statistics, Studies, and Information Systems)
SMPR: Service Médico-Psychologique Régional (Regional Medico-Psychological Service)
SOFRES: Société Française d'Enquêtes par Sondages (French Survey Group)
TRACFIN: Traitement du Renseignement et Action contre les Circuits Financiers clandestins (Processing of Information and Action against Clandestine Financial Circuits)
UDVI: Usager de Drogue par Voie Intraveineuse (Intravenous Drug User)
VHC: Virus de l'Hépatite C (Hepatitis C Virus)
VIH: Virus de l'Immuno déficience Humaine (HIV)

LAW ENFORCEMENT FOR DRUG-RELATED OFFENSES IN FRANCE

Law enforcement

offenses

MILDT - MILAD

Texts	Incriminations	Penalties
Public health code L. 628	- illicit drug use	- 1 year imprisonment - 25 000 francs fine
Public health code L. 630	- provoking a crime provided for in article L. 628 of the Public Health Code or an offense provided for in articles 222.34 to 222.39 of the penal code even if this provocation had no effects - showing these offenses in a more pronusing light - provoking (with or without effects) the use of substances shown as having the same effects as drugs	- 5 years imprisonment - 500 000 francs fine
New penal code Art. 222-39 1st paragraph	- supplying or selling for personal use	- 5 years imprisonment - 500 000 francs fine
Art. 222-39 2nd paragraph	- supplying or selling to minors in schools or administration premises	- aggravating circumstances 10 years imprisonment
New penal code Art. 227-18 1st paragraph	- inciting a minor to take drugs	- 5 years imprisonment - 700 000 francs fine
New penal code Art. 227-18 2nd paragraph	- aggravating circumstances : minors under 15 years old	- 7 years imprisonment - 1 000 000 francs fine
New penal code Art. 227-18-1 1st paragraph	- inciting a minor to traffic drugs (transporting, supplying, selling)	- 7 years imprisonment - 1 000 000 francs fine
New penal code Art. 222-18-1 2nd paragraph	- aggravating circumstances : minors under 15 years old	- 10 years imprisonment - 2 000 000 francs fine
New penal code Art. 222-37 1st paragraph	- illicit drug transporting, holding, supplying, selling, purchasing, using	- 10 years imprisonment - 50 000 000 francs fine
Art. 222-37 2nd paragraph	- facilitating drug use (false prescription, or complicity)	
Art. 222-36 1st paragraph	- importing or exporting illicit drugs	
New penal code Art. 222-39-1	- fait de ne pas pouvoir justifier de ressources correspondant à son train de vie tout en étant en relation habituelle avec une personne se livrant au trafic ou à l'usage de stupéfiants	- 5 years imprisonment - 500 000 francs fine
Art. 222-39-1 2nd paragraph	- aggravating circonstances : minors	- 10 years imprisonment - 500 000 francs fine
New penal code Art. 324-1	- money laundering (whatever the offenses)	- 5 years imprisonment - 2 500 000 francs fine
New penal code Art. 324-2	- laundering aggravated : 1 - usually committed or committed in the exercice of his duties 2 - committed by an organized group	- 10 years imprisonment - 5 000 000 francs fine
New penal code Art. 222-38 1st paragraph	- money laundering from drugs trafficking (importation, purchasing, selling, transportation, supplying)	- 10 years imprisonment - 5 000 000 francs fine
NB. Attempted crimes are punishable by the same sentences under articles 222-36 to 222-39 (Art. 222-40 in the new penal code)		

crimes

MILDT - MILAD

Texts	Incriminations	Penalties
New penal code Art. 222-35 1st paragraph	- illicit drug production or fabrication	- 20 years imprisonment - 50 000 000 francs fine
Art. 222-35 2nd paragraph	crimes committed by an organized group	- up to 30 years imprisonment
New penal code Art. 222-36 2nd paragraph	- illicit drug importing or exporting by an organized group	- 30 years imprisonment - 50 000 000 francs fine
New penal code Art. 222-34	- running or organizing a group whose goal is illicit drug production, fabrication, importation exportation, transportation, holding, supplying, selling, purchasing or using	- life imprisonnement - 50 000 000 francs fine
New penal code Art. 222-38 2nd paragraph	- money laundering from crimes cited in the below mentioned article (222-34, 222-35, 222-36 2nd paragraph)	- from 20 years to life imprisonment - 50 000 000 francs fine

Additional sentences may be added to any one of these sentences such as forbidding someone to stay in or come to a French territory, suspending civil rights

LIST OF LEGAL TEXTS RELATED TO THE HEALTH AND SOCIAL TREATMENT OF DRUG ADDICTS

-Loi n° 70-1320 du 31 décembre 1970 (modifiée) relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses.

Décret n° 71-690 du 19 août 1971 fixant les conditions dans lesquelles les personnes ayant fait un usage illicite des stupéfiants et inculpées d'infraction à l'article L.628 du code de la santé publique peuvent être astreintes à subir une cure de désintoxication.

-Décret n°87-328 du 13 mai 1987 portant suspension des dispositions du décret n°72-200 du 13 mars 1972 réglementant le commerce et l'importation des seringues et des aiguilles destinées aux injections parentérales en vue de lutter contre l'extension de la toxicomanie.

-Décret n°89-560 du 11 août 1989 modifiant le décret du 13 mars 1972 réglementant le commerce et l'importation des seringues et des aiguilles destinées aux injections parentérales en vue de lutter contre l'extension de la toxicomanie.

-Décret n° 90-657 du 25 juillet 1990 modifiant le décret n° 89-380 du 6 décembre 1989 portant création du comité interministériel de lutte contre la drogue et de la délégation générale à la lutte contre la drogue.

-Décret n° 92-590 du 29 juin 1992 relatif aux centres spécialisés de soins aux toxicomanes.

-Décret n° 94-1030 du 2 décembre 1994 relatif aux conditions de prescription et de délivrance des médicaments à usage humain et modifiant le code de santé publique.

-Décret n° 95-255 du 7 mars 1995 modifiant le décret n° 72-200 du 13 mars 1972 réglementant le commerce et l'importation des seringues et des aiguilles destinées aux injections parentérales en vue de lutter contre l'extension de la toxicomanie.

-Décret n° 96-350 du 24 avril 1996 relatif au comité interministériel de lutte contre la drogue et la toxicomanie et à la mission interministérielle de lutte contre la drogue et la toxicomanie.

-Arrêté du 26 janvier 1988 relatif aux établissements agréés pour la cure de désintoxication prévue aux articles L 355-16 et L 355-19 du code de la santé publique.

-Arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants.

-Arrêté du 23 juillet 1992 fixant le modèle de convention-type relative aux centres spécialisés de soins aux toxicomanes de statut associatif.

-Arrêté du 26 août 1992 fixant la composition du dossier de demande exigé lors de la création et de l'extension d'un centre spécialisé de soins aux toxicomanes.

-Arrêté du 26 août 1992 fixant le modèle de convention-type relative aux centres spécialisés de soins aux toxicomanes gérés par un établissement public de santé.

-Arrêté du 18 août 1993 relatif aux réseaux de familles d'accueil pour toxicomanes gérés par des centres de soins conventionnés spécialisés pour toxicomanes.

-Arrêté du 15 septembre 1993 fixant le modèle d'avenant conventionnel type relatif aux sections d'appartements thérapeutiques-relais des centres spécialisés de soins aux toxicomanes de statut associatif.

-Arrêté du 7 mars 1994 relatif à la création et à la composition de la commission consultative des traitements de substitution de la toxicomanie.

-Arrêté du 7 mars 1995 relatif aux conditions de mise en oeuvre des actions de prévention facilitant la mise à disposition, hors du circuit officinal, des seringues stériles.

-Arrêté du 28 mars 1995 modifiant la liste des spécialités pharmaceutiques remboursables aux assurés sociaux.

-Circulaire DGS/SD 2D/90/7 du 2 octobre 1990 relative au contrôle du remboursement par l'état des frais de sevrage réalisé en milieu hospitalier pour les toxicomanes.

-Circulaire n° 56 DGS/2D du 6 octobre 1992 concernant le décret n°92-590 du 29 juin 1992 relatif aux centres spécialisés de soins aux toxicomanes.

-Circulaire interministérielle du 14 janvier 1993 relative à la mise en oeuvre de conventions d'objectifs de la lutte contre la toxicomanie.

-Circulaire DGS du 15 février 1993 relative à la lutte contre la toxicomanie : l'injonction thérapeutique.

-Circulaire DGS n°14 du 7 mars 1994 relative au cadre d'utilisation de la méthadone dans la prise en charge des usagers de drogues.

-Circulaire DGS - DH n°15 du 7 mars 1994 relative aux lits réservés pour les cures de sevrage dans les services hospitaliers et au développement des réseaux ville-hôpital, dans le cadre de la prise en charge des usagers de drogues.

-Circulaire DH/DGS/DSS/DAP n°45 du 8 décembre 1994 relative à la prise en charge sanitaire des détenus et à leur protection sociale et guide méthodologique.

-Circulaire DGSn°04 du 11 janvier 1995 relative aux orientations dans le domaine de la prise en charge des toxicomanes en 1995.

-Circulaire DGS/SP3/95 n°29 du 31 mars 1995 relative au traitement de substitution pour les toxicomanes dépendants des opiacés

-Circulaire DGS n°37 du 12 avril 1995 relative à la prévention des risques infectieux chez les usagers de drogues par voie intraveineuse et à l'accessibilité au matériel d'injection stérile.

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

-Circulaire DGS/DH/DAP n° 739 du 5 décembre 1996 relative à la lutte contre l'infection par le virus de l'immunodéficience humaine (VIH) en milieu pénitentiaire : prévention, dépistage, prise en charge sanitaire, préparation à la sortie et formation des professionnels.

-Décision du 28 mars 1995 portant inscription sur la liste des spécialités pharmaceutiques agréées à l'usage des collectivités et divers services publics.

-Règlement CEE n°302/93 du 8 février 1993 relatif à la création de l'observatoire européen des drogues et des toxicomanies.